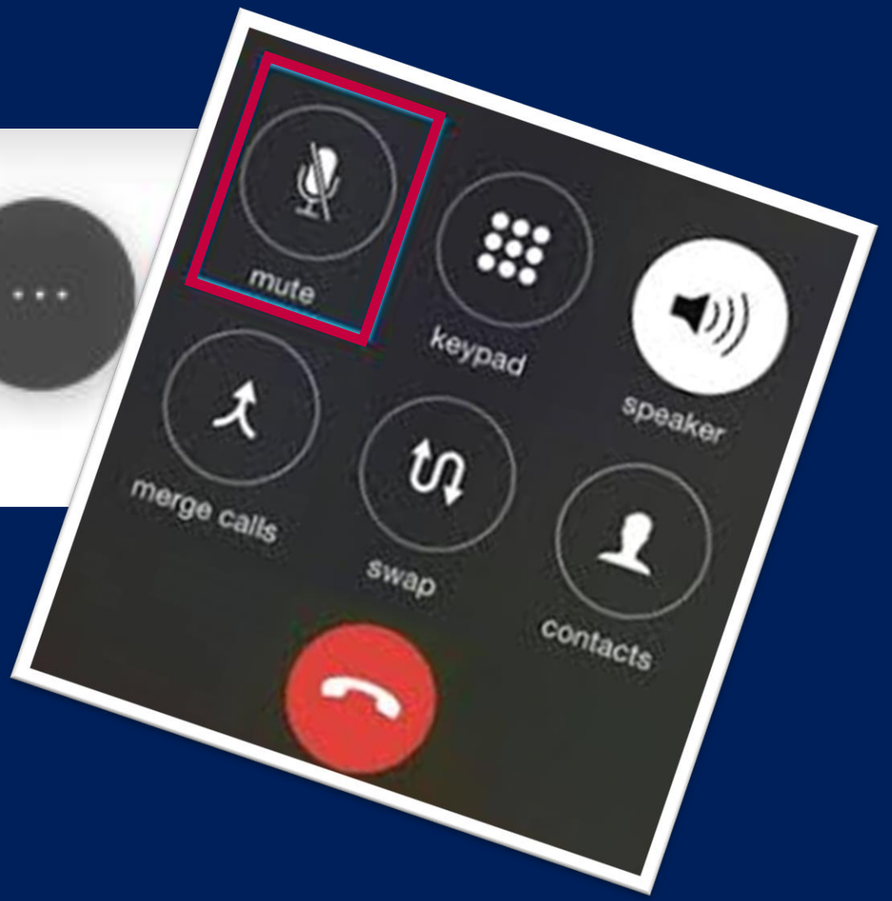
Welcome!

Please mute your phone and computer microphone and disable your webcam during this presentation



1st Quarterly MSHO/MSC+ Meeting

March 10, 2021

Agenda

- Delta Dental – Janis Brandt
- M Health FV Caregiver Assurance – Cindy Swanson
- REEMO Activity Tracker – Nicole Charboneau
- WW and Memory Kits – Shoua Vang
- MSHO Incentive/Voucher Updates – Nicole Lier
- MSHO STARS Update – Rachel Sterner
- CFSS Update – Esther Versalles-Hester
- ICLS Overview – Dawn Sulland
- Care Coordination Updates – Dawn Sulland

Delta Dental Care Coordination

Your partner in care for MHCP members

March 2021

DELTA DENTAL®

History of Dental Care Coordination

- It was realized that Minnesota Health Care Programs (MHCP) members would benefit from receiving care coordination assistance not only with their medical requests, but with their dental requests as well

- A Dental Care Coordination program was established in order to assist members in their search of dental services

The work we do

DELTA DENTAL®

Partnering with Medical Care Coordinators

- Dental Care Coordinators (DCCs) partner with Medical Care Coordinators (MCC) and Case Managers from the health plans and counties to assist members in finding and receiving the dental care they need

- The DCC team's purpose is to assist MHCP members in finding a provider who will meet their needs and work with the member and dental office to schedule an appointment, including transportation and interpretation services as needed

Partnering with Medical Care Coordinators

- The DCC team provides Enhanced Care Coordination for UCare members
- Every member looking for a dental provider and/or an appointment is warm transferred from Customer Service to Care Coordination
- The only time members are given a list of provider names is if they decline scheduling assistance
- DCCs also make reminder and follow-up calls, ensuring members are successful with their dental appointments

Making a successful Care Coordination request

- When calling the DCC team, it is best if the member can participate in the call. If the member is not available, the MCC will need to know:
  - Information related to the member's dental needs
    - Does the member need a check-up and cleaning, or are they experiencing a specific issue?
    - If they are experiencing a dental issue:
      - Where is it located (upper right, lower left, front, back, etc.)?
      - Is the member experiencing pain, swelling, or bleeding?

Making a successful Care Coordination request

- What is the member's schedule?
- Does the member need to utilize interpreter benefits?
  - If the member needs an interpreter:
  - What language will the interpreter need to speak?
  - Does the member have a gender preference for their interpreter?

Making a successful Care Coordination request

- Does the member need to utilize transportation benefits?
  - If the member needs transportation to and from their appointment:
  - Where is the pick-up location? Home, work, etc.?
  - Will the member be traveling alone, or will someone be with them?
    - If it is a child, do they need a car seat?

Making a successful Care Coordination request

- Is the member ambulatory, or do they use a walker or wheelchair?
- Does the member need special transportation?
- Does the member have a transportation provider they prefer?
- Does the member need to bring a therapy animal along to their appointment?

How we work with you

- Once the MCC has described the member's needs, the DCC will review claim history to determine if there was a general dentist seen in recent history
- This is to identify:
  - If the member would like to return to the practice
  - If the member would prefer a new provider
    - If the member would prefer a new provider, the DCC will verify the area of provider search

How we work with you

- The DCC will offer appropriate provider options, and once the member decides on an office, the DCC will:
  - Conference call the provider office
    - Connect all parties, introducing the call
    - Assist the member and MCC in answering the provider’s questions

How we work with you

- Once an appointment is secured, the DCC will ask the member and the MCC to remain on the line, and will then disconnect with the dental office
- The DCC will review appointment details, answer questions, and ensure all of the member’s needs are met before closing the call

Challenges for DDMN's team

- Some requests are more difficult than others for DCCs to fulfill:
  - Requests to work with family members of adults members; or for minor members, other, non-custodial family members such as grandparents, or an older sibling when they are not listed in our system as a designated representative
    - At this time, designated representative information is not coming over to DDMN from UCare

Challenges for DDMN's team

- MCC requests that the DCC reach out to a member with provider information, or to offer scheduling assistance
  - Care Coordination is primarily an inbound call center; outbound calling in this capacity is not the team's focus

Questions?

DELTA DENTAL®

UCare MSHO-Caregiver Assurance

with M Health Fairview

HEALTH FAIRVIEW

A collaboration among the University of Minnesota,
University of Minnesota Physicians and Fairview Health Services

Agenda

Introduction
History & Statistics
Services
Eligibility
Referral Process
Summary

Introduction

Caregiver Assurance History

- December of 2017-availability to community at cost of $300 for 6 months
- March of 2018-available as Wellness Benefit at no cost to employees

  M Health Fairview & HealthEast

  Preferred One
- January of 2021 available through UCare programs
  - UCare MSHO
  - UCare Medicare plans-only 2 (Care Core & Care Advantage)

Caregiver Statistics

- 4 in 10 adults are caregivers
- 34% of caregivers are caring for 2 or more individuals
- Average age is 49
- 66% of caregivers are female
- Care provided is 80 plus hours per month of direct care & 13 hours per month in coordination
- Sandwich generation

Services

- Assigned Caregiver Advisor who is a licensed social worker
- Emotional support & validation
- Referrals to resources both within M Health Fairview & outside of M Health Fairview
- Assist in navigation
- Education
- Self-care techniques/tools

All contact with caregiver is done telephonically or by email. There is no limit to number of contacts per month. Caregiver can use the program as many months at they want in a year.

Caregiver Assurance for UCare MSHO

Website that provides a description of the program.

https://www.caregiverassurance.com/ucare/CaregiverAssuranceMSHO

There is a FAQ found at
https://www.caregiverassurance.com/UCare/CaregiverAssuranceMSHO/FAQ

Questions answered are:

Who is eligible to use this program?

What if I don’t meet the MSHO program eligibility requirements?

How can I get started?

Are interpreter services available for non-English speaking members?

Who is eligible

- UCare MSHO member, or the caregiver of the member
- UCare MSHO member must have a diagnosis of amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS) or Parkinson’s or have dementia

How to refer

- By completing the referral form found at https://surveynet.fairview.org/redcap/surveys/?s=83NTYCM7AR.
- By calling 612-672-7996. (You will be asked for all the information that is required on the referral form)
- By sending an email to **CaregiverCoach@Fairview.org** (It will be sent to DEPT-CORP-CAREGIVER-ASSURANCE-SUPPORT & you will be contacted to provide the needed information.)

Please note that members/caregivers must be referred by their care coordinator.

When a caregiver is referred there must be a form on file showing that caregiver is the authorized representative of the member.

Snapshot of referral

Resize font:

A collaboration among the University of Minnesota,
University of Minnesota Physicians and Fairview Health Services

UCare 2021 Programs: Care Coordination Referral Form

Thank you for your referral to the M Health Fairview program offerings for UCare members in 2021. If preferred, you may contact the program advisors directly.

For UCare Medicare with M Health Fairview and North Memorial Health members interested in Wellness Advisor or Caregiver Assurance, call (612) 672-7995. For UCare MSHO members interested in Caregiver Assurance, call (612) 672-7996.

Program Selection

Please select the plan and program you wish to refer a member to:

* must provide value

- MSHO Plans: Caregiver Assurance
- Care Core and Care Advantage plans: Wellness Advisor
- Care Core and Care Advantage plans: Caregiver Assurance

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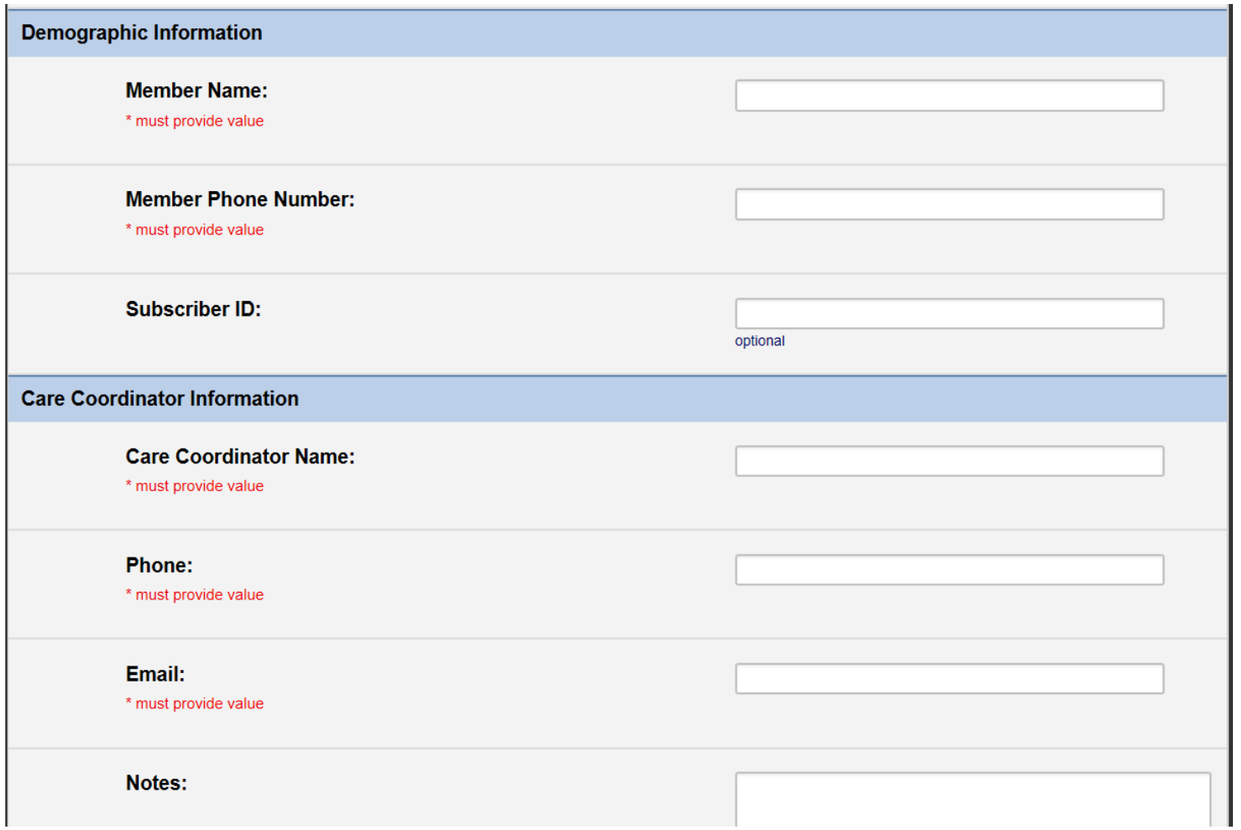


Demographic Information

Member Name:
* must provide value

Member Phone Number:
* must provide value

Subscriber ID:
optional

Care Coordinator Information

Care Coordinator Name:
* must provide value

Phone:
* must provide value

Email:
* must provide value

Notes:

What happens after referral is sent

- Caregiver Advisor will contact the member or caregiver within 2 business days of the referral being sent.
- Documentation is done in RedCap & Caregiver Assurance's portal.
  (No documentation will be found in EPIC.)
- In Epic, Caregiver Advisor will be added to the member's care team.
- Communication with care coordinator will be done by phone, email or staff messaging in EPIC.

In summary

What?

In 2021, eligible UCare MSHO plan members and their designated* caregivers have access to M Health Fairview's Caregiver Assurance™ program at no cost to the member. Caregiver Assurance pairs caregivers with a dedicated advisor—a licensed social worker trained in aging—who can help alleviate the stressors related to caring for a loved one by providing resources, referrals, and support. Program offerings include:

Emotional support and self-care guidance for caregivers

Resource coordination for caregivers

Senior housing navigation

Home health and service referrals in collaboration with MSHO care coordination

Advisor will also collaborate with and make referrals to care coordination as well as in-network UCare and community resources.

In summary continued

Who?

2021 UCare MSHO plan members who are living in the community with a diagnosis of multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), Parkinson's, or dementia are eligible for program referral. Members must be referred to Caregiver Assurance™ by their care coordinator.

*A single designated caregiver caring for a MSHO member may also use this benefit on behalf of the member. The designated caregiver must be an authorized representative of the care recipient.

How and when?

Unlimited telephonic consultations Monday-Friday from 9 a.m. - 7 p.m.

How can I refer?

Members **must be referred** to this program by their care coordinator. Referrals can be made online or by phone.

https://surveynet.fairview.org/redcap/surveys/?s=83NTYCM7AR

Thoughts about caregivers

The heart of a caregiver is a rare element of earth
They define the true meaning & value of God’s worth
The soul of a caregiver is precious & pure

Caregiver, a special place in heaven is waiting for you
There is a special place inside my heart that is reserved for you, too.
Thank you for everything, all of it, & more

Contact information

UCare MSHO Caregiver Assurance

P: (612) 672-7996

Email: CaregiverCoach@Fairview.org

Program Staff

Cindy Swanson, LSW, Caregiver Assurance Advisor

Molly Toenjes, LICSW, Advantage plans Wellness Advisor, Caregiver Assurance Advisor

Heidi Sklenar, LICSW, Program Manager

Q&A

- *Suggestions for how to best coordinate care?*
- *What questions or concerns do you have?*
- *Other…*

Thank you!

REEMO Health Activity Tracker

Activity Tracker Smartwatch – Reemo Health

Who is eligible?
All MSHO members (no impact to EW benefit)

When and how to order?
Assess for need during annual assessment. Order via order/auth form on Care Manager webpage.

Important:

- Authorization is for 12 months from auth date (renewal required)
- Include the member's Emergency Contact information

Where to get more info?
2021 MSHO Member Handbook

Reemo HEALTH

The personal independence smartwatch

UCare MSHO/MSC+ Quarterly Meeting
March 2021

AGENDA

- Smartwatch user experience
- Engagement
- Use Cases
- Q&A

Reemo HEALTH

Reemo HEALTH

User experience

USER EXPERIENCE

More than just a smartwatch.

Steps tracking

All day activity tracking

Emergency Support

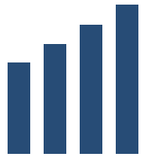
Mobile personal emergency response system (PERS)

Heart rate

All day and on demand heart rate tracking

GPS location

Works wherever you go



Cell service

No phone or internet needed

Waterproof

Wear showering, doing dishes or exercising

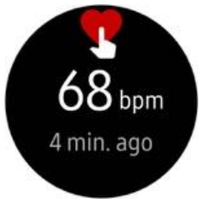
Reemo HEALTH

Simple user experience

Steps

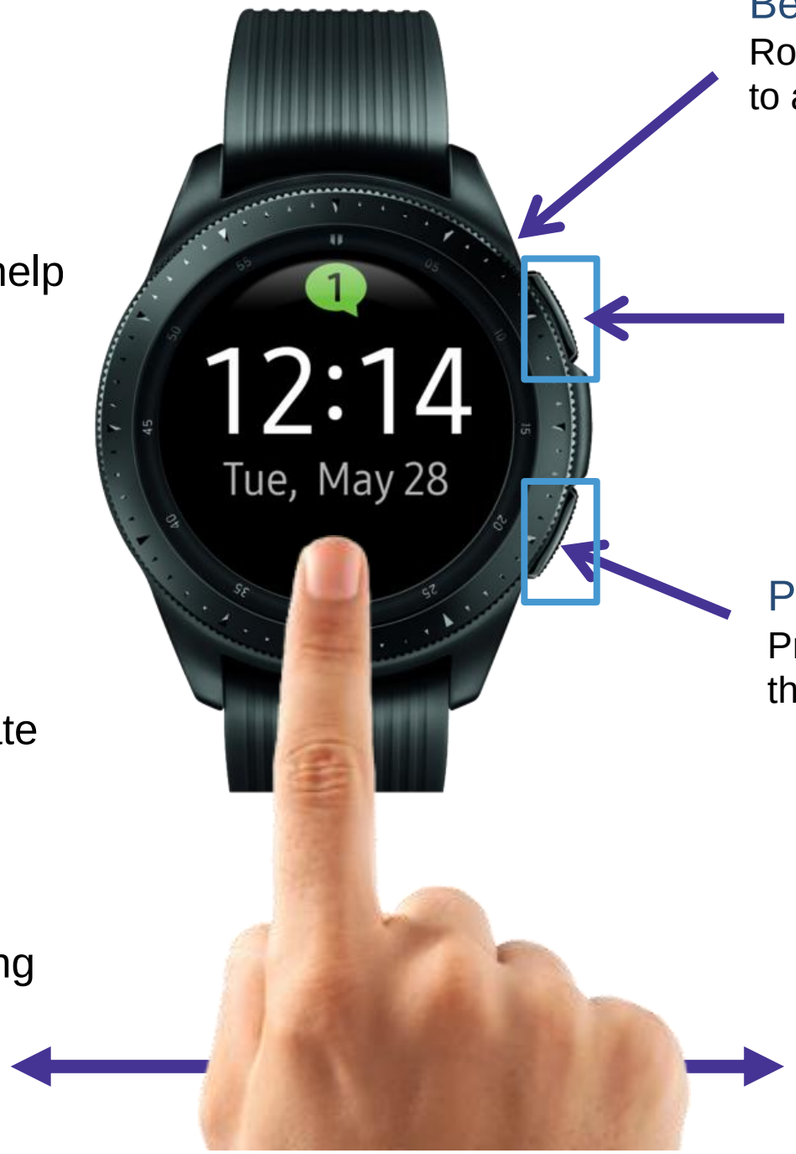
Call-for-help

Status



Heart Rate

Messaging



Bezel
Rotate left or right to access features.

Wake Button
Press once to display the watch face.

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

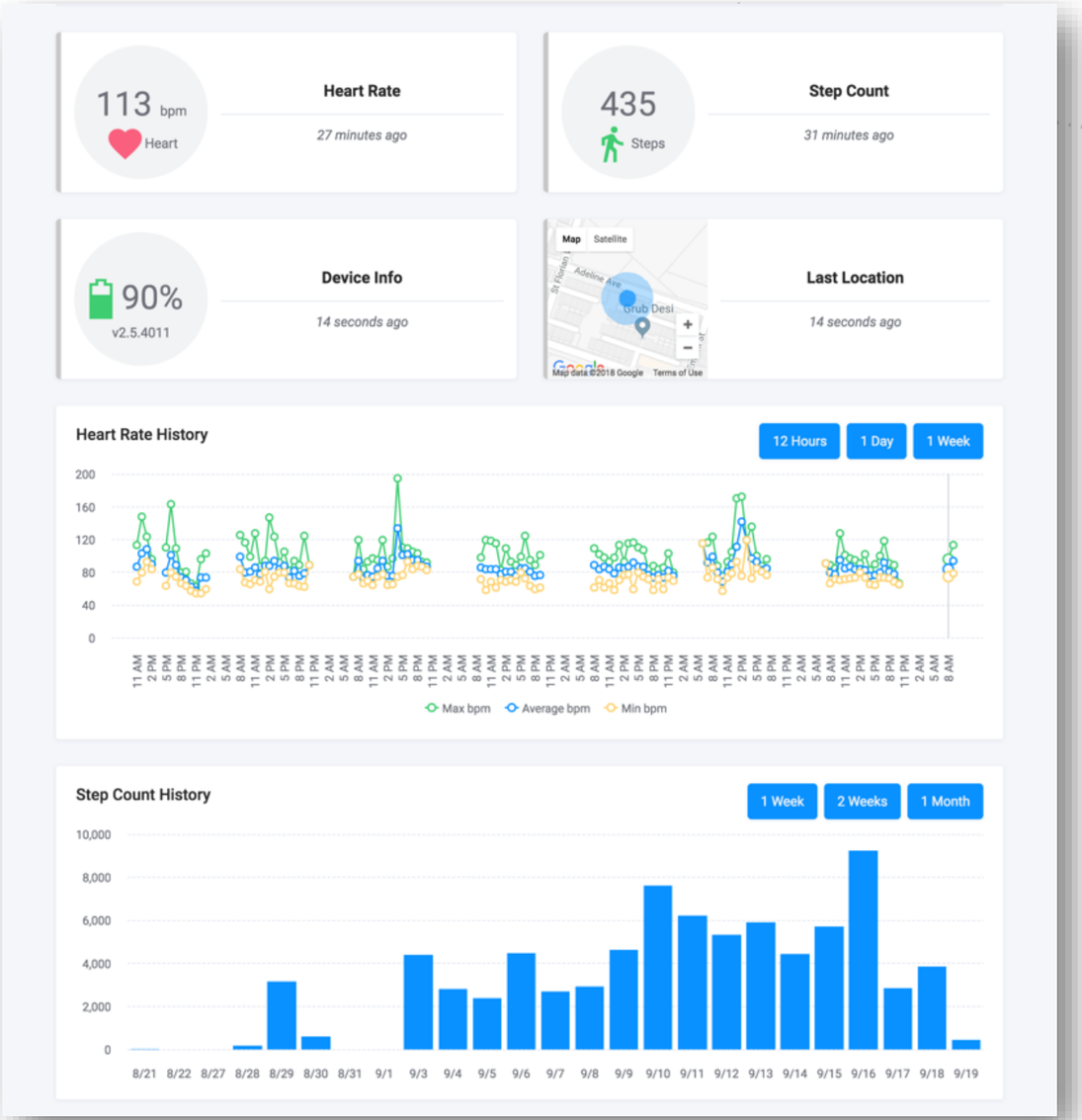
Finger Sweep
Swipe screen left or right to access features.

Reemo HEALTH

ONLINE DASHBOARD

Individual, Care Manager and care circle access

- Latest captured data
- Historical day, week, and month sorting to identify trends
- Download data for offline review
- Invite others to view



Reemo HEALTH

Reemo HEALTH

Engagement

ENGAGEMENT

Onboarding and support.

ONBOARDING

Quick Start Guide
Welcome call

SUPPORT

Helpline
Outreach

Reemo HEALTH

WATCH MESSAGING

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

Reemo HEALTH

ENGAGEMENT

Engagement that works.

ENGAGE

80%

begin using device within first 10 days

USE

74%

remain engaged 11 over months

TRUST

83%

users find Reemo useful

SUPPORT

68%

used call-for-help feature

MESSAGING

88%

open rate

24%

response rate

WELCOME CALLS

35%

spoken with

58%

left message

Reemo HEALTH

Reemo HEALTH

Use Cases

Use cases.

Reach wellness goals

Help with adherence to wellness programs and goals that are put in place.

Live independently

Individual wants to remain in their home with access to 24/7 help at home or away from home.

Care circle monitoring

The individual’s care circle wants to be able to view their loved one’s activity and location for piece of mind.

Stylish PERS device

Individual does not like wearing a traditional PERS pendant.

Heart rate monitoring

Ability to monitor heart rate continuously and access to help when there is concern.

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 an activity tracker or 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.”

Reemo HEALTH

Reemo HEALTH

Q&A

Reemo HEALTH

Thank you

WW & Memory Kits

Shoua Vang

Memory Support Kit

Eligible: MSHO only

- Must be ordered by MSHO Care Coordinator via order form

Kit A: Photo album, training game, motion sensor light, voice-controlled alarm clock, brain books

OR

Kit B:


Animatronic cat


Animatronic dog


Animatronic baby boy


Animatronic baby girl


One-button radio


Twiddle® Muff

5-pound weighted blanket

WW (formerly Weight Watchers)

Eligible: MSHO only

- **Member receives**: Packet in the mail with instructions and 13 workshop vouchers
  - Attend WW workshops for 13 consecutive weeks (no meeting registration fee required)
  - Use WW digital weight loss tools for 14 consecutive weeks

- **How to request:**
  - Care coordinator can send email to wellness@ucare.org
  - Or member calls Customer Service

MSHO Rewards and Incentives 2021

Nicole Lier

Health Promotion Manager

2021 MSHO incentives

	MSHO	Qualifications for incentive	Age on Date of Service
Mammogram screening	$50	Mammogram completed	Age 50 to Age 74
Colon Cancer screening (MSHO)	$50	Complete colonoscopy, sigmoidoscopy, or CT colonography earns $50 incentive. NEW** NO At home FOBT or Cologuard kit test incentive	Age 50 to Age 75
Diabetes Care: dilated eye	$30	Must have Diabetes diagnosis. Diabetic Dilated eye exam or Retinal eye exam complete	Age 18 to Age 75
Diabetes Care: A1c	$30	Must have Diabetes diagnosis. Diabetic A1c testing complete	Age 18 to Age 75
Diabetes Care: nephropathy	$30	Must have Diabetes diagnosis. Diabetic Nephropathy testing complete (Urine test)	Age 18 to Age 75
Osteo Screening	$100	Osteo screening completed; Pre-qualified and managed. Voucher will not be posted online	
Annual Wellness Check	$25	Complete an annual wellness visit with a primary care physician.	
Dental Check	$25	Complete a dental visit. The dental visit may not be six months from the previous visit.	No age restriction

2021 MSHO Incentives

- Incentive vouchers will be mailed to members in the 2nd quarter of 2021
- Vouchers are sent to members who have a gap in care for any of the services
- UCare will honor any dates of service in the 2021 calendar year
  - Example – member has Dental check up in March 2021, once vouchers are mailed in 2nd quarter, member will be able to redeem for the March visit

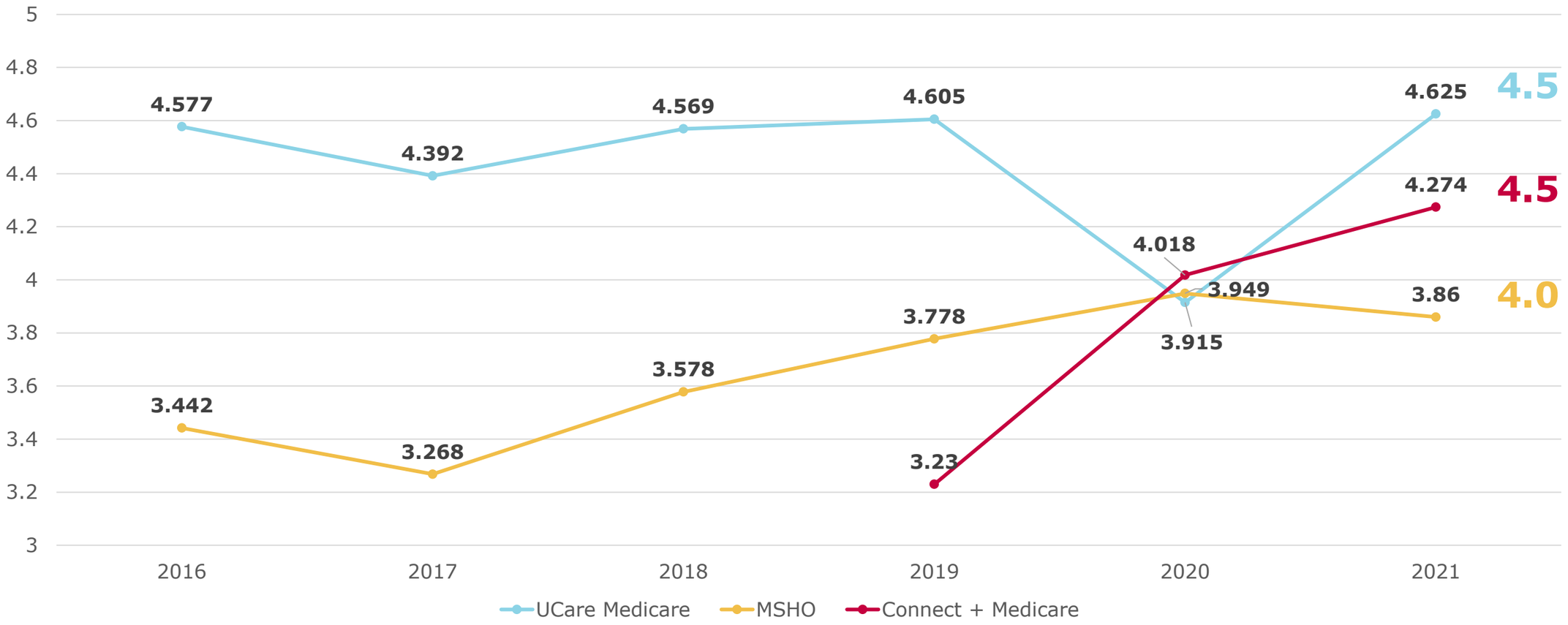
Medicare Star Ratings

Rachel Sterner, MPH
Star Ratings Manager

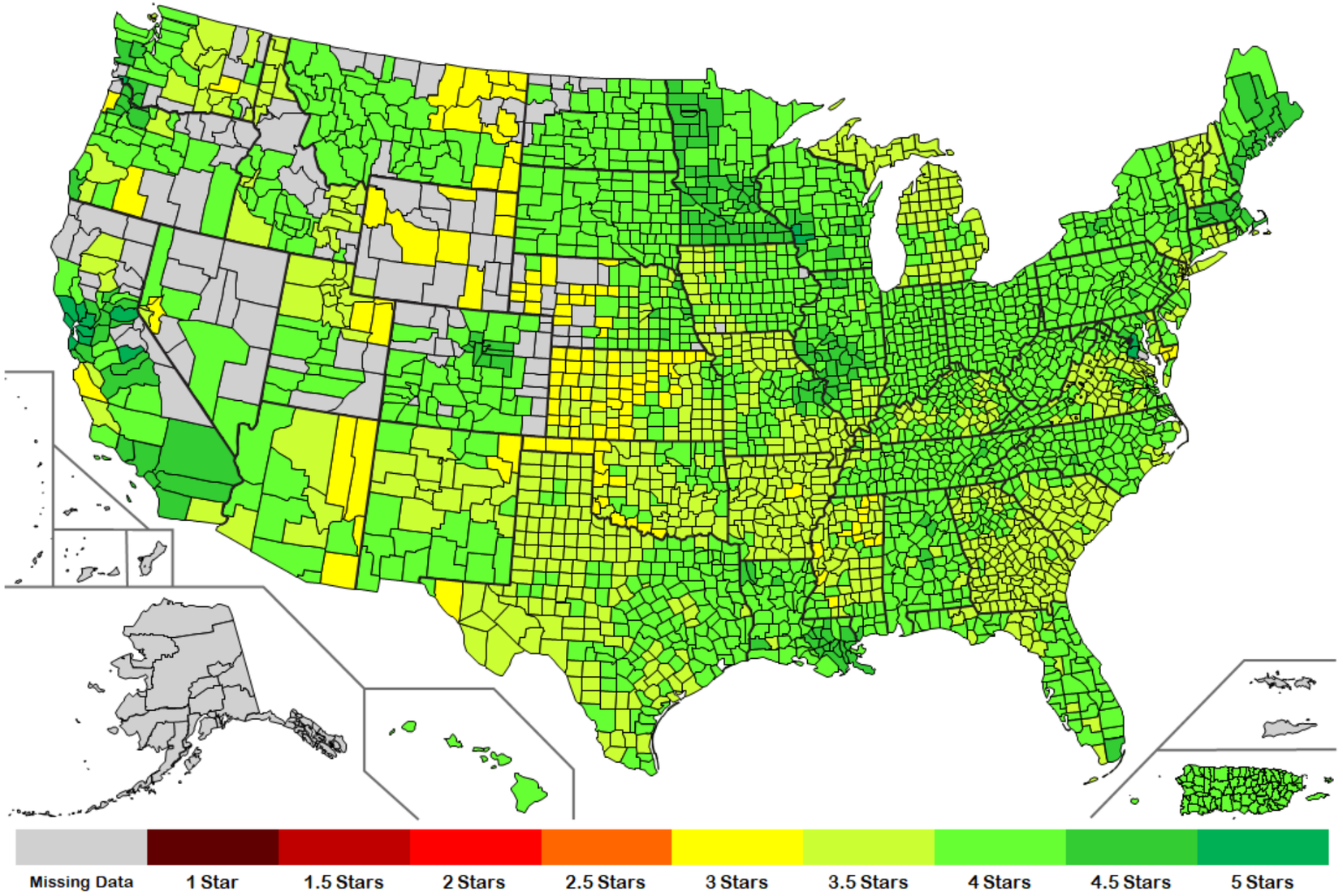
Medicare Star Ratings Overview

- 5 Star rating system that measures quality of care and clinical outcomes for Medicare Advantage and Prescription Drug plans.
- Designed to provide CMS and Medicare beneficiaries a way to assess health plans based on quality of care and clinical outcomes.
- Roughly 45 measures that target a broad array of clinical quality, customer satisfaction and other beneficiary experience areas. Measures change and evolve.

Star Rating Trending



2021 Star Ratings - Enrollment Weighted Average MA-PD Overall Rating in Non-EGHP Counties



Why Star Ratings Matter

- Plans achieving an overall rating of ≥ 4 Stars are eligible for bonus payments
  - Used to enhance or improve product and/or benefits offered.

Star Measures of Interest

- Preventive Cancer Screenings
  - Breast Cancer Screening
  - Colorectal Cancer Screening
- Chronic Condition Management
  - Diabetes Care: Eye Exams, A1c Control, & Nephropathy

- *"Extensive screening delays will lead not only to missed and advanced stage cancer diagnoses but also to a rise in cancer-related deaths."*
- *"Accelerate existing disparities in cancer screening and survival"*

You Contribute to our Success!

- **Help us influence member behavior**
  - Reinforce values of preventive and chronic screenings
  - Assist with scheduling appointments to close gaps in care
- **Take some time and listen**
  - Address member questions and connect with appropriate resources
  - Help resolve any outstanding issues
- **Reinforce your relationship with UCare**

2021 Quality Initiatives – *More Info to Come!*

- Several MSHO quality initiatives put on hold in 2021 as a result of new vendor
- BioIQ in-home test kit delivery – MSC+ only
- Carenet live calls to schedule preventive care visits – MSC+ only
- Hmong and Somali speaking Member Engagement Specialist temp staff
- Adult Day Center partnership
- Osteoporosis internal outreach
- Stars Workgroups

Questions?

Rachel Sterner, MPH

Stars Program Manager

rsterner@ucare.org

Presented by Esther Versalles-Hester

Community First Services and Supports Overview

History of PCA

- The Personal Care Assistance (PCA) program has been in existence in the State of Minnesota for over 40 years and was initially developed as a program for adults with physical disabilities who could direct their own care. The program has grown to add new populations and now serves persons of all ages and disabilities.
- Due to the Affordable Care Act and opportunities for more flexibility and self-directed state plan services, the state took advantage of these option and has chosen to participate in CFSS with the goal to keep Long term service and support system sustainability for the future.

CFSS

Like the Personal Care Assistance program, Community First Services and Supports will allow participants to have support in:

1. activities of daily living,
2. instrumental activities of daily living, and
3. complex health-related needs

However, Community First Services and Supports also includes:

1. assistance for the participant to acquire, maintain, or enhance the skills necessary to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks; and
2. the purchase goods that replace the need for human assistance or increase independence

CFSS

- In CFSS, participants will have a range of control over their services based on their choices. Either to be the employer of their own support workers with assistance from the Financial Management Services provider or to receive their services through a CFSS agency provider who employs their support workers.
- With new service options and the ability for the participant to be their own employer, CFSS also brings new providers into the program. The information below describes the new providers in CFSS.
- Consultation Services: Essential to CFSS is the newly designed Consultation Service. The Consultation Service is required and has three distinct tasks:
- 1. Service Set-up and Annual Orientation
- 2. On-going Consultation and Skills Development
- 3. Quality Assurance Support and Remediation

Consultation Services

- The Consultation Service is contracted by DHS and will bill DHS for Consultation services.
- They will provide each participant with standardized orientation to Community First Services and Supports at the beginning of the service. This orientation includes describing what CFSS is, how CFSS works, and the two service delivery models. This training will educate participants on their choices, range of responsibilities, roles, and risks under each model prior to the participant choosing the service delivery model.
- For those not on a waiver, the Consultation Service provider will approve the participant's CFSS plan. For participant's that are on a waiver, the Consultation Service provider will assist the participant to get the plan in order and the waiver case manager or care coordinator will approve it.

Agency vs. Budget Model

- The Agency Model - In the agency model, the participant and agency work together to ensure services are delivered as intended and the support worker carries out the duties as the plan describes. The agency is the employer of the participant's support worker(s); however, the participant retains the ability to select and dismiss the support worker(s) with assistance from the CFSS agency. **Similar to Traditional PCA.**
- The Budget Model - In the budget model, the participant is the employer of their support worker(s) and has more direct control and responsibility over their services and the support worker(s) they hire. The participant has support from the Financial Management Service provider for employer-related functions such as: support for required paperwork following State and Federal rules. **Similar to PCA Choice**
- Goods - Participants, in either the agency model or the budget model, can choose to purchase goods. Goods include environmental modifications and technology that are intended to replace human assistance or increase independence.

Questions submitted to DHS:

- How will CFSS be implemented in the senior population as health plan care coordinators are completing assessments?
  - Upon implementation, members will transition to CFSS at next LTCC/MnCHOICE/PCA Assessment.
- Health plan care coordinators have regulatory timelines for completion of care plans that must be met. How will communication between the various roles (i.e., consultation service providers, FMS providers, etc.) and health plan care coordinators occur so that these timelines may be met?
  - Consultation services will not interfere with the annual assessment or authorization process.
- Is the role of the CC similar in CDCS and CFSS?
  - CC's role does not change. Assessment info is given to Consultation service provider. CC review once member makes their choices. Reviews for duplication of services. MCO authorizes the services based on model or budget.
- For FMS and consultation service providers, what training about managed care is DHS providing and what role can we provide in it?
  - DHS will provide training however they can include MCO's in the training for FMS and consultation service providers
- Are the draft codes for this service considered final?
  - Yes, codes have been developed and finalized.
- How does the appeals process work? Is the consultations services provider included?
  - No changes to the appeal or SFH process however, a consultation service provider could be asked by the MCO to participate in a SFH.
- How will the CFSS "goods and services" budget be calculated and what is the interplay in EW caps?
  - Goods are typically non-EW related services however more to come.

Implementation Timeline

- DHS has communicated a 7/1/2021 implementation and transition of PCA to CFSS.
- Timeline will be developed
- Frequent workgroup meetings scheduled
- RFP issued for Consultation Service Providers
- Health Plans will continue to be the authorizing entity for CFSS
- Not clear if there will be a financial impact due to expanded services under both service models.

Individual Community Living Supports Service Overview

Dawn Sulland, LSW
Clinical Care Coordination Liaison

ICLS – overview, purpose and benefits

- ICLS is a bundled service that includes six service components.
- ICLS services offer assistance and support for older adults who need reminders, cues, **intermittent/moderate** supervision or physical assistance to remain in their own homes.
- ICLS is most appropriate when a member needs a combination of the six ICLS component services.
- ICLS is not intended to be an ala carte type of service
  - For example, if a member needs homemaking, health oversight, active cognitive support and assistance with using adaptive equipment – ICLS can provide this support through one provider.

ICLS Overview Continued

- Universal worker concept
  - Develop a broader service that a more universal worker could deliver
  - Decreasing the number of direct service workers that are in a member's home who can adapt to their change in needs more readily and can fill gaps that exist in other similar but ala carte services.
- ICLS workers can also provide higher competency tasks such as medication assistance and active cognitive supports
- The direct service worker providing the ICLS service must be trained and competent to provide all components of the ICLS service identified in the member's plan of care.
- At the core of ICLS is the single provider that offers day-to-day assistance
- The provider
  - Builds a relationship with the person
  - Provides component services as a bundle
  - Communicates with the member's informal supports (family, POA or other supports) and the care coordinator
- The component services address daily living, social, recreational, cognitive and health needs of the person.

ICLS Component Services

Active cognitive support

Adaptive support service

Activity of daily living (ADLs)

Household management

Health, safety and wellness

Community engagement

Active Cognitive Support

- This component of ICLS includes services to support the member with cognitive challenges and issues that are important to them.
- Active cognitive supports are the only ICLS services a person can receive both in person and remotely.

Examples:

Under this component, and ICLS provider can:

- Help problem-solve the member’s concerns related to daily living
- Provide assurance to the member
- Observe and redirect to address the member’s cognitive, orientation or other behavioral concerns
- Provide in-person and remote check-ins to identify problems and resolve concerns

Adaptive Support Service

- This component includes tasks to help the member adopt ways to meet their needs. The service encourages self-sufficiency and reduce reliance on human assistance.

Examples:

Under this component, an ICLS provider can:

- Provide verbal, visual and/or touch guidance to help the person complete a task
- Develop and demonstrate cues or reminder tools - e.g., calendars, lists
- Help the person understand assistive technology directors or instructions to maintain independence
- Practice strategies and similar support methods that promote continued self-sufficiency

Activities of Daily Living (ADLs)

- This component of ICLS includes support to help the member with ADLs.

Examples

Under this component, an ICLS provider can:

- Provide reminders or cuing systems to complete ADLs
- Cue and/or provide **intermittent/moderate** supervision or **intermittent** physical assistance with dressing, grooming, eating, toileting, mobility, transferring and positioning.
- Cue and/or provide **continual** supervision and physical assistance with bathing as needed.

Household Management

- This component of ICLS includes tasks to help the member manage their home.

Examples

Under this component, an ICLS provider can:

- Help with cleaning, meal planning/preparation and shopping for household and personal needs
- Help with budgeting and money management
- Help with communications
  - Such as sorting mail, accessing email, placing phone calls and making appointments
- Provide transportation when it is integral to ICLS household management goals and when community resources and/or informal supports are not available.

Health, Safety and Wellness

- This component of ICLS includes tasks to help the member maintain their overall well-being.

Examples

Under this component, an ICLS provider can:

- Identify changes in the person's health needs and notify the care coordinator and/or informal care givers as needed
- Coordinate or implement changes to mitigate environmental risks in the home
- Provide reminders about and assist with exercises and other health maintenance or improvement activities
- Provide medication assistance – e.g., medication refills, reminders, administration, according to written instructions from a licensed health professional
- Monitor the member's health according to written instructions from a licensed health professional and report any significant changes
- Use medical equipment devices or adaptive technology according to written instructions from a licensed health professional.

Community Engagement

- This component of ICLS includes tasks to help the member have meaningful integration and participation in their community.

Examples

Under this category, an ICLS provider can:

- Help the member access activities, services and resources that facilitate meaningful community integration and participation
- Help the member develop and/or maintain their informal support system
- Provide transportation when it is integral to ICLS community engagement goals and community resources and/or when informal supports are not available.

ICLS Service Planning

- The care coordinator works with the member to complete the ICLS Planning Form (DHS-3751) to communicate to the ICLS provider the specific service components the person will receive.
  - On the form the care coordinator must:
    - Identify the member’s individuals goals the ICLS service in intended to support
    - Describe and provide detail about the type of services the member will receive within each ICLS service component
    - Calculate the total amount of units and cost of ICLS services the member will receive each week
    - The member, care coordinator and provider must sign the completed form. Then the care coordinator must provide a copy to the member and provider.
    - Both the care coordinator and provider must keep a copy of the completed and signed form.
    - The ICLS planning form can be used to meet the provider signature requirements.

ICLS Authorizations and Service Limits

- The member can receive up to 12 hours of face-to-face ICLS services per day - i.e. 48, 15-minute, units per day.

Active cognitive support

- In addition to 12 hours of face-to-face services, a member who receive active cognitive support can receive 1, 15 minute unit, of remote services per day.
- Active cognitive supports is the only component of ICLS services a member can receive both in-person and remotely.
- If a member receive remote active cognitive support, the remote service must be provided via two-way communication between the member and provider – e.g. phone, live video.
- In-person and remote service must be provided by the same provider.

Non-covered services in ICLS

- The following EW services may not be authorized in combination with ICLS:
  - Customized living
  - Foster care

- A member can receive a combination of any set of other waiver services and ICLS.
- With the latest EW amendment effective 12/15/2020, this includes CDCS.
- The care coordinator must avoid duplication of services or tasks between service providers.

Constant vs Intermittent Supervision or Hands-on Assistance

ICLS ADL assistance review

- Provide reminders or cuing systems to complete ADLs
- Cue and/or provide intermittent/moderate supervision or intermittent physical assistance with dressing, grooming, eating, toileting, mobility transferring and positioning
- Cue and/or provide continual supervision and physical assistance with *bathing* as needed.

ICLS is **not** an appropriate service to meet the need for constant supervision or more intensive hands-on assistance to complete a task, except for bathing.

- PCA is the service designed to meet this more intensive level of need for ADL assistance

Additional Considerations

- ICLS vs chore services
  - Household management under ICLS does not include chore services. Chore services may be a good example of a service that may be needed in addition to ICLS.
  - Chore services is appropriate if the member is in need of heavy moving, shoveling, yard care, extermination, etc.
- ICLS vs waiver transportation
  - ICLS providers can enroll as waiver transportation providers and bill for waiver transportation separately from ICLS.
  - Transportation and ICLS cannot be billed for the same time period
  - Transportation is billed and paid at the EW transportation rate.
  - For example, if stated in the ICLS plan the ICLS provider will bring the member to the bank once per week
    - The ICLS provider does not bill ICLS while driving the member to and from the bank. The provider at that point is acting as a waiver transportation provider and bills for waiver transportation services
    - Upon returning to the member’s house the ICLS resumes delivering ICLS services

Care Coordination Updates

Transferring Members in a Skilled Nursing Facility

When a member is in a hospital or an acute/short-term skilled nursing facility stay they should not be transferred to a new Care Coordination Delegate until they are back to their normal setting.

Care Coordinators should work with the member and staff on discharge planning and ensuring that the member’s needs are met before sending in a Primary Care Clinic Change should the member be changing PCC’s.

Contents

New Link to MSHO Member Guide

- The UCare MSHO Member Guide can be found at ucare.org/mshoguide
- The member guide is mailed out to every new MSHO members and has information that may be helpful for current members as well.

MnCHOICES Updates

- All MnCHOICES Mentors should register for the MnCHOICES Launch Webinars on TrainLink.
- MnCHOICES will launch no sooner than September 1, 2021 and no later than December 31, 2021.
- All lead agencies will launch with MnCHOICES on the same date.
- All MSHO/MSC+ care coordinators will need to be MnCHOICES Certified Assessors.
- MSHO/MSC+ care coordinators may begin taking Step 1 and Step 2 at anytime via TrainLink.
- DHS will advise once they have updated Step 3 and once MCO care coordinators can begin working on Step 3.

Moving Home Minnesota – Eligibility Updated

- The goal of Moving Home Minnesota (MHM) is to create opportunities for Minnesotans to move from institutions to their own homes in the community. MHM promotes the development and implementation of transition plans that reflect the preferences of those receiving services and the opportunity to receive services in the most integrated setting.
- Effective January 27, 2021, eligibility requirements changed. The institutional stay requirement was reduced from 90 to 60 days, and previously, only Medicaid-paid days could be included in the 90 days. Now both Medicare and Medicaid-paid days may be counted in the 60-day institutional stay requirement.
- Example: A person may start their institutional stay in a hospital, and then move to a facility providing rehabilitative services paid by Medicare, and then to a nursing facility paid by MA. The stay is regarded as continuous and will apply to the 60-day institutional stay requirement.

HCBS Rights Modification Support Plan Attachment

HCBS Rights Modification Process

The HCBS settings rule allows the following rights to be modified when people live in settings where they receive customized living, foster care or supported living services.

- A. Have personal privacy (including the use of the lock on the bedroom door or unit door)
- B. Take part in activities that he/she chooses and have an individual schedule that includes the person's preferences supported by the service provider (this right cannot be modified in customized living settings.)
- C. Have access to food at any time
- D. Choose his/her own visitors and time of visits.

The modification must be:

- Necessary to ensure the health, safety and well-being of the person
- Based on a specific and individualized assessed need that is justified in the support plan
- Approved by the person through informed consent

HCBS Rights Modification Tools and Resources

DHS developed an DHS-7176H-ENG HCBS rights-modification support plan attachment form (PDF) for case managers/care coordinators, providers, people who receive services and their legal guardian (if applicable) to document and coordinate rights modifications.

DHS also created a video, Tutorial for the Home and Community Based Services Rights Modification Support Plan Attachment, and a rights modification FAQ webpage.

Questions

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