CHAPTER 6: LONG TERM SERVICES AND SUPPORT (LTSS)

UNIT 2: CASE MANAGEMENT FOR LONG TERM SERVICES AND SUPPORT (LTSS)

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6.2 PLAN OF CARE

Overview

The Plan of Care is developed by the Case Manager taking into consideration the needs of the member identified during an assessment, the care plan to address those needs, the facilitation of the plans, and advocacy for the member.

Case Manager assessment

The assessment will consist of the Case Manager gathering relevant, comprehensive information and data by interviewing the member, caregiver, and family. When indicated, the primary care physician/provider or physician specialist, other members of the health care team, and other appropriate individuals as approved by the member may also be interviewed.

The Case Manager utilizes formal assessment tools prior approved by the State and in accordance with protocols specified by the State, telephonic assessment strategies, electronic communication, and/or other efficient modes of communication in addition to face-to-face visits as a means to perform careful evaluation of the Diamond State Health Plan Plus Long Term Services and Support (DSHP Plus LTSS) Program member's situation.

Assessment is important for the Case Manager to gather information concerning the member's health behaviors, cultural influences, socio-economics, and behavioral health information related to the current or proposed plan of care to identify potential barriers, clarify or determine realistic goals and objectives, and seek appropriate alternatives for the member.

The Case Manager should recognize the importance of the member's involvement in a successful assessment process and should provide and encourage opportunities for the member to communicate and collaborate with the Case Manager or any member of the member's health care team.

Coordination with local departments and agencies

Service needs are identified by the Case Manager during development of the Plan of Care. Health Options does not require home and community-based services to be ordered by a treating physician, however, the Case Manager may consult with them as appropriate regarding the member's physical health, behavioral health, and long-term service and support needs.

All services the member will receive, regardless of payer source, are incorporated into the Plan of Care. In addition to LTSS, the Case Manger helps coordinate other Medicaid State Plan services, referral to Behavioral Health, referral to Care Coordination, and services provided for Duals by Medicare. All efforts of coordination are documented in the Member's Plan of Care.

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6.2 PLAN OF CARE, Continued

Coordination with local departments and agencies

Based upon the member's needs as identified during the Needs Assessment, the member selects their top three service providers for each LTSS that is documented on their Plan of Care. The member's selection of providers is documented on the Provider Selection List. The Provider Selection List is submitted to the Member Associate in the Support Center for coordination. The Member Associate secures the providers, creates the authorizations, and sends the authorization confirmation to the providers so service initiation can begin.

6.2 LONG TERM SERVICES AND SUPPORT (LTSS) PROVIDERS

Overview

The Member Associate secures providers per the member's Plan of Care to initiate services within the required time frames. Upon verbal confirmation that the provider can begin, the Member Associate authorizes the service to the specified provider in the system of record and sends the provider a *Provider Plan of Care* which serves as an Authorization Confirmation.

Diamond State Health Plan Plus Long Term Services and Support (DSHP Plus LTSS) providers receive a *Provider Administration Manual* as well as a *LTSS Claims Reference Guide*. Health Options has a full-time staff person dedicated to DSHP Plus and DSHP Plus LTSS provider services and provider relations, including all network development, staff and management issues, provider payment issues, and provider education.

Monitoring quality and performance

Health Options monitors quality and performance of participating providers using an interdisciplinary model that includes all departments contributing information in support of maintaining quality of care for members. All information is reported to the Quality Improvement Department, which develops and tracks performance measures including appropriate utilization management patterns and quality of care concern trends.

Home and Community-Based Services (HCBS) providers will be subject to quality monitoring and reporting, and Health Options will develop performance triggers relevant to in-home service providers. These could include such measures as provider-associated trends in:

- Member use of back-up plans and gaps in care
- Member complaints and grievances
- Member satisfaction survey results
- Frequent discrepancies between HCBS billing and service documentation

When HCBS services are provided in a member's residence, the service provider is required to document the service through service logs. Health Options will select a random sample of service logs and phone records on a monthly basis for review to verify services provided. In addition, HCBS providers will be audited on a regular basis to ensure that services billed have been provided.

6.2 LONG TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS

Overview

Diamond State Health Plan Plus Long Term Services and Support (DSHP Plus LTSS) members receive intake and ongoing case management by licensed Registered Nurses (RNs) and/or Social Workers with Bachelor or Master Degrees with active licensure and credentials serving as Case Managers who engage the member, caregiver, and family in the planning and decision-making process. The Case Manager is the primary point of contact with the member.

Role of the Case Manager

The Case Manager is responsible for assessment, planning, coordination, implementation, and evaluation as follows:

FUNCTION	DESCRIPTION
Assessment	**<u>Information to Members:</u>** • At the time of the initial assessment, the Case Manager provides and reviews with each member an *LTSS Education Materials* booklet. The *LTSS Education Materials* booklet includes, but is not limited to, an overview of the LTSS program, services available, member Grievances and Appeals process, identification and reporting of abuse, neglect and exploitation, and contact information for the Case Manager. **<u>Member Needs:</u>** • The Case Manager utilizes a Comprehensive Needs Assessment (Plan of Care Summary) to identify the strengths, capacities, and preferences of the member, as well as to identify the member's LTSS needs and how to meet those needs. • The assessment analyzes and describes the medical, social, behavioral, and LTSS services that the member will receive, as well as goals for longer term strategic planning. • Member Needs are assessed upon Intake and at each on-site review. **<u>Member Safety:</u>** • During each assessment, the Case Manager creates a Risk Agreement in conjunction with the member. The Risk Agreement includes any risk identified, a plan to reduce or prevent each risk, and the member's acknowledgement and acceptance of each risk. • During each assessment, the Case Manager completes an evaluation of the member's physical environment (Home Safety Monitoring Checklist) to ensure member safety. • Member Safety is assessed upon Intake and at each on-site review.

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6.2 LONG TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS,
Continued

Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
Planning	The Case Manager, in conjunction with the member, develops a person-centered Plan of Care (Plan of Care Services). The Plan of Care considers appropriate options for the member related to his/her medical, behavioral health, psychosocial, case-specific needs as a specific point in time. The Plan of Care Services includes the type of service, tasks to be performed at each service, frequency of service, hours/amount, start/end dates, daily schedule, scheduled start time, and provider type. The Plan of Care Services is signed by the member and is reviewed and updated upon Intake, when there is a change in services, and at each onsite review.
Coordination	• All services the member will receive, regardless of payer source, are incorporated into the Plan of Care. In addition to LTSS services, the Case Manger helps coordinate other Medicaid State Plan services, referral to Behavioral Health, referral to Care Coordination, and services provided for Duals by Medicare. All efforts of coordination are documented in the member's Plan of Care. • Based upon the member's needs as identified during the Needs Assessment, the member selects their top three service providers for each LTSS service that is documented on their Plan of Care. The member's selection of providers is documented on the Provider Selection List. The Provider Selection List is submitted to the Member Associate in the Support Center for coordination. The Member Associate secures the providers, creates the authorizations, and sends the authorization confirmation to the providers so service initiation can begin.
Implementation	• The Case Manager ensures the provision of all services to meet the member's needs occurs as soon as possible. Services determined to be Medically Necessary must be provided to the member within fourteen (14) calendar days of the on-site visit during which the need for the service was determined. • If the member's life, health, or ability to attain, maintain, or regain maximum function would otherwise be jeopardized, then a decision regarding the provision of services must be made within three (3) business days.

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6.2 LONG TERM SERVICES AND SUPPORT (LTSS) CASE MANAGERS,
Continued

Role of the Case Manager (continued)

FUNCTION	DESCRIPTION
Evaluation	Service provision and the need for such services are continually monitored and evaluated at each on-site visit, and at monthly telephonic contacts. Time frames for member contacts are as follows: **<u>On-site Reviews:</u>** • At least every one hundred eighty (180) calendar days for a member in an institutional setting (this includes members receiving hospice services and those in a nursing facility); • At least every ninety (90) calendar days for a member receiving Home and Community-Based Services (HCBS), including members residing in Assisted Living Facilities; • At least every ninety (90) calendar days for a community-based DSHP Plus LTSS member with HIV/AIDS (May be conducted on-site, via telephone, or by certified letter. However, an on-site visit with the member must be completed at least once a year.); and, • For members in the Money Follows the Person (MFP) program, in accordance with the monitoring requirements in the State's MFP Protocol. **<u>Nursing Facility Case Conferences:</u>** • The Case Manager attends all Nursing Facility Case Conferences as an opportunity to discuss the member's needs and services jointly with the member, providers, and the member's family. **<u>Monthly Contacts:</u>** • The Case Manager contacts members, at a minimum of monthly, between on-site reviews to monitor the status of the delivery of approved services and any changes to the member's needs or circumstances. **<u>Significant Change:</u>** • The Case Manager conducts an on-site review within ten (10) business days following notification of a significant change. A significant change is considered: ▪ Member has had a change of placement type; or, ▪ Member has had a change in needs or circumstances that might require a revision to the member's Plan of Care.