

Overview

WellCare Senior Partnership is a Florida Long Term Care Community Diversion Plan designed to provide frail elders with safe and appropriate community-based care alternatives and enhanced benefits in lieu of nursing home placement. This section will outline specific information related to benefit coverage, eligibility, enrollment and more. It will also show the distinctions in benefit coverage and services provided for members of the WellCare Senior Partnership Plan from those available to traditional fee-for-service Medicaid members.

Any topics not specified in this section will be governed by the applicable section of the manual. For additional information about this Plan, contact your WellCare Senior Partnership Network Development Specialist

About the Long Term Care Community Diversion Program

Our Long Term Care (LTC) Community Diversion Plan, WellCare Senior Partnership, was created to help meet the clinical, social and long-term care needs of frail elders with chronic illnesses or disabilities who require assistance with Activities of Daily Living (ADLs).

An essential part of the program is a collaborative team approach that partners a WellCare Care Manager with the member, the member's family and Primary Care Physician (PCP), as well as other health care providers. This team approach focuses on the integration of preventive and primary care with long-term care, ancillary and other support services. Our goal is to provide WellCare Senior Partnership members with a healthier and safer lifestyle at home and in their communities.

Enrollment in WellCare Senior Partnership is voluntary and available to enrollees who are both financially and clinically eligible. It is designed to offer members a comprehensive list of benefits - all of which are coordinated through an appointed Care Manager. The Care Manager is responsible for collaborating with the (PCP) and other health care professionals to help

optimize each member's clinical and non-clinical needs.

Definitions

Care Management Services shall mean the establishment and implementation of a written care plan and the assistance for members to access services authorized under said care plan. Care Management Services include referrals and coordination of necessary medical, social, educational, psychosocial, financial and other services pertaining to the care plan irrespective of whether such services are Covered Services.

Care Manager shall mean a provider of Care Management Services.

WellCare Senior Partnership

WellCare Senior Partnership was developed for Medicaid recipients in need of supportive long term health care services such as assistance at home and personal care. These services are identified to help members maintain some independence and remain in their homes and communities longer.

The program is a voluntary alternative to other community-based Medicaid long term care programs. Members of WellCare Senior Partnership continue to receive traditional Medicaid services. In addition to those offered with traditional Medicaid, they also receive other community-based benefits. These benefits include home-delivered meals, chore services and adult day health care.

Acute care services rendered by physicians, hospitals and other providers will continue to follow current Medicaid authorization rules since Medicare is the primary health insurance for all members.

Member Eligibility

An individual who meets the following requirements is defined as eligible for enrollment with WellCare Senior Partnership. An eligible member must:

- Be 65 years of age or older;

- Have Medicare Parts A & B as reflected in the Florida Medicaid Management Information System (FMMIS) through the Medicaid Eligibility Verification System (MEVS);
- Be Medicaid eligible up to the Institutional Care Program Level (ICP);
- Reside in program service area;
- Be determined by CARES to be at risk of nursing home placement and meet CARES clinical criteria:
 1. Require some help with five or more activities of daily living (ADLs); or
 2. Require some help with four ADLs plus requiring supervision or administration of medication; or
 3. Require total help with two or more ADLs; or
 4. Have a diagnosis of Alzheimer's disease or another type of dementia and require some help with three or more ADLs; or
 5. Have a diagnosis of a degenerative or chronic condition requiring daily nursing services.
- Be determined by Comprehensive Assessment and Review for Long-Term Care Services (CARES) to be a person who, on the effective date of enrollment, can be safely served with home and community-based services.

Covered Benefits

Each member will receive coordination of care and benefits through their Care Manager. Care Managers will:

- Work with members, their health care providers and caregivers to decide which services will deliver the best care possible;
- Arrange and monitor services and care;
- Coordinate medical and long term care with all providers and payers; and
- Coordinate discharge planning needs after a hospital stay.

Coverage includes the following, with authorization from WellCare:

- Adult Companion Services
- Adult Day Health Services
- Assisted Living Facility
- Care Management Services
- Chore Services
- Consumable Medical Supply Services
- Environmental Accessibility Adaptation Services
- Escort Services
- Family Training Services
- Financial Assessment and/or Risk Reduction Services
- Home Delivered Meals
- Homemaker Services
- Nutritional Assessment and/or Risk Reduction Services
- Personal Care Services
- Personal Emergency Response Systems (PERS)
- Respite Care Services
- Occupational Therapy*
- Physical Therapy*
- Speech Therapy*
- Nursing Facility Services*

*These services may be paid for in whole or in part by Medicare. Providers should bill Medicare or the Member's Medicare Managed Care Plan, as applicable prior to billing WellCare Senior Partnership for Medicare covered services. WellCare Senior Partnership will pay co-insurance or deductibles in accordance with established Medicaid guidelines for crossover payments.

If Medicare is the primary payer, the member may choose any Medicare provider. When Medicare payment limits are met for these services, the member may need to change to a provider within our network. Please note that if the member has Medicare or any other health insurance, WellCare Senior Partnership is the payer of last resort.

WellCare Senior Partnership also offers dental care and optometry services without prior authorization (refer to the Florida Long Term Care Quick Reference Guide).

Over the Counter (OTC) Expanded Benefit

Members receive a \$25.00 per month OTC benefit, which includes health and hygienic items. Members can access this benefit by contacting their Care Manager.

Pharmacy Benefit

WellCare Senior Partnership covers a select list of drugs not covered by Medicare Part D or Part B.

The Care Manager is responsible for coordinating all acute care and long term care services. If services require authorization, the Care Manager will issue the authorization and coordinate the services with the member.

See the Covered Services section of this manual for a summary of covered services. Complete benefit descriptions, including limitations and exclusions are outlined in the applicable Medicaid Provider

Handbooks. All requests for covered services will be coordinated through the Care Manager who may be reached toll-free at (866) 581-0903.

Provider Responsibilities

A WellCare Senior Partnership network provider will be responsible for providing the following long term care coordination services:

- Collaborate with Care Managers and other providers by making themselves available via telephone and/or fax. In addition, they must ensure that services are provided in a manner that is (i) timely, appropriate and necessary for the support of the member's social and safety needs (ii) within his or her profession and provided in an ethical, legal and culturally competent manner (iii) at efficient, economic and appropriate levels of safety.
- Create and maintain a record of member health information and make it accessible for the Plan's Care Manager and Provider Relations. The plan requires that its direct service care providers record and maintain information regarding each member including:
 - Member demographics;
 - Medical history, details of the present illness, and relevant past, social and family history (appropriate to the member's age);
 - Diagnosis or clinical impressions;
 - Plan of care including any preventive, diagnostic and therapeutic orders;
 - Progress notes and weight log;
 - Positive or negative history of allergic and adverse drug reactions relevant to member's care;

- Discharge summaries as applicable; and
- Evidence of advance directives, as appropriate.

The following documentation standards apply to the elements included in medical record documentation*:

- Confidentiality;
- Legality;
- Sufficient health information as necessary to enhance continuity and coordination of care and health services;
- Completeness and accuracy; and
- Availability and accessibility to those providing professional and ancillary health care services, appropriate Federal and state representatives, health plan representatives involved in delivery and oversight of care and quality management activities.

*This does not encompass all documentation requirements.

Direct service providers are also required to collaborate with Care Managers to:

- Coordinate, plan and arrange transition between care settings (assisted living facility, home/community, hospital, nursing facility);
- Reinforce and promote LTC program efforts to encourage and facilitate member independence and preserve dignity;
- Support and cooperate in quality improvement, continuing education and similar programs established by Plan and Department of Elder Affairs;

- Be responsive to Care Manager inquiries within the guidelines set by the Plan, such as:
 - Emergent within 30 minutes;
 - Urgent within 24 hours; and
 - Routine/non-emergent within two business days.
- Cooperate with Plan efforts to assist members in receiving appropriate preventive health services (e.g., annual flu shot, pneumococcal immunization);
- Identify and provide information on a timely basis to the Care Manager about any observable changes in a member's health care status or other issues that would have an impact on a member's health care status or care plan; and
- Contact the Care Manager within 24 hours and other appropriate agencies in circumstances such as temporary or permanent move, hospitalization, hospice admission, evacuation or death.

Provider support services are available through orientations and scheduled visits. An in-service visit will be conducted where the provider's role and responsibilities are established. Support services will include education materials, review of billing and claims information, overviews of the Plan's roles and responsibilities and assistance with re-credentialing requirements through monitoring visits.

Enrollment Process

Membership in WellCare Senior Partnership is voluntary. Potential enrollees must undergo an eligibility process administered by the Comprehensive Assessment and Review for Long-Term Care Services

(CARES) program, managed by the Department of Elder Affairs.

Potential members may choose to receive community-based services while awaiting Medicaid eligibility. The Department of Children and Families (DCF) determines financial eligibility for Medicaid. The approval process may take up to four months to complete. During the four-month span, the Plan must provide community-based services to the “Pending” enrollee.

The enrollment process begins when CARES dispatches a Case Manager to assess a potential enrollee for eligibility and provide choice counseling. The potential enrollee will have the opportunity to choose a Long Term Care (LTC) Contractor within their service area if they are deemed eligible to participate in the program by CARES.

Once the member is determined to be eligible and selects WellCare Senior Partnership Plan, CARES will send an enrollment packet to WellCare Senior Partnership.

Prior to the member’s initial enrollment date, the member will be contacted by a WellCare Senior Partnership Field Care Manager to welcome the member to the Plan, confirm his or her location and schedule a new member visit. If the Field Care Manager is not able to contact the member he or she will:

- Contact the involved/responsible caregiver if such individual has been identified; and
- If no involved/responsible caregiver has been identified, he or she will contact the CARES Case Manager that referred the potential enrollee.

The Care Manager will schedule the appointment and conduct an in-person orientation within five business days of enrollment for members who reside in a community setting or within seven business days for

members who reside in a facility. During the orientation, the Care Manager will:

- Introduce himself or herself;
- Provide the member with addresses and telephone numbers where the Care Manager can be reached;
- Identify the Primary Care Physician (PCP);
- Explain to the member his or her rights and responsibilities, as well as WellCare Senior Partnership's responsibilities;
- Explain the grievance and appeals process;
- Inform the member of services provisions offered by the program and coordination of care with Medicare;
- Explain the Plan's hours of operation and what to do in the case of an emergency;
- Confirm the PCP information a second time;
- Instruct member on how to access his or her medication using the new Plan ID;
- Request and document all of the member's medication with doses and frequencies;
- Complete the "Release of Information" form and explain why it is needed;
- Request Advanced Directive forms if any; if not, complete form stating that member has none;
- Complete the new member checklist to verify all necessary information is obtained;
- Provide the member with a Provider Directory and a Member Handbook; and

- Complete the member assessment.

Once the assessment is complete, the Field Care Manager will finalize the care plan and review its contents with the member and their caregiver or family member.

The Field Care Manager will send all documents to the Telephonic Care Manager for continued care management and will also forward copies of the care plan to the member and PCP.

Voluntary Disenrollment

Members may request disenrollment from WellCare Senior Partnership at any time. This request can be made verbally or in writing to the member's Care Manager. Upon receipt of a voluntary request for disenrollment, the Care Manager will immediately inform the member of the disenrollment procedures. A disenrollment form will be sent to the member for completion to document and process the request. The Care Manager will confirm the effective disenrollment date with the member.

A member who chooses to join and/or receive services from another managed care plan that is capitated by Medicaid (a hospice or a home and community-based service waiver program) is considered to have initiated Disenrollment from WellCare Senior Partnership on a voluntary basis. Effective September 1, 2007, hospice enrollees will no longer be required to disenroll from the Long Term Care Diversion Wavier Project.

WellCare Senior Partnership will provide a monthly Disenrollment report to the Department of Elder Affairs (DOEA).

WellCare Senior Partnership will continue to provide and/or arrange for the provision of covered services until the effective date of disenrollment.

**Involuntary
Disenrollment**

Involuntary disenrollments are limited to the following reasons:

- Enrollee death
- Ineligibility for Medicaid
- Ineligibility for the program
- Moving outside the program's service area
- Fraudulent use of the Medicaid ID card
- Incarceration
- Non-cooperation, subject to DOEA approval
- The Department of Children and Families (DCF) determines if an applicant does not meet financial eligibility criteria. This may include a determination that the applicant:
 - Is no longer eligible for Medicaid and/or will not be able to meet Medicaid eligibility.

If DCF makes this determination and notifies the Program of this outcome, the Care Manager will notify the member and inform him or her of DCF's determination.

Involuntary disenrollment initiated by WellCare Senior Partnership Plan will require approval from the Florida Department of Elder Affairs (DOEA). The Plan will submit information pertinent to the involuntary disenrollment request to DOEA with sufficient time to allow DOEA to approve the disenrollment. Before requesting an involuntary disenrollment, the Plan must provide at least one verbal and one written warning of the full implication of failure to follow the recommended care plan. A written explanation of the reason for disenrollment will be given to the member prior to submitting the disenrollment request to DOEA. If the member continues to be non-compliant with the care plan, the Plan may request an involuntary disenrollment.

Members who are disenrolled involuntarily are not eligible for re-enrollment without the permission of the Plan.

**Utilization
Management**

WellCare Senior Partnership's Utilization Management (UM) Program will actively promote the most effective patient care services for its members while maintaining quality of services that is in-keeping with professionally recognized standards of care.

The focus of the UM program is on:

- Promoting a wide concept of UM to identify and eliminate inefficient process that result in prolonged and unnecessary services;
- Promoting the efficient utilization of services through concurrent and retrospective review;
- Ensuring the medical record demonstrates the quality and utilization of services needed to:
 - Manage the progress of each member;
 - Evaluate the appropriate use of clinical support and ambulatory services;
 - Identify and analyze the patterns of under utilization;
 - Develop and implement strategies to improve utilization of resources when indicated; and
 - Monitor the impact of problem resolution strategies.
- Use in the re-appraisal and re-appointment process of participating providers;
- Serving as the basis of education for providers and members regarding

appropriate resource use;

- Monitoring resource consumption;
- Identifying practice patterns;
- Assessment of effectiveness of recovery groups, protocols and utilization management strategies;
- Providing analysis;
- Serving as a resource in the reconsideration and appeals process, and assistance to develop corrective action plans for quality issues indicated; and
- Working concurrently with provider groups, regulatory bodies and members of the Plan.

Care Management

Members of WellCare Senior Partnership will be assigned a Care Manager. A Care Manager's responsibilities include:

- Becoming a single point of contact for member education and information;
- Providing a comprehensive assessment of the member's needs;
- Developing and implementing member care plans;
- Coordination and authorization of services;
- Integration of the member's medical and long term care plans; and
- Coordination of support services that help members stay at home or in the community as long as feasible and safe.

Claims Overview

Please refer to the **Claims** section of this manual for additional information on claims submission. The information below should be considered additional for the purposes of specifying information for WellCare Senior Partnership services.

All claims will be submitted to WellCare Senior Partnership for processing except for those related to vision and dental.

WellCare Senior Partnership is responsible for Medicare co-insurance and deductibles as the secondary payer according to Medicaid guidelines and Medicaid's Medicare cost-sharing policies. There may be instances where Medicare has paid more than Medicaid would allow or the member's Medicare Part A & B benefits are covered through a Medicare HMO. In these instances, the provider will not be eligible for additional reimbursement.

Providers must bill WellCare in accordance with HIPAA approved billing standards including the billing codes outlined in the provider's contract with the Plan.

WellCare's Claim Submission Information

Claims may be submitted to WellCare in one of the following formats:

1. Electronic Claims Submission (EDI)
2. CMS 1500 Form (original forms only)
3. UB04 Form (original forms only)

WellCare's address for **paper** claims is:

WellCare Senior Partnership
Attn: Claims Department
P. O. Box 31414
Tampa, FL 33631-3414

Claims should not be submitted using White-out® or other corrective material.

WellCare's electronic claims submission guidelines require the following information:

- Clearing House Name
- Telephone Number
- Payer ID

For additional information on electronic claims submission to WellCare, refer to the Web site at www.wellcare.com or contact your WellCare Senior Partnership Network Development Specialist

To check the status of claims submitted to WellCare Senior Partnership, call our toll-free hotline at 866-581-0904.

Please refer to the Florida Long Term Care Quick Reference Guide for additional claims information.

Grievances

Please refer to the **Appeals and Grievances** section of this manual for a comprehensive description of related policies.

Grievances and/or Appeals for WellCare Senior Partnership related services will be processed according to Medicaid rules.

A *grievance* is an expression of dissatisfaction by the member or provider on the member's behalf about the care and treatment that does not amount to a change in scope, amount or duration of service.

Members may file a formal grievance either verbally or in writing within one year of the date of service or occurrence. All grievances will be acknowledged in writing within five business days.

A written grievance request may be mailed or faxed directly to the WellCare Grievance Department at:

WellCare Senior Partnership
Attn: Grievance Coordinator
P.O. Box 31370

Tampa, Florida 33631-3370
Fax: (866) 388-1769

The Member Services Department will provide members with assistance to file a grievance with WellCare. A member may contact the Member Services Department at (866) 581-0903 Monday through Friday, from 8:00 a.m. to 6:00 p.m. ET.

Expedited Grievance Process

A request to accelerate the review of a grievance may be requested if the standard time frame for resolution could jeopardize the member's health or safety. A determination will be as prompt as the member's condition requires, but no longer than 72 hours from receipt of request for review.

Standard Grievance Process

A grievance will be investigated and a closure letter sent to the complainant within 45 calendar days from receipt but not longer than 60 calendar days from receipt of the grievance. The closure letter will include the determination and date of such determination.

If the member remains dissatisfied with the results of the grievance determination, the member may request a meeting with the Grievance Committee whether in person or via telephone conference.

After a member has completed all levels of review available through the Plan, he or she may submit their grievance in writing to the agency listed below within 365 days of the Plan's final decision.

Subscriber Assistance Panel
2727 Mahan Dr
Building #1, Room 339
Tallahassee, FL 32307

For assistance during or after the grievance process, the member may also contact the agencies via telephone at (888) 419-3456 or (850) 921-5458.

The member may also request a Medicaid Fair Hearing but loses their right to a review by the Subscriber Assistance Panel. To start the Medicaid Fair Hearing process, the member must make a request within 90 calendar days of the original Plan denial to the Department of Children and Families (DCF) at the following address:

Office of Public Assistance Appeals Hearing
1317 Winewood Blvd.
Building 5, Room 203
Tallahassee, FL 32307

For a member to continue benefits while waiting for a hearing decision, the member must send a request in writing to the Grievance Coordinator.

Requirements needed for continuation of benefits:

- The member must file their appeal within ten calendar days of the date on the notice of denial with an additional five calendar days if the notice was sent via U.S. mail, or on or before the intended effective date of the Plan's proposed action;
- The appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment;
- The services must be ordered by an authorized provider;
- The authorization period cannot be expired; and
- The member must request an extension of benefits.

If the Plan's denial is upheld in the hearing, the member will be liable for the cost of any benefits that were continued.

If a member files a grievance against a provider in reference to the quality of care or service provided, a request to respond to the issue the member has raised will be faxed and mailed to the provider. The provider is given ten business days to respond and submit medical records for review. If a provider has not responded within ten business days, a second fax and letter is sent giving an additional ten business days. If no response is received, then a final letter is sent and signed by the Medical Director giving five business days to comply with the request.

Continued failure to respond may result in the provider's panel being closed to new patients and will be interpreted that the provider does not disagree with the member's issue. The case is then forwarded to the Quality Improvement Department for further investigation.

Once referral is made to the Quality Improvement Department, the case is referred to a nurse to review the medical records to determine if a possible quality issue exists. If the nurse feels a possible quality issue exists, the case will be referred to a Medical Director for review.

If the Medical Director determines a quality issue exists, the case is referred to the Quality Improvement Department for further investigation. If no quality issue is identified, the case is sent for tracking and trending.

Providers are also expected to participate in the appeals process as necessary.

Appeals

The appeal process is the procedure of addressing adverse determinations and/or claims payment disputes that require review of an action. Actions are defined below:

1. The denial or limited authorization of a requested service, including the type or level of service.

2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of the plan to act within the time frames provided in 42 CFR 438.408(b).
6. For a resident of a rural area with only one managed care entity, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

The member and a provider, acting on behalf of the member and with the member's written consent may file an appeal.

The member, member's representative or a provider may file an expedited or standard appeal request verbally or in writing within 30 days of the date of the action. A verbal request can be filed by calling Customer Service at: (866) 581-0903. All verbal requests must be followed with a written signed appeal.

Expedited Appeals

In cases where a delay in resolution of the Appeal would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. A determination will be made as expeditiously as the member's health condition requires, not exceeding 72 hours from receipt of appeal.

Standard Appeals

In all other cases, the standard appeal procedure shall apply. A determination will be made and notice

provided to the member or designee within 30 days.

Filing an Appeal

Members or their designees may file an appeal via telephone or in writing.

- If filing an appeal by telephone, a member or their designee may call the WellCare Member Services department at (866) 581-0903.
- Written requests should be mailed or faxed directly to the Appeals department at:

WellCare Senior Partnership
Attn: Appeals Coordinator
P.O. Box 31368
Tampa, FL 33631-3368
Fax: (866) 201-0657

- WellCare will acknowledge the appeal with a written response within 15 days.
- The date of the verbal filing will be considered the receipt date of the Appeal for purposes of calculating the time frames for resolution of the appeal.

If a decision is not wholly in the members favor the member may request a Medicaid Fair Hearing at the following address:

Office of Public Assistance Appeals Hearing
1317 Winewood Blvd.
Building 5, Room 203
Tallahassee, FL 32307

For a member to continue benefits while waiting for a hearing decision, the member must send a written request to the Appeal Coordinator.

Requirements needed for continuation of benefits:

- The member must file their appeal within ten calendar days of the date on the notice of denial with an additional five calendar days if the notice was sent via U.S. mail, or on or before the intended effective date of the Plan's proposed action;
- The appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment;
- The services must be ordered by an authorized provider;
- The authorization period cannot be expired; and
- The member must request an extension of benefits.

If the Plan's denial is upheld in the hearing, the member will be liable for the cost of any benefits that were continued. If the appeal is not resolved to the satisfaction of the member, the member has 365 days in which to send a written request for a review to:

Subscriber Assistance Panel
2727 Mahan Dr.
Building #1, Room 339
Tallahassee, FL 32307

WellCare Senior Partnership will pay for disputed services, in accordance with State payment regulations, if the services were furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing Officer reverses a decision to deny, limit, or delay services.