July 2022

Medica | CARE COORDINATOR NEWSLETTER

All Products

Member Satisfaction Survey

The annual Minnesota Senior Health Options (MSHO), Special Needs Basic Care (SNBC), Minnesota Senior Care (MSC+) Member Satisfaction Surveys will be mailed in August to a random sampling of MSHO, MSC+, SNBC and Integrated Special Needs Basic Care (ISNBC) members. New this year, we are offering this survey in Russian and Spanish. The survey is designed to help Medica evaluate the effectiveness of its care coordination services from the member's perspective.

Medica will communicate about the survey again closer to the mailing date to ensure that Care Coordinators are aware and can respond accordingly if they were to receive a phone call from a member who receives the survey. If Care Coordinators receive a call from a member asking about this mailing, please encourage the member to complete the one page satisfaction survey and return it to Medica in the self-addressed stamped envelope provided to them to share their thoughts and opinion. Completion of the survey is optional and responses are confidential.

We hope for a strong response from our Medica Members and want to hear from them!

Medica Stakeholder Group

Medica recently completed our first stakeholder group of 2022. We completed individual listening sessions with members, providers, county representatives and advocates instead of a group in person meeting due to ongoing Covid-19 precautions. Our hope is to hold a group meeting this fall, dependent on community conditions at the time.

Engagement:

- 46 participants identified and contacted
- 17 participated in a listening session

- *All 17 participants indicated a desire to participate in a group stakeholder meeting in the future.*

Themes and Feedback:

- Many members shared specific challenges that make health care communications very hard for them – a stroke, hearing loss, learning disability, memory loss. Members desire for simple, reassuring communications in their own language when possible.
- Care Coordinators are critical for members, and are seen as especially helpful when they connect members to needed resources like energy assistance, housing, or food support.
- There is a desire for Medica to focus efforts on prevention, wellness, and Social Determinants of Health (SDoH) needs.
- Transportation, prescription coverage, and the OnePass fitness program are the most important/favorite benefits of the individuals interviewed.
- Several participants expressed a perception that overall health care quality has gone down since the pandemic began, much has been put on hold and regular care is rushed, clinics and doctors seem overloaded and to have less time for each patient.

Next Steps:

- Share feedback from stakeholders internally at Medica, and identify opportunities to incorporate stakeholder feedback into communications, processes, future benefit design, etc.

REMINDER: Long Term Services & Supports (LTSS) Signature Requirements Back in Effect July 1, 2022

As previously communicated via email, Department of Human Services (DHS) announced on June 15 that the COVID-19 waiver CV.89 related to LTSS signature requirements would expire on June 30, 2022. Waiver CV.89 allowed for verbal, written or expressed approval of LTSS-related documents that typically require in-person signatures.

What this Means for Care Coordinators:
Effective July 1, 2022, Care Coordinators must again obtain written approval of LTSS documents. Verbal or expressed approval of LTSS documents no longer meets DHS requirements.

- Medica requires Care Coordinators to attempt to obtain written signatures from members on the Member Signature Sheet (SNBC/I-SNBC) or the Member Signature Sheet section of the Collaborative Care Plan (MSHO/MSC+) for all products.
- If the Member Signature Sheet is not completed at the time of a face-to-face assessment, the Care Coordinator is expected to mail the Member Signature Sheet with a copy of the Post-Visit Letter and a return envelope to the member.

- Care Coordinators are expected to make at least two attempts to obtain the member's signature and to document such attempts (e.g., in case notes, on the care plan or on the Member Signature Sheet itself).

Upcoming Events

Our County and Community Engagement Team is excited to sponsor and participate in several upcoming community events.

- 8/2/2022 Farmers Market - Crystal
- 8/13/2022 Community Health Fair - Brooklyn Center
- 8/18/2022 – 8/19/2022 Many Faces of Community Health Conference (virtual)
- 8/23/2022 Farmers Market - Crystal
- 8/23/2022 Operation Community Connect - Onamia
- 8/23/2022 Fond du Lac Health and Human Services Health Fair - Carlton, MN
- 8/25/2022 Operation Community Connect - Milaca

Are you planning to attend any of these events? Please stop by to say hello!

Minnesota Senior Health Options (MSHO) + Minnesota Senior Care (MSC+)

Benefit Exception Inquiry Form Reminders

When completing the BEI (Benefit Exception Inquiry) form:

Date	Date you are submitting the request, not the date you started the form
Service/item description	Include both HCPC (Healthcare Common Procedure Coding) code and description of the item
Units	Cannot be left blank
Provider name/phone/fax	Please include address of the provider
Duration of service	MUST include start and end dates

If PCA (Personal Care Attendant), please be sure to note if it is OON (Out of Network) PCA or over budget.

If glasses, the rendering provider should be Eye Kraft, not who is dispensing the

glasses. Each code (lenses, frames, etc.) should have the price listed with the HCPC code, not the total cost.

Out of Network (OON) Personal Care Assistance (PCA) Providers Reminder

As a reminder, Medica will authorize an out of network PCA provider **only** when member is newly enrolled with Medica with a current PCA authorization using an out of network provider. The Care Coordinator can authorize the out of network provider for up to 120 days from the Medica enrollment date.

It is important that the Care Coordinator is working with the member to transition the member to an in network PCA provider upon enrollment and coordinate the transfer with the member, and both PCA providers. For members on a waiver managed by the county, such as the Community Access for Disability Inclusion (CADI) waiver, it is important that the Care Coordinator communicate with the county case manager to only authorize PCA services with an in network PCA provider.

Out of Network PCA Authorization Process:

- The Medica Care Coordination Products (CCP) Support Specialist will receive referral request form from the CC. It is very important that the CC complete the referral request form fully including the PCA provider name, address, phone, fax, **email address and include provider Tax Identification Number (TIN) or National Provider Identifier (NPI) number**. Indicate in the comments section this is a **new member with an out of network PCA provider**.
- The Medica Support Specialist will complete the authorization and send an authorization letter to the member and the provider. The letter includes the authorization details and that the member needs to work with their care coordinator to transition to an in network provider. Per usual process, the care coordinator will still need to communicate the authorization with the provider and work with the member to transition to an in network provider upon enrollment with Medica.
- The Support Specialist will send an email to the provider and copy the CC. You do not need to not reply to this email, it is for your informational purposes only. If you receive questions from the provider about set up, please refer them to Medica Provider Service Center (1-800-458-5512). The OON PCA provider will need to give information to PSC representative to get set up to bill Medica.
- If you receive questions about claims, refer providers to Medica Provider Service Center (1-800-458-5512) and can also reference the following document on **Medica.com**.

Requests for out of network PCA that do not meet the 120 day continuity of care, require a prior authorization.
Care Coordinators can submit the Benefit Exception Inquiry (BEI) form

completing the required information for OON PCA requests. This will need to include the attempts to transition member to an in network provider. The BEI will be forwarded to Medica Utilization Management for a Prior Authorization review. The member, provider and CC (via fax) will be notified if it is approved or denied. If denied, the letter will include the member's appeal rights.

PCA Assessment documents for the Member, Provider and Physician Reminder

To meet statute requirements, PCA Assessments completed by the Care Coordinator must be sent to the member and the provider within 10 business days from the date of the assessment. It is the Care Coordinator/delegate's responsibility to send the assessment to the provider and the member when authorizing the services or when a Denial, Termination or Reduction (DTR) is completed.

The Communication to Physician of PCA Services document (DHS-4690) is completed by the Care Coordinator and shared with the member's Primary Care Provider when authorizing PCA services.

Special Needs Basic Care (SNBC) + Integrated Special Needs Basic Care (ISNBC)

Ovia Health Benefit

Ovia Health gives on-demand support and clinically backed guidance to help members achieve their health goals, whether that's tracking their period, getting pregnant, or navigating pregnancy, postpartum and parental wellness. Medica members have access to enhanced and personalized Ovia Health features including one-on-one coaching, symptom tracking, tools, and more.

In light of the recent Supreme Court reversal of Roe vs. Wade, Ovia has made the following commitments in support of Medica members:

- **Evidence-based guidance.** We'll continue to provide members with clinically-backed, digestible education, including help navigating maternal health, mental healthcare, and safe abortion access in accordance with clinical guidelines from the American College of Obstetricians and Gynecologists, and overseen by our Chief Medical Officer, Dr. Leslie Saltzman.
- **Unlimited access to Ovia's in-house Care Team** of licensed RNs to equip members with unbiased, clinical information. Our diverse Care

Team provides members with expert advice and 1-1 psychosocial, culturally-sensitive support.

- **Navigation to your covered benefits and resources.** We will continue to deliver mental health and social determinant assessments, along with customized benefits education to break down each individual's unique barriers to self-advocacy and equitable care.

Members can access Ovia Health by simply downloading one of the Ovia Health apps, and choosing "I have Ovia Health as a benefit" before tapping "Sign up." **Visit Ovia Health** to learn more.

We're here to help

Call or email, whichever works best for you.

Call us at 1-888-906-0971 (TTY:711)

Email us at **MedicaCCSupport@medica.com**.

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