Washington State Aging and Long-Term Support Administration
Medicare Connect (DSNP) Enrolled Individuals and the LTC system:
Coordination of LTC and Medical benefits

Purpose

Proactive collaboration between Apple Health Medicare Connect Dual Special Need Plans (DSNP) and the Long-term care (LTC) system increases client/beneficiary ability to return to and remain in the community, with the right support in place. This document establishes processes to improve coordination.

Optimizing Coordination for Better Outcomes

Many of Washington's most vulnerable dual eligible individuals receive LTC and are also enrolled in a DSNP. Coordination between these plans and the LTC system is critical to ensure client/beneficiaries receive coordinated care and to avoid unnecessary inpatient stays or health complications. Utilizing a collaborative care coordination process between plans and the LTC case management system, including Area Agencies on Aging (AAA) and Home and Community Services (HCS), will lead to more efficient and timely transitions of care, support whole person health and achieve better integration of services at the local level.

When and How to Engage System Partners

Medicare Advantage (MA) Plans and LTC system should coordinate with each other as they become aware of a client who would benefit from cross-system coordination.

MA Plans and LTC system can initiate coordination via email or through established biweekly care coordination meetings. To add a client to the biweekly HCS/AAA/MA Plans, please send: client's name, DOB and ProviderOne number via secure email to a HCS Managed Care Systems Consultant.

- HCA/AAAs can find the contact list of the MA health plans on the ALTSA Intranet
- MA plans may find the HCS/AAA case manager listed in PRISM if the individual has LTSS authorized services.

Understanding Entities' Roles

Individuals responsible for achieving successful transitions of care and care or case management should be well versed on the services available to clients/beneficiaries and how to access them. While we can not all be experts in all the things, we can partner across the delivery systems to address gaps in care and achieve more efficient and cost-effective service delivery. See details in the next page.

Not sure how to initiate care coordination or need further support?

MA Plans and LTC case managers can reach out to the HCS Managed Care System Consultant, for support.

Region 1

North Central, Spokane, Greater Columbia and Klickitat County

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Region 2

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Region 3

Salish, Thurston-Mason, Pierce, Great Rivers, Clark and Skamania

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General Information:

MA Plans can find a list of locations and general contact information for AAA and HCS Offices on the ALTSA Resources webpage.

- Community Health Plan of Washington
- Coordinated care (Wellcare)
- Humana
- Molina Healthcare of Washington
- UnitedHealthcare Community Plan of Washington
- Wellpoint (WLP)

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Area Agency on Aging (AAA):

- Information and Assistance (no wrong door access to local community services and supports)
- Case management of Medicaid LTC clients served in their home.
- Conduct ongoing functional assessments for LTC and service plans
- Assist with transition to LTC services or settings
- Case management for other programs like supportive housing, state funded family caregiver support programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Some AAAs have special programs like Health Homes or care transitions
- Contract Medicaid LTC providers
- Other social support services (local expertise) e.g.:
    - Transportation
    - Nutrition Services – congregate or home delivered meals
    - Family Care Giver Support
    - Information and Assistance
    - Environmental modifications

Home and Community Services (HCS)

- Initial eligibility determination for referrals to the Medicaid LTC system.
- Financial eligibility determination for some Medicaid clients
- Conduct person centered initial and ongoing functional assessment and service plan
- Residential and SNF case management
- Assist with referrals as identified in the functional assessment
- Assist with transitions of care from inpatient to community LTC and from different LTC settings.
- Authorize Medicaid LTC services
- Contract LTC residential settings and services

Medicare Advantage Dual Special Needs Plan (D SNP):

- Responsible to conduct an Initial Health Risk Assessment and offer care management services if indicated.
- Assist with transition planning and responsible to locate and assist with scheduling post discharge appointments with providers
- Coordination with the BHSO (behavioral health plan) as appropriate
- Reviews/approves authorization requests for Durable Medical Equipment (DME)
- Timely Prior Authorizations for medically necessary care like SNF, Home Health or other care
- Track in-patient stays and identify opportunities for early intervention, assist with transitions
- Responsibility for Medicare-covered benefits and to coordinate Medicare benefits and services
- Offer Supplemental Benefits (vary depending on the plan) could include:
    - Transportation
    - PERS
    - Transitional Meals
    - Utilities, Over the Counter (vitamins, basic supplies), and Healthy Food Card