Home & Community Care Transitions:

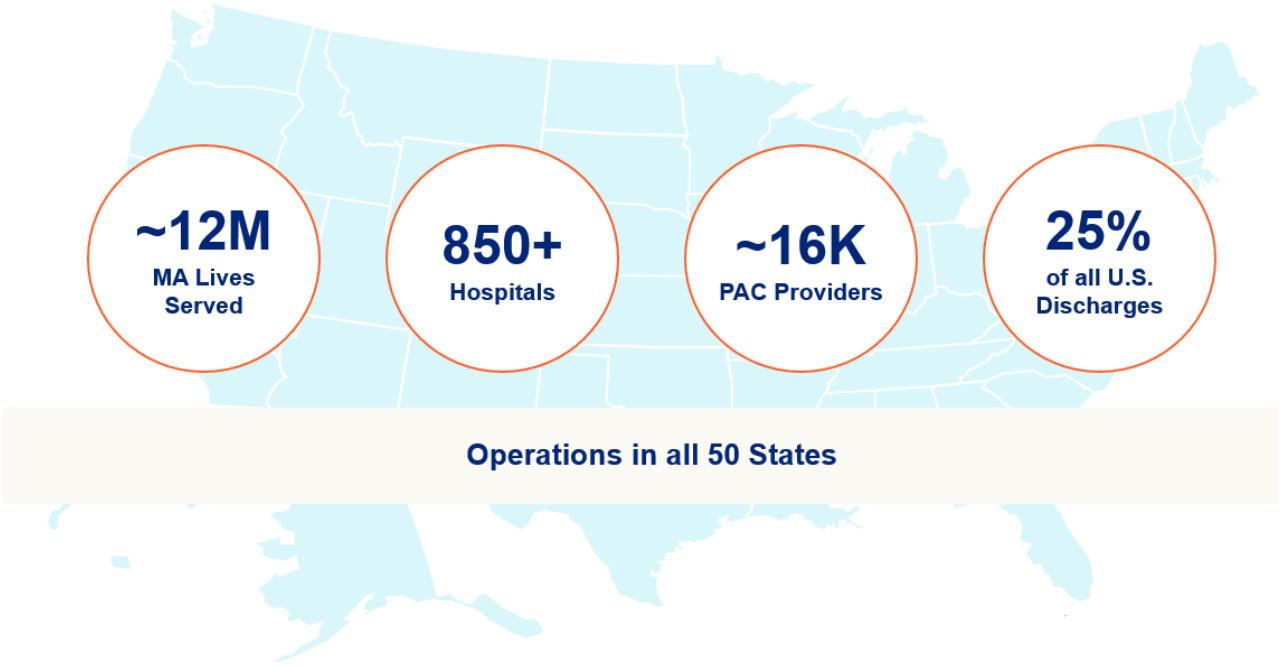
Post-acute care management for Blue Medicare and Experience Health members

On February 2, 2015, Home & Community Care Transitions (naviHealth) began managing pre-service authorizations for post-acute care services as well as continued stay requests, discharge planning and care management for our Blue Medicare[SM] (Medicare Advantage) members in skilled nursing facilities (SNFs).

Through proven processes, Home & Community Care Transitions uses a targeted member and provider engagement model to predict and evaluate the most appropriate post-acute care (PAC) option based on the member's unique needs.

Home & Community Care Transitions works with facilities, providers, members, and families to ensure that the right amount of care is delivered at the right time and in the most appropriate PAC setting for Medicare members. Evidence-based protocols optimize care, resulting in reduced hospital readmissions, increased member satisfaction, and improved member outcomes.

Home & Community Care Transitions' decade of experience managing PAC (as of August 2023 serving more than 12 million Medicare Advantage (MA) members in 50 states) will help Blue Cross and Blue Shield of North Carolina (Blue Cross NC) improve on measurable functional outcomes for Blue Medicare members in a SNF setting.



Frequently Asked Questions:
About Home & Community Care Transitions

Q1: Who is Home & Community Care Transitions?

Home & Community Care Transitions has been a trusted partner for the nation's top health plans, health systems, and at-risk physician groups navigating the shift from volume to value. Home & Community Care Transitions enables our partners to effectively and efficiently manage care transitions through our unique patient care management. We pair in-market clinical support with proprietary technology to help guide the individual's path to recover, increase patient satisfaction, reduce unnecessary post-acute care spend and streamline processes.

Q2: What does Home & Community Care Transitions do?

Home & Community Care Transitions uses a team-based approach that operates as connective support between the member, providers and the member's health plan. Work begins in the hospital prior to discharge to conduct prior authorization medical necessity reviews. Once approved for admission to the skilled nursing facility, in-market clinicians support members and family in discharge planning and help members set and achieve reasonable goals through use of proprietary tools and technology.

Q3: How does Home & Community Care Transitions work with providers and members in post-acute care?

In-market clinical personnel work directly with the member, family, and SNF care team to help our Blue Medicare and Experience Health members navigate the next level of care upon discharge from SNF.

Q4: How do acute-care hospitals and SNFs contact Home & Community Care Transitions?

- Home & Community Care Transitions call center toll-free number: 1-844-801-3686
- Home & Community Care Transitions fax number/prior auth requests: 1-855-847-7242 (hospitals)
- Home & Community Care Transitions fax number/concurrent review: 1-844-206-7051 (SNFs)
- Home & Community Care Transitions fax number/appeals: 1-855-531-9753

Submitting information for one member per fax will allow for a more streamlined review process.

Home & Community Care Transitions also offers **Access**. It is an easy-to-use online platform that simplifies your workflow. You can electronically share documentation, process authorizations, and communicate with clinicians in real time. Remove the inconvenience of phone and fax and spend more time doing what you do best — member care. For more info please visit the **Access** resource page.

Q5: What is Home & Community Care Transitions hours of operation?

You can contact Home & Community Care Transitions from 8 a.m. to 5 p.m. EST Monday through Friday, except for national holidays. For afterhours/weekend/holiday requests, providers should continue to make independent care decisions, based on the best interest of the member. Please contact Home & Community Care Transitions within one business day for review and authorization determination.

Q6: What technology does Home & Community Care Transitions use to make member assessments?

The **Predict** tool leverages historical functional outcomes from similar patients to develop personalized post-acute plan, known as Outcome Reports. These outcomes are drawn from high performing providers who have top quality and efficiency measures.

The **Predict Outcome** report is a data-driven care support tool that provides predictions related to the post-acute stay to assist with care coordination and allow patients and their caregivers to be better prepared for eventual discharge planning.

Authorization process from hospital to SNF and continued SNF care

Q7: How is Home & Community Care Transitions notified of a hospital admission?

Home & Community Care Transitions receives an electronic census and diagnostic information from Blue Cross NC daily for Blue Medicare members.

Q8: What is Home & Community Care Transitions' role during discharge planning?

If a member meets criteria for admission to a SNF, the Home & Community Care Transitions clinical coordinator conducts a function-based member assessment to assist with discharge planning. The Home & Community Care Transitions team member serves as a valuable adjunct to the SNF team, as a liaison to Blue Cross NC, and helps support the member and the family during the PAC recovery process.

Q9: When should providers contact Home & Community Care Transitions for a SNF authorization?

Authorizations must be generated BEFORE a member is admitted to a SNF. If a transfer happens after normal business hours, the SNF must notify Home & Community Care Transitions within 24 hours or the next business day.

Q10: Will the Home & Community Care Transitions' care coordinator be available to have conversations with members and/or their families?

Yes, Home & Community Care Transitions' care coordinators can discuss current course of care and/or the expectations with the member and/or family regarding the next level of care, where, and when appropriate.

Q11: Which services does Home & Community Care Transitions authorize?

Home & Community Care Transitions authorizes care delivered at a SNF, including the initial admission and continued stay requests. They also issue the notification for the last covered day for the SNF to deliver care. Home & Community Care Transitions only manages Blue Medicare and Experience Health members' inpatient benefits.

Q12: Which services does Home & Community Care Transitions not authorize?

Blue Cross NC retains responsibility to authorize all other PAC services for its Blue Medicare and Experience Health members, including ambulance services, acute inpatient rehabilitation and long-term acute-care admissions, durable medical equipment, home health agency services, and other at-home services. Requests related to outpatient benefits should be directed to Blue Cross NC.

Q13: What happens if a request for a SNF admission is sent to Blue Cross NC instead of Home & Community Care Transitions?

Providers should submit all SNF requests to Home & Community Care Transitions. In the event a request is submitted to Blue Cross NC in error, the request will be forwarded to Home & Community Care Transitions for review and processing. The provider does not need to resubmit the request to Home & Community Care Transitions.

Authorization process for therapy services/home health/medical iv

Q14: Is therapy evaluation required by Home & Community Care Transitions for every hospital admission?

For those Blue Medicare members you believe will require placement in a SNF, Home & Community Care Transitions strongly encourages a therapy evaluation as soon as possible while the member is in the acute-care setting.

Q15: Do SNFs need to call Home & Community Care Transitions for prior authorization for outpatient?

No, prior authorization for outpatient therapies is handled by Blue Cross NC.

Q16: Does Home & Community Care Transitions provide prior authorization for home health visits?

No, prior authorization for home health visits is handled by Blue Cross NC.