Section 3 - Care Management Teams

3.1 Care Management

Care Management is a process that ensures consistent oversight, coordination, and support to members and their families in accessing Managed Long Term Care covered services, as well as non-covered services. Working with members, the Care Management team develops a care plan of all services members require. The mutually agreed upon care plan is reviewed and revised over time in response to the changing needs of the member. Senior Health Partners is dedicated to the provision of services that will enable members to remain safe and secure in their own homes.

Upon enrollment, a member will be assigned to a Primary Care Manager (PCM). Their PCM is responsible for managing the member's chronic health problems, supported by the Clinical Consultant Team (CCT), including a nutritionist, nurses, and social workers with specialized knowledge of various clinical topics, and ample support staff to assist with the member's care. The Primary Care Management Team monitors changes in their health status, provides appropriate care, and encourages self-help. Members may request to change any member of their Primary Care Management Team at any time.

The Primary Care Management Team is available to assist the members with any issue.

The Primary Care Management Team will "coordinate services" the member receives, and will communicate with the member's doctors on an ongoing basis. "Coordinate services" means that the Primary Care Management Team may arrange appointments for the member, arrange for transportation to and from appointments, and communicate with other care providers, regarding services covered by Senior Health Partners, as well as services not covered by Senior Health Partners.

When needed, the Primary Care Management Team may also help a member modify the member's home to improve safety and convenience and coordinate for assistance from family, friends, and neighbors.

By helping the member manage all aspects of their care, the Primary Care Management Team can identify problems early, prevent problems from getting worse, and help the member avoid trips to the hospital and emergency room

3.2 Coordination of Services

Senior Health Partners coordinates services designed to keep members safely living in their own homes for as long as possible. Senior Health Partners does this by providing a comprehensive approach in the delivery of long-term care services. The Primary Care Manager—a nurse or social worker with support from specialty teams—is responsible for coordinating services needed by members. Every member has their own Primary Care Manager and Care Management support who works with the member and their family/caregiver to provide an optimal and safe care plan.

At enrollment, Senior Health Partners has clinical and non-clinical staff dedicated exclusively to facilitating newly enrolled members. The staff work together to ensure coordinated services are in place at enrollment. The Welcome Team provides care management and service coordination for the first month of enrollment. Newly enrolled members are then transitioned to their permanent Care Manager for ongoing services.

The Senior Health Partners Primary Care Manager coordinates the services members receive, and communicates with the doctors and other health care providers on an ongoing basis. The Primary Care Manager may schedule appointments for members and ensures transportation services are available to and from appointments.

Senior Health Partners members develop a unique and strong relationship with their Primary Care Manager, who acts as an advocate and liaison between providers and the member. The Primary Care Manager should be contacted whenever opportunities for improvement are identified. The Primary Care Manager will contact the provider's staff when barriers are recognized and will work together to optimize care and satisfaction. In

addition, each Primary Care Manager has a network of resources within Senior Health Partners to assist them in their role.

Service Authorizations
Service authorizations are care decisions determined by Senior Health Partners with input from the member, family, physician, and other persons involved in the care of the member. Service authorizations ensure that covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished subject to the following:

- The services must be medically necessary
- The services furnished must reasonably be expected to achieve their purposes
- The services are authorized to maintain the member's health and safety

Procedures for authorizing services:

- Once services are approved, the appropriate servicing provider is contacted by phone
- Upon authorization of the service, the member, the servicing provider, and/or requesting provider are provided a written notification of the authorization detailing the type, frequency, amount of service, duration and expected date of commencement
- Authorizations will be mailed to the member and faxed as well as mailed to the provider to confirm approval. Authorizations are also posted to the provider portal
- Providers should initiate providing services **only upon receipt of written authorization to ensure payment**. **Servicing providers will receive written authorizations within 24 hours following a verbal approval, or the next business day. All authorizations are available on the provider portal.**

3.2 a Sample Service Plan Letter (Page 2)

This authorization does not guarantee payment. Payment is based on the member's active enrollment in Senior Health Partners at the time services are received. Coordination of benefits guidelines also apply.

Providers may confirm eligibility by contacting Senior Health Partners at 1-877-737-2693, our automated phone system is available 24 hours a day 7 days a week, live representatives are available Monday-Friday 9:00am-5:00pm or you can visit our website at www.healthfirst.org.

Senior Health Partners staff is here to assist with all our member's healthcare needs. Should you have any questions, please call:

Member Services Department 8:30am - 5:00pm (Monday - Friday)
1-800-633-9717
TTY 1-888-542-3821

Sincerely,

Clinical Services Department

Healthfirst will reimburse providers at the applicable i) statutory rate (see NYS PHL 2807-c(a-2), 42 USCS § 1396u-2 and 1395w-22(k); ii) the Multiplan rate or iii) the Healthfirst fee schedule. If you do not agree to this reimbursement, you may call 1-855-709-3083 prior to services being rendered so that we may arrange for care with another provider

<<NYSDOH Approved 09/01/2016>>

3.2 b Sample Service Plan Update Letter (Page 1)

Senior Health Partners, Managed Long-Term Care Plan
100 Church Street, New York, NY 10007
1-800-633-9717
TTY/TDD 1-888-542-3821

APPROVAL NOTICE

<<today_date_mmmm_ddyyyy>>

<<r_first_name>> <<r_last_name>>
<<r_address1>>
<<r_address2>>
<<r_city>> <<r_state>> <<r_zip>>

Enrollee ID: <<m_id>>
Coverage type: <<m_coverage_plan_name>>
Service: [describe requested or claimed service including: amount/duration/date of service]
Provider: <<sp_full_name>>
Plan Reference Number: <<re_authorization_number>>

Dear <<m_full_name>>:

You are getting this notice because your health plan has approved your Outpatient Service.

On <<insert auth request date>> you asked Senior Health Partners, Managed Long-Term Care Plan for the service listed above.

Senior Health Partners Plan has decided this service is [a covered benefit] [medically necessary] [approved to be provided by an out-of-network provider].

[[Provider Name] is a [participating provider.] [an out of network provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any].

This approval does not guarantee payment. Payment is based on your active enrollment in Senior Health Partners Plan at the time you received the service. Your provider may confirm eligibility by contacting Senior Health Partners Plan at 1-877-737-2693, our automated phone system is available 24 hours a day 7 days a week, live representatives are available Monday to Friday 9:00am-5:00pm or your provider can visit our website at www.healthfirst.org. Coordination of benefits guidelines may also apply.

This review was done for coverage purposes and does not replace the professional opinion of your provider of care. The final decision about treatment belongs to you and your provider.

If you would like to speak to Senior Health Partners Plan about this decision, please call 1-800-633-9717.

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3.2 b Sample Service Plan Update Letter (Page 2)

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Clinical Services Department

cc: Requesting Provider

{*Insert as applicable*}[At your request, a copy of this notice has been sent to:

[Enrollee Representative(s)]

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst"). Coverage for Senior Health Partners, Managed Long-Term Care Plan, is provided by Healthfirst PHSP, Inc.

Home Health Care Determinations

Effective January 1, 2010, subdivision 3 of PHL 4903 was amended to change the timeframe for utilization review determinations of home health care following an inpatient hospital admission. Typically, the request for these home health care services following an inpatient stay is for skilled services and is reimbursable by Medicare.

If a service is Medicare qualified, it is the provider's responsibility to determine if the member is Medicare eligible. If the member is Medicare eligible and the service is Medicare qualified, the provider must bill Medicare, and Senior Health Partners will be responsible for the co-pay of covered services.

Senior Health Partners will furnish utilization review determinations of home health care services following a Medicare denial or exhaustion of a Medicare benefit following an inpatient hospital admission: i.e., in a

general hospital that provides inpatient care or inpatient services in an Article 28 rehabilitation facility, as follows:

- Within one business day of receipt of the necessary information OR
- Within 72 hours of receipt of the necessary information if the day after the request for services falls on a weekend or holiday

If a request for home health care services and all necessary information is provided to Senior Health Partners prior to a member's inpatient hospital discharge, Senior Health Partners will make arrangements to coordinate benefits with the Medicare plan. If no Medicare insurance plan is in place, Senior Health Partners shall not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the determination is pending.

An appeal of a denial for home healthcare services following a discharge from a hospital admission will be treated as an expedited appeal.

Reports of Services Rendered

Providers are required to provide written reports to care managers following authorizations for service evaluations and after services provided to members. Payments may be deferred due to delays in receipt of required reports.

3.4 Assessments of Members

The member must be determined eligible for long-term care services (CBLTCS)* by the Conflict Free Evaluation and Enrollment Center (CFEEC) before joining a Managed Long-Term Care Plan like Senior Health Partners. Once the member is determined eligible, the member has sixty (60) days to select a Managed Long-Term Care Plan like Senior Health Partners for enrollment.

The CFEEC is a statewide resource that will provide independent and conflict-free evaluation, education and enrollment services for new applicants in need of community based long-term care services. In New York, Maximus (New York Medicaid Choice) serves as the independent and conflict-free entity. This policy does not apply to individuals transferring from one plan to another or from one Managed Long-Term Care product to another. All new Managed Long-Term Care enrollees may contact the CFEEC at **1-855-222-8350.** The member may call anytime Monday to Friday, 8:30 am to 8:00 pm or on Saturday, 10:00 am to 6:00 pm.

Once New York Medicaid Choice determines that a consumer is eligible for community based long-term care for more than 120 days, the consumer can choose a Managed Long- Term Care Plan. The consumer has several weeks to select a plan; however, the CFEEC evaluation will remain valid for 60 days. After such time, a new evaluation will be required if the consumer does not select a plan but continues to seek CBLTC.

Enrolling in Senior Health Partners is voluntary. If the member is interested in joining Senior Health Partners, the member or a member's representative can call Senior Health Partners and our staff will assist clients **new** to Managed Long-Term Care in contacting New York Medicaid Choice to find out more about our program. If the member is 21 years of age or older, lives in our service area, has completed a New York Medicaid Choice evaluation, and has chosen Senior Health Partners, our Enrollment Medicaid Specialist will come to the member's home to share more information about our program, at which time we will be able to collect more information about the member and their health care needs. The member may have a family member, or anyone else the member may wish, present when the Enrollment Medicaid Specialist comes to their home. If the member is still interested in joining Senior Health Partners after our Enrollment Medicaid Specialist has described the program to the member, our Enrollment Medicaid Specialist will confirm their Medicaid eligibility.

Medicaid eligibility must be reviewed and established for potential enrollees by the NYC Human Resources Administration or Local Department of Social Services

If the member does not currently have Medicaid, we will help the member apply for Medicaid coverage

unless the member is a private pay member

Our Enrollment Medicaid Specialist will:

- Ask the member to sign an authorization for intake and nurse assessment, which allows the Clinical Eligibility Nurse to assess their healthcare needs and clinical eligibility
- Ask the member to sign a consent form that allows their healthcare providers to release their medical information to us
- Review the Member Handbook with the member

Our Clinical Eligibility Nurse will come to the member's home within 30 (thirty) days of the request to join Senior Health Partners or upon referral from the CFEEC to:

- Conduct an initial assessment
- If the member has Medicaid only, the initial assessment will determine if the member is eligible for nursing home level of care as required for enrollment
- Determine if the member requires community-based long-term care services offered by Senior Health Partners for more than 120 days
- Provide the member with information and the form regarding electing a Health Care Proxy
- Discuss the service needs with the member

After completing the initial assessment, our Clinical Eligibility Nurse will ask the member to sign the Enrollment Agreement. By signing the Enrollment Agreement the member agrees to:

- Receive all covered services from Senior Health Partners and our network providers
- Participate in Senior Health Partners according to the terms and conditions described in the Member Handbook

During the time prior to their enrollment, the Welcome Team social worker will maintain contact with the member to answer any of their questions, discuss the Person Centered Service Plan (PCSP), and help the member with any service needs prior to their enrollment date.

A member's enrollment becomes effective on the first of the month. The member will receive their membership letter and a Senior Health Partners membership identification card.
Following enrollment, their Primary Care Management Team will contact the member to review their satisfaction with the PCSP and discuss any concerns the member may have. Changes in the PCSP can be made as needed based on the member's needs. The Primary Care Management Team will ask the member, their physician and their family/caregivers for input in development of changes in their PCSP. If the member's services have been changed, the member will receive a letter explaining the change.

The PCSP changes as the member’s needs and condition change, and is re-evaluated at least every six (6) months.