

# Special Needs Basic Care (SNBC) – What You Need to Know

Beginning January 1<sup>st</sup>, 2012 anyone younger than 65 years old who is enrolled in Medical Assistance (MA) and is certified as having a disability will be automatically enrolled into a managed care plan known as Special Needs Basic Care (SNBC) unless they choose to opt-out. Everyone who will be affected by this change will receive a letter explaining the situation very soon if they haven't already. This will not include children on the TEFRA program at first but will in the future.

*Here's what you need to know if you or someone you know receives a letter:*

**People can opt out.** People can choose not to enroll in an SNBC plan and stay with their current fee-for-service Medical Assistance plan. In order to do this, people will have to complete the opt-out form included with the letter and mail it back.

**People may have a choice of plans.** Depending on what county a person lives in there may be from than one plan to choose from.

**People can change their minds.** If someone initially opted-out and now wants to be on an SNBC plan, they can decide to do so at the end of each month. People who do decide to enroll in an SNBC plan will also be able to return to their original fee-for-service medical assistance plan if they decide the SNBC plan is not a good fit. People in counties where more than one plan is available will have the option to switch to a different SNBC plan as well.

**Switching to managed care can be a good thing.** Many managed care plans offer additional benefits such as help coordinating a person's care, transportation to appointments or even gym membership.

*Before choosing a plan (or choosing to enroll in an SNBC plan at all), be sure to find out the answers to these questions:*

## **Does the plan cover my providers and medications?**

Make sure the plan you choose covers your preferred providers (psychiatrist, physician, therapist, etc.) and your medications. Also check if the plan requires Prior Authorization or Step Therapy (trying an older, cheaper medication first) for your medications; if this is the case the plan may not be a good choice for you.

## **Does the plan cover the mental health services I use?**

Before enrolling with a managed care plan, request a copy of what mental health services the plan covers to make sure the services you use are covered.

## **Does the plan require prior authorization to see a provider?**

Some plans require prior authorization before seeing certain providers, especially providers you haven't seen in the past. Be sure to find out if this is the case.

The answers to all these questions can be found by either calling the health plan, visiting their website or by calling the Disability Linkage Line at 1-866-333-2466. If you have a case manager you may be able to work with them as well to decide if an SNBC plan is right for you.

## **Resources are available to help make a decision.**

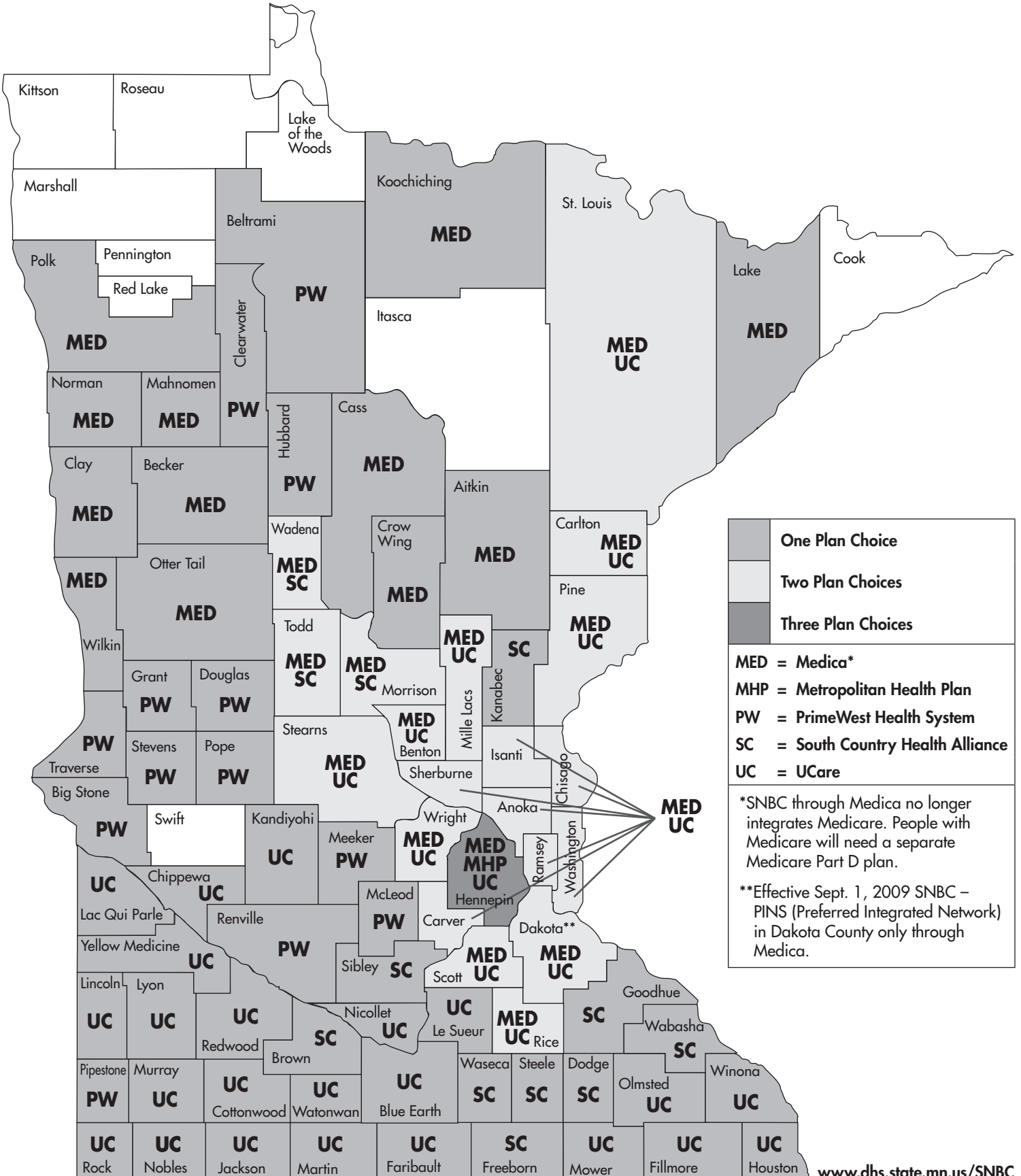
A map of which plans cover each county and a side-by-side comparison of the key features of each plan can be found at the end of this guide. If you have additional questions or concerns call the NAMI Minnesota office at 1-888-NAMI-HELPS.



Minnesota Department of **Human Services**

# Health Plan Choices by County for Special Needs BasicCare (SNBC)

Effective Jan. 1, 2011



**Managed Care for People with Disabilities Health Plan Grid  
Special Needs BasicCare - 2011**

<b>Health plan</b>	<b>South Country Health Alliance</b>	<b>Medica</b>	<b>MHP</b>	<b>PrimeWest Health</b>	<b>UCare</b>
<b>SNBC program name</b>	<b>Ability Care</b>	<b>AccessAbility Solution (Medicaid Only)</b>	<b>Cornerstone Solutions</b>	<b>Prime Health Complete</b>	<b>UCare Connect</b>
<b>Counties served</b>	Brown, Dodge, Freeborn, Kanabec, Goodhue, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, Waseca	Aitkin, Anoka, Becker, Benton, Carlton, Carver, Cass, Chisago, Clay, Crow Wing, Dakota, Hennepin, , Isanti, Koochiching, Lake, Mahnomen, Mille Lacs, Morrison, Norman, Otter Tail, Pine, Polk, Rice, Ramsey, Saint Louis, Scott, Sherburne, Stearns, Todd, Wadena, Washington, Wilkin, Wright,	Hennepin	Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, Traverse	Anoka, Benton, Blue Earth, Carlton, Carver, Chippewa, Chisago, Cottonwood, Dakota, Faribault, Fillmore, Hennepin, Houston, Isanti, Jackson, Kandiyohi, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, Mille Lacs, Mower, Murray, Nicollet, Nobles, Olmsted, Pine, Ramsey, Redwood, Rice, Rock, Scott, Sherburne, Stearns, St. Louis, Washington, Watonwan, Winona, Wright, Yellow Medicine
<b>Phone numbers</b>	<b>Member services</b> 866-567-7242 TTY 877-824-5611	<b>Customer Service:</b> 952-992-2300 800-234-8755 <b>AXIS:</b> 651-556-0887 <b>Medica Behavior Health:</b> 800-848-8327	<b>Member services</b> 1-866-903-4733 TTY: 1-800-627-3529	<b>Member services</b> 1-877-600-4913	<b>Member services</b> (612) 676-6868 1-866-280-7202; TTY (612) 676-6810 or 1-800-688-2534.
<b>24-hour nurse line</b>	Ask Mayo Clinic at 1-800-504-3451.	Medica Call Link Nurse Line: 1-800-962-9497	<i>HealthConnections:</i> 1-888-859-0202 TTY: 1-800-627-3529 Also call to help with after-hours transportation.	<i>Ask Mayo Clinic</i> at 1-888-668-4336 (toll free)	Health Connection at 1-800-942-7858. TTY: 1-877-728-3311
Who do I contact with pharmacy issues/questions? After hours?	Members can call Member Services or their local county Care Coordinator. Information about network pharmacies and formularies is on SCHA's website at <a href="http://mnscha.org/acare.htm">http://mnscha.org/acare.htm</a>	Member can call their Care Coordinator, Customer Service or the after-hours nurse line.	Call your Care Guide, Member Services, or after hours contact HealthConnections.	Call Member Services, or after hours call <i>Ask Mayo Clinic</i> .	Members can call their case coordinator, Member Services or after hours Health <i>Connection</i> .

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<p><b>Member Services</b> What does Member Services do?</p> <p>How do I know if my doctor is in the network? How do I change my provider? Address change? ID card?</p>	<p>Member Services are available from 8 a.m. to 8 p.m., 7 days a week. They can help with:</p> <ul style="list-style-type: none"> <li>• Eligibility</li> <li>• Covered benefit questions</li> <li>• Clinic changes</li> <li>• Interpreter needs</li> <li>• Grievance and appeals</li> <li>• ID card replacement</li> <li>• Transportation</li> <li>• Locating network specialists and providers.</li> </ul>	<p>Customer Service can help with:</p> <ul style="list-style-type: none"> <li>• Claims questions</li> <li>• Verify if providers are in network</li> <li>• Order ID cards</li> <li>• Grievances</li> <li>• Connect with your care coordinator.</li> </ul>	<p>Member Services are available from 8 a.m. to 8 p.m., 7 days a week. They can help with:</p> <ul style="list-style-type: none"> <li>• Changes, lost or stolen ID cards</li> <li>• Complaints or appeals</li> <li>• Locating or changing providers</li> <li>• Provider bills</li> <li>• Connecting to your Care Guide</li> <li>• Transportation,</li> <li>• Covered benefits</li> <li>• Interpreter needs.</li> </ul>	<p>All calls are answered by a live person. Member Contact Specialists are available to provide you with accurate and timely response to all of your questions. They should always be your first point of contact. If they cannot help you directly, they will find someone who can. This saves you the worry that you might be transferred to several different people before you find someone who can help.</p>	<p>Member Services are available from 8 a.m. to 8 p.m., 7 days a week. They can help with:</p> <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Claims</li> <li>• Primary care clinic changes</li> <li>• ID cards</li> <li>• Complaints</li> <li>• Finding the health plan navigator and/or case coordinator</li> <li>• Pharmacy</li> <li>• Transportation</li> <li>• Locating providers in the network in English, Hmong, Somali and Spanish.</li> </ul> <p>UCare also has a “Find A Doctor” search at <a href="http://www.ucare.org">www.ucare.org</a>, which lists primary care providers and other service providers.</p>
<p>How do I reach my care coordinator?</p>	<p>Within 10 days of enrollment, you will get a letter with your care coordinator’s name and how to contact them.</p> <p>If you need to know before you get the letter, contact Member Services or the County Care Connector (contact information for the County Care Connector is in your Certificate of Coverage).</p>	<p>Medica uses care systems. If you know your care system, you can contact them directly. If you do not know your care system contact Medica Customer Service.</p>	<p>Your care coordinator, (Care Guide) will call you soon after you enroll.</p> <p>You can also call Member Services.</p>	<p>PrimeWest Health contracts with the county social service and public health agencies for case management. Your county case manager will contact you by phone or through a home visit. You can also call Member Services.</p>	<p>Within 10 days of enrollment, you will get a phone call or letter with your case coordinator’s name and phone number. UCare partners with several entities at the local level to provide case coordination. Case coordination is assigned based on county of residence and disability type. For help contacting your case coordinator, call Member Services or 612-676-6622 or 1-866-242-2497</p>

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<p>Must I pick a primary care clinic (PCC)?</p>	<p>Yes, you need to select a PCC, however, this can be changed simply by calling Member Services.</p> <p>A specialty provider may act as your primary care provider/medical home. Your care coordinator will provide support to the specialty provider to ensure access to preventive care, disease management and chronic care management.</p>	<p>It is encouraged but not required. Your care coordinator can help you find a primary clinic.</p> <p>A specialty provider may act as your primary care provider/medical home. Your care coordinator will provide support to the specialty provider to ensure access to preventive care, disease management and chronic care management.</p> <p>Creative options to primary care (i.e. visiting home nurse practitioner) will be available to those who meet criteria.</p>	<p>It is encouraged, but not required. You can also change providers at anytime by calling Member Services.</p> <p>You may identify a primary care provider on the enrollment form. If one is not identified on the enrollment form, your Care Guide will help you choose a primary care provider.</p>	<p>Yes, but you can change your provider by calling Member Services. You may also have a specialist as your PCC.</p> <p>If you do not choose a PCC, PrimeWest will work with you to find a provider that meets your needs.</p>	<p>Yes, but you can change your provider by calling Member Services.</p> <p>If you do not choose a primary care clinic, one will be assigned to you.</p> <p>UCare has a “Find A Doctor” search at <a href="http://www.ucare.org">www.ucare.org</a>, which lists primary care clinics and other service providers; you can also contact your health plan navigator for provider information and changes.</p>
<p>When do I need a referral?</p>	<p>No referrals necessary within the SCHA network.</p>	<p>No referrals needed for in network providers. Referrals are needed for out of network providers. Benefit exceptions require a referral.</p>	<p>No referrals are necessary.</p>	<p>No referrals are necessary.</p>	<p>No referrals necessary within UCare network.</p>
<p>When do I need a prior authorization (PA)?</p>	<p>Providers are responsible for obtaining the appropriate prior authorization.</p> <p>Member Services can help you identify services that require prior authorization. Additional information is in the Certificate of Coverage mailed to members upon enrollment or found on the website <a href="http://www.mnscha.org">www.mnscha.org</a>.</p>	<p>Prior authorization is needed to see out-of-network providers and for certain procedures such as gastric by-pass surgery.</p> <p>Medica will coordinate benefits with Medicare for members who have Medicare.</p>	<p>Authorization is needed for certain drugs, a few medical procedures and out-of-network DME and home care. See the Cornerstone Formulary (drug list) for medications that require prior authorization and the Certificate of Coverage for procedures that require prior authorization, including when 18-21 year olds require nursing home entrance.</p>	<p>You will <u>not</u> need a PA to see an out-of-network specialist. You will need a PA to see other out-of-network providers. Certain services require a PA. Refer to the Certificate of Coverage (COC) for specifics. The COC is on the PrimeWest Health website at <a href="http://www.primewest.org">www.primewest.org</a>. A COC is also mailed to members upon enrollment, annually, and as requested.</p>	<p>Services requiring PA are listed on the Authorization Grid in the Provider Manual online at <a href="http://www.ucare.org">www.ucare.org</a>.</p> <p>Additional information is in the Certificate of Coverage mailed to members upon enrollment.</p> <p>Member Services can also answer questions about PA.</p>

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	A list of specific services needing prior authorization is on the SCHA website at <a href="http://mnscha.org/provider_s.htm">http://mnscha.org/provider_s.htm</a>		Call Member Services with any questions.	Providers should call Provider Services at 1-866-431-0802 with questions. The member may also call Member Services.	
How to access Indian Health Services?	No referral or prior authorization needed.	No referral or prior authorization needed. The Care Coordinator will coordinate services with IHS and/or the tribe.	No referral or prior authorization needed.	No referral or prior authorization needed. If a tribal or IHS clinic provider refers a member to a provider in our network, we will not require the member to see a network primary care provider prior to referral.	No referral or prior authorization needed.
Access to ACT, IRT, ARHMS and MH providers: How?	<p>The provider must be certified by the Department of Human Services (DHS).</p> <p>Notification is needed for ACT and ARHMS services.</p> <p>Prior Authorization is needed for ARHMS and IRTS after thresholds are achieved (ARHMS 1200 units/combined by all providers, IRTS 90 days).</p> <p>PA is needed for all out-of-network providers regardless of the service.</p>	<p>No referral or PA needed</p> <p>Access services directly with contracted Medica Behavioral Health providers. For assistance finding providers, contact Medica Behavioral Health at 1-800-848-8327.</p>	<p>Must be certified by DHS. No referral needed. Open access.</p>	<p>Providers must be certified, licensed, or approved by DHS. A mental health provider or other qualified professional needs to refer a person to IRTS. ACT programs have many providers that can refer individuals to the program but the program decides if the admission is appropriate. MH providers that are in the PrimeWest Health network do not need referrals or a PA. Out-of-network providers always need a PA (except crisis or emergency care).</p>	<p>For ACT, IRTS, and ARMHS, the program must be certified by DHS. Pre-Notification is a requirement for ACT and IRTS. No Pre-Notification is required for ARMHS. No referral is needed.</p> <p>For more information; contact the case coordinator or Member Services.</p>
Where can I find a listing of your formulary?	<p>SCHA's formulary is online at <a href="http://mnscha.org/acare.htm">http://mnscha.org/acare.htm</a></p> <p>Information can be found under "Our Programs" tab.</p>	<p>Our formulary is online at <a href="http://Medica.com">Medica.com</a></p> <p>You may also request a printed formulary from Customer Service.</p>	<p>Go to <a href="http://www.cornerstone-solutions.org">www.cornerstone-solutions.org</a> under prescription drugs</p> <p>If there are any questions members can also call Member Services.</p>	<p>Got to the PrimeWest Health website at <a href="http://www.primewest.org">www.primewest.org</a>. Click on Members &gt; Drug&gt; choose appropriate benefit group &gt;enter drug name&gt;dosage&gt;view</p>	<p>For members with Medicare Part D, go to: <a href="http://ucintst/healthplans/mhcp/snp/Pages/PartDInformation.aspx">http://ucintst/healthplans/mhcp/snp/Pages/PartDInformation.aspx</a> then on the left side of the page, click on the formulary link for</p>

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	<p>Click on AbilityCare and then “Check the Drug List” in the Search Online box.</p> <p>Members also receive a copy of SCHAs Comprehensive Formulary upon enrollment.</p>			<p>formulary status</p> <p>You may also get a printed copy of the formularies from your County Case Manager or by calling Member Services.</p>	<p>the Part D covered drugs.</p> <p>Part D members will also have access to Medicare Excluded drugs through their Medicaid benefit.</p> <p>The formulary for members without Part D is at:  <a href="http://www.ucare.org/SiteCollectionDocuments/providers/formularies/MHCP%20Formulary.pdf">www.ucare.org/SiteCollectionDocuments/providers/formularies/MHCP%20Formulary.pdf</a></p> <p>Call Customer Service with any questions.</p>
<p>Do you have a separate pharmacy directory or is it combined with the provider directory?</p>	<p>SCHA combines the provider and pharmacy lists into one directory. The most current directory is at <a href="http://mnscha.org/acare.htm">http://mnscha.org/acare.htm</a></p> <p>Click on “Our Programs” tab, select AbilityCare and the Provider Directory will be listed on the right of the page under 2011 AbilityCare Member Materials.</p> <p>The formulary exception process/form and other Medicare Part D information is online at <a href="http://www.mnscha.org/aca_re_partd.htm">http://www.mnscha.org/aca_re_partd.htm</a></p> <p>Pharmacy information is also available by calling Member Services.</p>	<p>Pharmacy is a separate directory and can be found online at <a href="http://Medica.com">Medica.com</a></p>	<p>The Member Handbook includes the Pharmacy and Provider Directory which lists medical homes, urgent care, specialty providers, pharmacies and dental providers.</p> <p>Members can also go to <a href="http://www.cornerstone-solutions.org">www.cornerstone-solutions.org</a> to get a copy of the pharmacy and provider directory under member materials or use the pharmacy under prescription drugs.</p>	<p>Both. We have a separate pharmacy directory but also publish a current listing of pharmacy providers annually in our <b>Provider Directory</b>.</p>	<p>The pharmacy directory is combined with the provider directory.</p> <p>Network pharmacy information can also be found through “Find A Pharmacy” at <a href="http://ucintst/Pages/FindAPharmacy.aspx">http://ucintst/Pages/FindA Pharmacy.aspx</a></p> <p>For the latest information call Member Services.</p>

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How do I enroll?	<p>The enrollment application can be obtained by calling Member Services or from our website  <a href="http://mnscha.org/acare.htm">http://mnscha.org/acare.htm</a></p> <p>Click on “Our Programs” tab, select AbilityCare and &gt;How to Enroll. Under #3 is an enrollment form you can print.</p>	<p>Call Medica sales line  952-992-2030  1-800-266-2157</p>	<p>Call the enrollment line at  1-866-601-8962  TTY: 1-800-627-3529</p> <p>Prospective members may also go to  <a href="http://www.cornerstone-solutions.org">www.cornerstone-solutions.org</a> and go under member materials and print out an enrollment form to complete and mail or bring in to the MHP office listed on the enrollment form.</p>	<p>Call Member Services</p>	<p>Call UCare at  612-676-3554  1-800-707-1711  TTY: 612-676-6810  1-800-688-2534</p> <p>Find enrollment materials and information on our website at <a href="http://www.ucare.org">www.ucare.org</a>.</p>
How do I disenroll?	<p>Call Member Services or send a letter to us stating the desire to disenroll to:  SCHA  110 West Fremont St.  Owatonna, MN 55060</p>	<p>Call Customer Service or contact your Care Coordinator.</p>	<p>Call your Care Guide or Member Services.</p>	<p>Call Member Services or send your request in writing to:  2209 Jefferson St.  Suite #101  Alexandria, MN 56308</p>	<p>Call Member Services or contact your Health Plan Navigator.</p>
What phone number do I call to file an appeal or grievance?	<p>Call Member Services to file an appeal for medical claims.</p> <p>For DentaQuest appeals, call 1-800-516-2940  TTY 1-800-466-7566.</p>	<p>Call Customer Service or contact your Care Coordinator</p>	<p>Call Member Services or the MHP Grievance and Appeals Coordinator at  1-800-657-3778  TTY:1-800-627-3529</p>	<p>Call Member Services</p>	<p>Call Member Complaints, Appeals and Grievances at  612-676-6841  1-877-523-1517;</p> <p>Send it in writing to:  UCare  Attn: Member Complaints, Appeals and Grievances  PO Box 52  Minneapolis, MN 55440-0052  or  Email <a href="mailto:cag@ucare.org">cag@ucare.org</a>.  Or by Fax to Member Complaints, Appeals and Grievances at  612-884-2021  1-866-283-8015</p>

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<p>How far do I have to travel to get to see a dentist within 30 days?</p>	<p>This depends on the providers in your area as well as the openings that available at the dental provider.</p> <p>To find a dentist please go to this link to search for dentists in your area.  <a href="http://www.dentaquestgov.com/FindProvider/FindProvider.aspx">http://www.dentaquestgov.com/FindProvider/FindProvider.aspx</a></p> <p>For help scheduling a dental appointment, SCHA offers a dental appointment scheduling assistance through DentaQuest. Call the DentaQuest Customer Service Appointment Scheduling Line 1-800-516-2940 (option #4)</p>	<p>Medica has not guaranteed a time frame; however the Care Coordinator will work with the member and Delta Dental to arrange appointments which are convenient and timely.</p> <p>Delta Dental has also hired staff specifically to address issues for SNBC Care Coordinators and expedite services.</p>	<p>MHP serves only Hennepin County residents, access to see a dental provider within 30 days is not an issue.</p> <p>Delta Dental can be called at 1-800-774-9049 for help locating a dentist.</p> <p>Delta Dental has also hired staff specifically to address issues for Cornerstone Solutions Care Guides.</p>	<p>This timeframe is subject upon several variables such as if the member has a regular dentist, what their dental needs are, where they live, and other factors that impact their access and timeframe. All members have access to a care coordinator/case manager who will help them arrange appointments.</p>	<p>That depends on where you live. To find a dentist in the UCare network, go to <a href="http://www.ucare.org">www.ucare.org</a> and select “Find a Dentist”</p> <p>See-A-Dentist Guarantee Hotline (1-800-235-0564; TTY 1-800-466-7566) will offer a member a dental appointment within 30 days for cleanings and routine check-ups. The phone line will also help schedule appointments for more complex dental needs and appointments on UCare’s mobile dental clinic (when it is in the service area). For an appointment call 651-455-1555 1-866-451-1555 TTY 1-877-627-3848.</p>
<p>Do you have a mail order pharmacy?</p>	<p>No</p>	<p>Yes. Members can get up to a 90-day supply through mail order pharmacies. Members can get up to a 90-day supply through certain preferred retail pharmacies listed in the pharmacy directory.</p>	<p>Yes.</p> <p>Members can also call Member Services or get the mail order form on the <a href="http://www.cornerstone-solutions.org">www.cornerstone-solutions.org</a> website.</p>	<p>No</p>	<p>Members with a Part D benefit can receive up to a 90-day supply of maintenance medications through mail order or designated retail pharmacies listed in the pharmacy directory.</p>

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<p>Describe in detail transitional pharmacy services</p>	<p>The transition period is 90 days from the effective date. The transition process or period is automated at the point of sale. The claims system allows for a one-time temporary fill and tracks when a member has received the fill. For a member in a LTC setting, multiple fills are allowed.</p> <p>The temporary fill is for a 30-day prescription unless written for less. In LTC settings, it is 31 days unless written for less.</p> <p>After the member gets their temporary fill, a letter is sent to the member explaining the temporary fill and need for a formulary exception for future fills. The letter is sent by regular mail within 3 business days of the claims transaction.</p> <p>The process allows for a transition extension. This is a one-time post-transition extension for members whose exception request or appeal has not been completed and is granted on a case-by-case basis.</p> <p>If questions, call Member Services.</p>	<p>Members with Medicare get Part D medications through their chosen Part D plan. Their Care Coordinator can help facilitate this process.</p> <p>Members without Part D benefits are eligible for a one-time continuity of care transition fill by contacting Customer Service. .</p> <p>At any time, the member can call Customer Service or work with their Care Coordinator for special circumstances.</p>	<p>For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 60-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. The Care Guide is available to help during this transition period.</p>	<p>New members will be granted a transitional supply of non-formulary medication they were taking before enrollment. The month-long supply (unless written for less) is available to new enrollees who request it.</p> <p>If subsequent fills are needed, they will be granted on a case-by-case basis during the 90-day transition period. The prescribing physician must submit a formulary exception form to Prime Therapeutics, LLC (our pharmacy review organization) to determine if continuation past the 90-day transition is medically necessary. Forms are at <a href="http://www.primewest.org">www.primewest.org</a> under Partners and providers &gt; Pharmacy &gt; Formulary Exception Process. Fax forms to Prime Therapeutics at 1-800-693-6703 or 651-846-8199.</p> <p>PrimeWest Health tries to identify members that may need transitional pharmacy services; however it is the member's responsibility to inform us when they need this benefit. They should call Member Services to initiate this process.</p>	<p>New members with a Part D benefit will be provided a one-time transition fill (LTC members will be provided up to three transition fills) for any non-formulary or PA required drug. A transition fill will also be provided for members with a level-of-care change.</p>

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What services need a notification?	<p><u>Behavior Health</u></p> <ul style="list-style-type: none"> <li>• Acute inpatient mental health – within 24 hours of admission</li> <li>• ARMHS – at the start of care</li> <li>• CTSS – at the start of care for the 30<sup>th</sup> calendar day</li> <li>• Crisis stabilization, residential – upon admission</li> <li>• Intensive outpatient treatment – for the first 10 days</li> <li>• Partial hospitalization – for the first 10 days</li> <li>• Residential CD treatment (in-patient level of care) – within 24 hours of admission</li> <li>• All other CD treatment – Free standing, primary residential, half-way house, extended care, methadone treatment</li> </ul> <p><u>Medical/Surgical</u></p> <ul style="list-style-type: none"> <li>• Non-emergent medical hospital admission – within 24 hours of admission</li> <li>• Hospice care</li> <li>• Skilled care days</li> <li>• Skilled Nursing Facility</li> </ul>	Home care providers are encouraged to notify the Care Coordinator for continuity of care, but notification is not required for service delivery. Hospitals notify the health plan of admissions.	Some specific drugs need authorization from Care Mark (our pharmacy benefit manager ). The pharmacist is responsible for getting authorization.  Members can also call Member Services.	Provider notification is requested for nursing home admissions, the birth of a baby, and notification of hospitalizations for the purpose of obtaining a Service Authorization.  Members should notify PrimeWest Health when they are requesting transitional pharmacy services or seeing an out-of-network specialist. The member’s county must be notified of admission to chemical dependency treatment. Additional notification is requested from County Case Managers. Notification is requested for the following: <ul style="list-style-type: none"> <li>•Emergency room visits</li> <li>•Admission to IRTS</li> <li>•Admission to ACT</li> <li>•Civil commitment</li> <li>•Court involvement if it affects the member’s physical or emotional health</li> <li>•Admission to a crisis bed</li> <li>•72-hour hold</li> </ul> Change of status such as a urinary tract infection, fall, and death of spouse, rehab, or other.	Services requiring authorization are listed on the Authorization Grid in the Provider Manual at <a href="http://www.ucare.org">www.ucare.org</a> .  For more information call Member Services.
What is the difference between a notification/PA/and referral?	<u>Notification</u> is the process in which SCHA receives verbal or written communication about a	<u>Notification</u> Communication from a provider to notify the Care Coordinator or health plan	A <u>notification</u> is used by providers to notify the health plan that services are being initiated.	“ <u>Notification</u> ” is when a member or a provider informs PrimeWest Health that a service/benefit has	<u>Notification</u> is the process of informing UCare of a specific medical treatment or service involving a

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	<p>specific medical treatment or service being provided.</p> <p><b>Referral</b> is a process in which a primary care provider (or authorized provider) provides verbal or written communication requesting that the member be allowed to see an out-of-network provider.</p> <p><b>Prior Authorization</b> is a request for the delivery of a service/benefit by the member or provider acting on behalf of the member. The service/benefit requires approval from the health plan prior to the service being delivered.</p> <p><b>** Please note</b> that ANY out-of-network services do require a referral and a prior authorization.</p>	<p>of a service.</p> <p><b>Referral:</b> Payment instructions for claims processing</p> <p><b>Prior Authorization (PA):</b> Approval in advance to obtain services.</p>	<p>A <b>referral</b> is typically a process where a primary care provider refers a member to a specialist.</p> <p>No referrals are required for Cornerstone Solutions members. Members have open access to specialists and other needed services.</p> <p>A <b>service authorization</b> prior authorization is needed in certain situations for the health plan to pay a claim.</p>	<p>been provided. A “notification” is a more casual approval with little to no rules needing to be followed. Notifications are not required before the provision of the service.</p> <p>A <b>Prior Authorization (PA)</b> is also contact with PrimeWest Health but is stricter with information being applied to strict criteria sets before payment of a service/benefit will be given. A PA should be requested before delivery of the service/benefit by the provider.</p> <p>A <b>“referral”</b> is the process of a primary care provider (or any authorized provider) requesting that the member be able to see another provider. Referrals are only needed for providers out of plan/network. The referring provider should contact PrimeWest Health for a service authorization. A referral is not needed for the member to see an out-of-network specialist. Providers can contact PrimeWest Health Provider Services at 1-866-431-0802.</p> <p>Members may contact Member Services.</p>	<p>member prior to or within a specified time period of the treatment or service.</p> <p><b>Referral</b> is the verbal or written direction from a member’s Primary Care Clinic (PCP) or Clinic to see another provider. Referrals to UCare non-network providers require a Prior Authorization by UCare or an approved authorizing entity.</p> <p><b>Prior Authorization</b> is an approval by an Approval Authority prior to the delivery of a specific service or treatment. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service or treatment is medically necessary, an eligible expense and that appropriate, less expensive alternatives have been considered.</p>

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<p><b>Care Coordination Model</b> How case management activity works at the health plan. Overlap with other types of case management.</p>	<p>Each member receives access to a Care Coordinator upon enrollment.</p> <p>Care Coordination delivery is based upon a partnership between South Country Health Alliance and local county human services and public health agencies.</p> <p>The Care Coordinator is the central point of contact for the health plan and will assist the member with coordinating health plan services and local agency services.</p> <p>Care Coordinator will coordinate an inter-disciplinary team (public health nurse, social worker, specialty care provider, home care nurse, waiver case manager, licensed psychologist, etc...) based upon the member's needs.</p> <p>Care coordination services are member-centered and will include developing a comprehensive care plan based upon information from the member's health assessment, county service plan, preventive needs or focus, self-management plans, etc.</p> <p>Interventions and self-</p>	<p>Every member is assigned a care coordinator upon enrollment.</p> <p>Care coordinator delivery based on health plan care systems          AXIS Healthcare (expertise is population with physical and developmental disabilities) and United Behavioral Health (expertise is people with mental health diagnosis) and Medica Care System (working with people with physical and developmental disabilities in Greater MN). As needed AXIS staff will train and consult with greater MN Medica staff.</p> <p>All the care systems will work in cooperation with the county case manager, if the member has a county case manager.</p> <p>Coordinators attend clinic visits with primary provider at member direction.</p> <p>Members in Greater MN 1 have choice of Medica staff or UBH for coordination.</p> <p>Care coordination will be completed by a primary coordinator with additional coordination provided on a consult or co-coordinator basis.</p>	<p>Every member is assigned a Care Guide upon enrollment.</p> <p>The Care Guide is the central point of contact for the member. The Care Guide helps coordinate services for the member. Care Guide is familiar with the health plan and other county and social services.</p> <p>The Care Guide will coordinate a Care Team made up of a case manager, the enrollee, medical providers and any other integral providers</p>	<p>If the member so chooses, a county case manager will be assigned to them upon enrollment.</p> <p>The PrimeWest Care Management delivery system is based on collaborative partnerships between the member, the provider, the county case manager, and the PrimeWest Care Coordinators. PrimeWest delegates case management to 10 county partner public health and human service agencies.</p> <p>Case management at the county level will be in collaboration with PrimeWest's care coordinators for a team approach with includes, access to coordinating the member's pharmacy, dental, chronic disease management, (asthma, diabetes, depression, vascular care), maternal child health and behavioral health needs.</p> <p>The County Case Manager is assigned based on where the member lives and the member's needs and preferences. The County Case Manager could be either a Social Worker or a Registered Nurse.</p>	<p>Every member is assigned a Case Coordinator upon enrollment. The Case Coordinator can be someone from UCare, the county, or a delegated entity.</p> <p>UCare partners with several entities to provide case coordination at the local level. Case coordination is assigned based on county of residence and disability type. Contact UCare at 612-676-3554 or 1-800-707-1711 for more information.</p> <p>Each member is also assigned a Health Plan Navigator at UCare. The Navigator can coordinate and establish a healthcare home, promote access to preventive care, refer members to UCare's Disease Management program, as appropriate, coordinate transitional care, and provide access to health promotion programs. This person can also serve as a resource for the case coordinator.</p> <p>If the member receives home and community based services, the Case Coordinator collaborates with the Waiver Case</p>

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	<p>managements will be developed by the member and care coordinator to assist the member in achieving the highest possible health outcomes.</p> <p>County Care Connectors who are separate from the member's care coordinator are located in all member counties and are available to act as a single point of contact to new enrollees to access appropriate case management.</p>	<p>Comprehensive person centered care planning will include screening, risk assessment, advance directives, preventive focus, facilitating self monitoring and self management intervention, and ongoing evaluation.</p> <p>After assessment and development of care plan members will receive a copy of the care plan, primary MD will receive copy of the care plan and additional case management based on identified needs of member.</p>		<p>Depending upon the member's needs and preferences, the member could have both a Social Worker and a Register Nurse working with them to achieve their stated care plan goals.</p> <p>The County Case manager does not replace the member's existing county case manager if the member already has a county case manager assigned to them.</p> <p>The County Case Manager will supplement any already existing County Case Management.</p>	<p>Manager as needed.</p> <p>If a member requires complex medical case management, an RN at UCare provides case management for acute complex medical needs. The Complex Medical Case Manager can refer the member to UCare's Disease Management Program and to specialty providers as needed.</p> <p>UCare's model of care includes initial contact with the member within 10 days of assignment, a welcome letter, comprehensive assessment, a comprehensive care plan, contact with the member every three months, an annual reassessment, transition management, and coordination with local agencies.</p> <p>In addition, UCare pharmacy staff review and discuss medication concerns.</p>
Initial Health Risk Screening.	<p>Members contacted by phone or in person and are offered a comprehensive health assessment within 30 days of enrollment.</p> <p>From the assessment, a care plan will be developed</p>	<p>Initial and annual in-person coordination assessment visits for AXIS and Medica Care System. Medica Behavioral Health provides in-person visits when needed or requested by the member.</p>	<p>The Care Guide will help each member complete a health risk assessment within 30 days of enrollment.</p> <p>Additional assessment and screenings will be</p>	<p>Case management can be conducted by phone, mail or in person. The county case manager conducts Health Risk Screening and other assessments as necessary. The goal is to have the initial health</p>	<p>Within 15 days of enrollment, the member receives a Welcome Call from Customer Service designed to help new members understand <i>UCare Connect</i>, address any concerns and provide</p>

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	<p>with special attention to mental health, chemical health, and medical and social service needs.</p> <p>The care plan is monitored at least quarterly or as needed based upon the member's needs.</p> <p>Referrals will be encouraged and coordinated to the local county agencies (Human Services and Public Health) as appropriate after health assessment is completed and member shows need for additional local agency services.</p>	<p>Subsequent meetings may be conducted in person, by phone or mail, depending on the member's needs and desires.</p> <p>For members at risk of or struggling with depression, the PHQ-9 will be administered at least monthly as a monitoring tool. Members with other diagnosis will be offered appropriate risk screening</p>	<p>performed when indicated by the health risk assessment.</p> <p>Additional assessments:</p> <ul style="list-style-type: none"> <li>• Members with severe mental illness will complete a diagnosis assessment to assist with development of a comprehensive care plan.</li> <li>• Members with developmental disabilities will complete a DD screening if one has not been done.</li> <li>• Members with a physical disability will complete a LTCC assessment.</li> <li>• Members needing PCA services will be referred to the county for PCA assessment.</li> </ul> <p>Individual treatment plans are developed based on needs identified at assessment, evaluation of the plan as necessary, and focus on early identification, intervention, prevention as well as integration of social and medical needs.</p>	<p>assessment within 30 days of enrollment.</p> <p>After the Health Risk Screening is completed, a Comprehensive Assessment will be conducted. Based on the member's needs and diagnosis, this will be a LTCC or DD Screening. If risk assessment tool indicates the member is at high risk, the Comprehensive Assessment will be expedited. The case manager will help the member determine the needs for follow up and preventive care services.</p> <p>If the member is residing in a facility, the County Case Manager will work with the facility to review health care needs.</p> <p>Comprehensive care plan will be designed to accommodate the member's cultural, linguistic needs and disability condition. Coordination and communication of a member's primary, acute, long-term care, mental health and social service needs as necessary, prevention focused, and advanced directive planning.</p>	<p>members with additional information about <i>UCare Connect</i> programs and services.</p> <p>A health risk assessment is sent to members within 30 days of enrollment. The assessment can be completed by the member or on their behalf by someone else involved in their life. A member can also contact UCare for help completing the assessment.</p> <p>After the screening is reviewed by UCare, potential gaps in care are identified and addressed. For example, a member may be referred to a disease management program for diagnoses such as asthma, diabetes, and heart failure.</p> <p>Then the health risk assessment is shared with the member's case coordinator.</p>

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				<p>Minimum annual review/revision of care plans with member. Other reviews/revisions may be conducted based on member's needs and/or change of status.</p> <p>Every 3 months case managers will contact the member to assure proactive approach. If member is receiving ACT services, case manager will have contact every 6 months.</p>	
<p>Your additional benefits – especially fitness benefit , describe in detail</p>	<p>Community Education Reward: SCHA will cover up to \$15 of the registration fee for most Community Education classes (up to 5 classes per registration session). Call your local Community Education program or SCHA's Member Services for more information.</p> <p>Mammogram Reward: Women who are over age 40 can get an incentive after having their mammogram.</p> <p>Be Fit Exercise Reward: Members who work out at least 8 days a month at a participating health club can receive up to \$20 off their monthly health club</p>	<p>Silver Sneakers membership-members can attend group fitness classes and access general gym membership at participating locations. Transportation is included.</p> <p>Smoking cessation program.</p> <p>Health Coaching program: Members can access workbooks and 1:1 coaching by phone to work on any preventions or disease management topic.</p>	<p><b>Access to the Twin Cities metro area YMCA;</b> a fitness assessment, full use of fitness equipment and all group exercise classes. Show your Cornerstone Solutions ID. Go as little or as often as you like; Branch locations and phone numbers can be found at: <a href="http://www.ymcatwincities.org">www.ymcatwincities.org</a></p> <p>The Care Guide can assist members with accessing transportation as needed.</p> <p>Bus passes can be issued for transportation to the YMCA.</p>		<p><i>ActiveU</i> fitness program includes a free YMCA membership. UCare covers 100% of the monthly membership fee. No visit requirement applies.</p> <p><b>The Connect to Fitness kit</b> includes an exercise DVD, a stretch band and materials to help members maintain active lives.</p> <p><b>\$300 supplemental dental benefit</b> (annual allowance) for preventive and restorative dental services not covered by Medical Assistance. Certain limitations and exclusions apply.</p> <p><b>S.E.A.T.S.</b> (Seats, Education &amp; Travel</p>

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	<p>membership fees.</p> <p>Disease Management programs for members with diabetes, heart disease, asthma and postpartum depression.</p> <p>A free tobacco cessation program through the Mayo Clinic Tobacco Quitline. A trained counselor can talk with you over the phone and provide information, support, and advice. You can call the Mayo Clinic Tobacco Quitline at 1-800-504-3451 or TTY 1-877-728-3311.</p> <p>Rewards for a variety of health maintenance activities such as Child &amp; Teen checkups, blood lead screening and many more.</p> <p>Free car seats for members with eligible children.</p> <p>Call Member Services for more information.</p>				<p>Safety) car seats &amp; education for pregnant women.</p> <p><b>MOMS program</b> for pregnant women, including coaching by phone with Mayo Pregnancy Advisor, award winning MOMS booklet, gift card incentives for prenatal and postpartum medical visits, and pregnancy book and DVD at no charge.</p> <ul style="list-style-type: none"> <li>• Pregnancy and childbirth classes.</li> <li>• Breast pump at no charge.</li> </ul> <p><b>\$15 Community Education discount</b> for most classes offered through local school districts.</p> <p><b>Mammogram reward</b> for eligible members: \$25 gift card</p> <p><b>Mayo Clinic Tobacco Quitline</b>, coaching by phone at no charge, with nicotine replacement therapy customized for the member.</p> <p><b>Disease Management</b> programs for qualifying members with asthma, heart failure, and diabetes.</p>

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<p><i>Provider Network</i></p>	<p>Members have direct access to contracted medical specialists.</p> <p>Providers are in all of SCHAs networks: MMSI (Mayo), DentaQuest, CRG Chiropractic and Prime Therapeutics (pharmacies) are all available without a referral.</p> <p>There is no need for referrals for Skilled Nursing Facility stays.</p> <p>Access to:</p> <ul style="list-style-type: none"> <li>• 6,000 primary care providers,</li> <li>• 39 urgent care centers,</li> <li>• 79 hospitals,</li> <li>• 7,000+ specialty providers,</li> <li>• 43 nursing homes,</li> <li>• 432 home care and Elderly Waiver providers,</li> <li>• 1,800+ mental health/chemical dependency providers,</li> <li>• 620 eye care providers,</li> <li>• 112 chiropractic providers,</li> <li>• 1,300+ dental providers,</li> <li>• 1,100+ pharmacies,</li> <li>• 206 durable medical equipment providers.</li> </ul>	<p>Members may self refer for any covered service with any in-network provider.</p> <p>No prior authorization needed for SNF stays at contracted facilities, or for home care services.</p> <p>Tele-psychiatry initiative. Received a grant for tele-medicine focusing on psychiatry and psychology hope units will be deployed in greater MN quickly to increase access to these services.</p> <p>Elevated contract requirements regarding the service and delivery of durable medical equipment.</p> <p>Limited number of services that require prior authorization (e.g. bone growth stimulators, gastrointestinal surgery for morbid obesity)</p> <p>Physical accessibility guidelines will be developed and shared with ALL provider types to educate them on optimal accessibility.</p>	<p>Open access to all contracted specialty providers or noncontracted providers as long as they accept the MA fee schedule for payment.</p> <p>Does not require an authorization for any medical supplies under \$5,000 from network DME providers.</p>	<p>Direct access to all providers in network.</p> <p>No service authorization requirements on covered mental health services</p> <p>Will lift all Service Authorization requirements for any request to see a non-participating specialist if the member notifies PrimeWest so it can contact the provider to ensure they will accept PrimeWest payment in full and hold the member harmless.</p>	<p>Members have direct access to contracted medical providers in the network. Referrals to specialists are not required.</p> <p>UCare has an extensive network of specialist, physician, and durable medical equipment providers. We also strive to ensure that providers understand and know how to treat the unique needs of members with disabilities.</p> <p>Members have access to dental benefits such as our <b>See-A-Dentist Guarantee appointment hotline</b>, which guarantees a dental appointment within 30 days for cleanings and routine checkups.</p> <p>Members also have access to UCare’s mobile dental clinic, with three dental chairs and lab. It’s staffed and supervised by University of Minnesota School of Dentistry faculty and students. It travels one week every month to locations in Greater Minnesota. To make an appointment call: 651-455-1555 or 1-866-451-1555 TTY: 1-877-627-3848</p>