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. 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.

Objectives:

- Ensure primary accountability for case management, beginning with pre-enrollment and continuing through transition and enrollment
- Establish effective systems to ensure consistent oversight of care and services are met across all service settings
- Establish protocols for routine and event monitoring, e.g., hospitalization, short/long term nursing home placement, new diagnosis, major social or environmental change, increasing frequency of falls, pain management concerns or change in cognitive status
- Establish standards for documentation and practice
- Applying cost containment controls when clinically appropriate and with consideration for member/family preference

Contact with Members/Families/Caregivers

- Members, families and caregivers are instructed that they should contact the Care Team if they have any questions, concerns, compliments or complaints related to providers. They should not contact providers directly.
- Members, families or caregivers who contact providers for service issues, e.g., aide change, should be told to contact the Senior Health Partners Care Management Team **and** provider staff should inform the member's Care Management Team that they have been contacted.

3.2 Coordination of Services

Senior Health Partners provides and coordinates services designed to keep members living in their own homes for as long as possible. Senior Health Partners does this by providing a comprehensive team approach in the delivery of long-term care services. The Care Management Team (CMT)—a nurse, social worker and service coordinator—is responsible for coordinating the Medicaid and Medicare services needed by members. Every member has their own CMT, and the CMT works with the member and their family/caregiver to provide an optimal and safe care plan.

In January 2008, Senior Health Partners introduced a "Welcome Team" and in 2012 a "Transition Team" comprised of a nurse, social worker and service coordinator dedicated exclusively to facilitating newly enrolled members. Each of the following team members performs a valuable and integrated service designed to introduce Senior Health Partners' comprehensive care management:

- **The Welcome and Transition Team Nurse**

- Develops the Initial Plan of Care based on the initial needs assessment
- Secures necessary home care services with providers (vendors)
- Monitors change of health/service status
- Contacts Primary Care Providers to coordinate service delivery

- **The Welcome and Transition Team Social Worker**
  - Maintains contact with enrollee/family/caregiver prior to enrollment
  - Refers them to temporary community services as needed
- **The Welcome and Transition Team Service Coordinator**
  - Assists with telephone contacts
  - Arranges for commencement of initial services

The Welcome and Transition Teams provide care management and service coordination for the first month of enrollment. Newly enrolled members are subsequently transitioned to their permanent Care Management Teams for ongoing services.

The Senior Health Partners CMT coordinates the services members receive, and communicate with the doctors and other health care providers on an ongoing basis. CMTs will schedule appointments for members, provide for transportation to and from appointments, and arrange to meet members' needs.

Senior Health Partners members develop a unique and strong relationship with their CMT while the team acts as an advocate and liaison between both providers and members. CMTs should be contacted whenever opportunities for improvement are identified. CMTs will contact provider staff when barriers are recognized and will work together to optimize care and satisfaction. In addition, each Care Management Team has a network of resources within Senior Health Partners to assist them in their role. For example, direct supervisors, provider relations coordinator, contract administrator, quality assurance supervisor are just a sample of what is available to oversee provider performance and member outcomes.

Service Authorizations

Service Authorizations are care decisions determined by the CMT with input from the member, family, physician and other persons involved in the care of the member. Service Authorizations will ensure that covered services are sufficient in amount, duration or scope to reasonably be expected to 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, a member of the CMT determines the appropriate provider to contact
- Upon verbal acceptance of the case by a provider, the CMT member will prepare a written authorization detailing the type, frequency, amount of service duration and expected date of commencement
- Authorizations will be mailed or faxed to the provider to confirm approval and made available to Senior Health Partners' claims processor
- Providers should initiate providing services **only upon receipt of written authorization to ensure payment. Written authorizations should be received by providers within 24 hours following a verbal approval, or the next business day.**

3.2 a Sample Service Plan Letter (Page 1)

3.2 a Sample Service Plan Letter (Page 2)

Authorized Service(s) and/or Item(s):

Requesting Provider: <<rp_full_name>>

Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>>

Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>

Service Description: <<re_procedure_code1>>

Authorization Number: <<re_authorization_number>>

Requesting Provider: <<rp_full_name>>

Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>>

Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>

Service Description: <<re_procedure_code1>>

Authorization Number: <<re_authorization_number>>

<<SHP_28 01/2011>>

3.2 b Sample Service Plan Update Letter (Page 1)

3.2 b Sample Service Plan Update Letter (Page 2)

Authorized Service(s) and/or Item(s):

Requesting Provider: <<rp_full_name>>

Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>>

Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>

Service Description: <<re_procedure_code1>>

Authorization Number: <<re_authorization_number>>

Requesting Provider: <<rp_full_name>>

Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>>

Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>

Service Description: <<re_procedure_code1>>

Authorization Number: <<re_authorization_number>>

<<SHP_29 01/2011>>

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 follow an inpatient stay is for skilled services and 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 health 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.

3.3 Covered and Non-Covered Services

Covered Services

Care Management

Home health care

Nursing Services

Private Duty Nursing

Non-emergent transportation

Podiatry and routine care

Optometry (including eyeglasses)

Audiology, hearing aids and batteries

Dental care

Prosthetics and orthotics

Medical equipment and supplies

Enteral and parenteral nutritional supplements (limitations may apply)

Personal emergency response system

Social and Environmental supports

Dietary counseling

Nursing home care

Respiratory therapy

Physical, occupational and speech therapies (limited # outpatient visits)

Medical Social services

Adult Day Health Care

Social Day Care

Home-delivered meals

Coordinated Services

Your care team will coordinate medical services not covered by Senior Health Partners to help you remain at your best.

In-patient and outpatient hospital services

Laboratory and radiology services

Prescription and non-prescription drugs

Physician services

Psychiatry services

Mental health services

Alcohol and substance abuse services

Chronic renal dialysis

Emergency transportation

Family planning services

Services covered by the Office of mental Retardation and Developmental Disabilities

Non-Covered Services

Inpatient and outpatient hospital services

Laboratory and Radiology services

Prescription and non-prescription drugs

Physician services

Mental Health services

Chronic Renal Dialysis

Emergency Transportation

Rural Health Clinic Services

3.4 Assessments of Members

Senior Health Partners builds a strong relationship with our members that starts before enrollment, a relationship that grows deeper over time. Providers partner with us in growing this relationship by supplying services to maximize care and satisfaction, and by communicating any changes in the member's status promptly to a Senior Health Partners care manager.

The Initial Assessment

An Intake Nurse goes to the prospective enrollee's home to conduct an assessment to evaluate the member's medical, cognitive and functional status, and also to evaluate the home environment. Based on the assessment, a Plan of Care/Service Plan is developed. The Plan of Care/Service Plan is communicated and agreed to by the enrollee, family and/or caregiver.

The new enrollee's Care Management Team (CMT) contacts providers based on the member's needs to arrange for required services. Thus begins the strong and unique relationship between the member/member's family/caregiver, the provider and Senior Health Partners.

It is the responsibility of Senior Health Partners CMT to assess or re-assess the need for a personal care aide, home health aide and housekeeper services, and to evaluate the member's resources. The Provider is responsible for servicing the member according to the services authorized by Senior Health Partners. The Provider must follow the Plan of Care. The Provider is responsible to open the case and supervise the Home Health Aides or Personal Care Aides according to contract or NYSDOH policies and procedures. The Provider should communicate any recommendations or revisions required to the service plan directly to the Senior Health Partners CMT.

Ongoing Assessments

Outgoing monthly telephone calls are made to each member by the CMT. The purpose of the calls is to ascertain if the member's needs are being met, distinguish changes in functionality, identify opportunities for improvement and maximize satisfaction. Results of these calls assist in determining changes in services or the Care Plan. Team nurses and/or social workers may also conduct home visits, as needed, to assist members in maximizing care and functionality and to deal with clinical and social issues.

Semiannual Assessments

Every 180 days, a formal assessment is conducted by a nurse during a visit to the member's home. As in the initial visit, the nurse conducts an assessment of the member's medical, cognitive and functional status, as well as the home environment. Based on the assessment, a Plan of Care/Service Plan is developed. The Plan of Care/Service Plan is communicated and agreed to by the enrollee his/her family/caregiver and to the designated CMT. CMT staff will then contact providers to meet the identified needs.