FIDELIS CARE®

Care Management Services

Fidelis Care offers Care Management services to help members who need extra health support. Care Management helps members coordinate their care, learn about their health conditions, and find helpful resources in their community.

To learn if a Fidelis Care member has Care Management Services or to refer a member for Care Management Services, call **1-800-247-1441 (TTY: 711) from 8:30 AM to 5 PM Monday through Friday. Then, press "3" for Medicare or "4" for Medicaid.**

If your call is received after 5 PM and is an urgent matter or an expedited appeal request, a Nurse Care Manager will return your call on the same day.

Temporary Case Management

For all Acute Inpatient Mental Health settings, Fidelis Care members are assigned a Transition of Care (TOC) Care Manager upon discharge for up to 30 days. Prior to discharge, send contact information to: **BHTOCfollowup@fideliscare.org**

- A supervisor will connect you to the assigned TOC Care Manager within 1-2 business days.
- If you need a more immediate response, please call **1-888-FIDELIS (1-888-343-3547), ext. 11679**.

TOC Care Managers can assist providers with:

- Medical/behavioral health linkage, coordination, and utilization history.
- Medication override and other troubleshooting.
- Closing the gap and improving continuity of care for members who may visit a high number of hospitals or providers.
- Assistance with health home care coordination and/or referral.

Ongoing Care Management

The following members will always have a Care Manager:

- HealthierLife Health and Recovery Plan (HARP) members
- Children's Home Community Based Services (HCBS) members
- Managed Long Term Care/Long Term Services and Supports (MLTC/LTSS) members

It is important to know if your patient is in a Care Management program. To determine if a member is HARP or Children's HCBS, use ePaces at https://www.emedny.org/epaces

- A HARP members will have an H code
- Children's HCBS members will have a K code

To learn more about the eligibility for Managed Long Term Care/Long Term Support Services visit: https://www.health.ny.gov/health_care/managed_care/mltc

Care Management Call 1-800-247-1441	
Line Of Business	**Extension**
HARP	16077
Children's HCBS	16879
MLTC/LTSS	Press "3" for Medicare, Press "4" for Medicaid

Care Management Programs

Program Name	Program Eligibility	Program Benefits to Member
Transitions of Care	All Dual-SNP and Medicare members, Tier 1 and 2 HARP and (Supplemental Security Income) SSI Medicaid members, high-risk Qualified Health Plans (QHP) members	Care Manager works with member for up to 30 days after hospital discharge to reduce likelihood of hospital readmission by ensuring PCP follow-up, medication reconciliation, and education.
Behavioral Health Medicare Transitions Team	All Dual (SNP) and Medicare members	For all Mental Health and Substance Use Disorder (MH/SUD) admissions, a designated Transition of Care (TOC) Care Manager and TOC Associate work collaboratively toward reducing hospital readmissions and ensuring aftercare follow-up. TOC team follows case during admission and up to 30 days post discharge. Interventions include, but are not limited to: discharge plan follow-up, appointment scheduling, appointment reminders, transportation assistance, assistance obtaining medication, linkage to community social services, and education related to MH/SUD conditions.
Mental Health Transitions Of Care	Medicaid, HARP, Qualified Health Plans (QHP), Essential Plans	Telephonic case management for up to 30 days post discharge. This includes, but is not limited to: assistance with discharge plan follow-up, appointment scheduling, transportation, assistance obtaining medication, linkage to community social services, member education, and member self-advocacy.
Dual-SNP Primary Case Management	All active Dual-SNP members	Assist member with obtaining PCP/specialist. Program also helps to promote preventive care, coordinate care between providers, locate community resources, arrange medical supplies/durable medical equipment (DME), recover after hospital stay, and provide member education.

Care Management Programs

Program Name	Program Eligibility	Program Benefits to Member
Comprehensive Case Management Program: Sickle Cell / Hemophilia HIV High Risk OB/NICU Oncology Breast Cancer Transplant Complex Conditions General Disease Management	All LOBs with the exception of Dual members	Comprehensive telephonic case management program outreach performed by registered nurses. Multiple specialties within the program to help support the most vulnerable and acute members. Receipt of referrals from many sources, including directly from members themselves and their providers. Goal is to connect with our members, encourage them to engage with the case manager to drive better health outcomes. Case managers work with the members to complete a comprehensive risk assessment. Helps to identify gaps in care and potential barriers such as low health literacy and social determinants of health (SDOH). Case manager and member work to create an individualized care plan to address gaps and barriers. One goal is to assist the member in developing a self-management plan to help them take charge of their health needs. Ongoing member engagement is largely dictated by the member's level of engagement and how fast care plan goals are met. Members can be admitted and discharged from case management based on their needs and with significant changes.
MSW	Members are referred internally from medical case management programs	Assist members with social determinants of health (SDoH) barriers, including financial and legal issues, Home Energy Assistance Program (HEAP), food banks, housing issues, vocational training, and other community resources.
ER Reduction Program	Medicaid, Medicaid SSI, Child Health Plus (CHP), Qualified Health Plans (QHP), Essential Plans	Telephonic outreach to members with frequent ER utilization for non-emergent reasons. Goal is to help reduce unnecessary ER utilization by identifying/removing barriers to care, promoting PCP linkage, and urgent care usage. Members may also be linked with a case manager.
Health and Recovery Plans (HARP) Care Management - HealthierLife	Medicaid members 21 and older identified by NYS as eligible to join a Health and Recovery Plan (HARP)	Provides member all Medicaid Managed Care benefits. Some qualify for HARP BH Home & Community Based Services. Members are assigned dedicated HealthierLife Care Manager through the entirety of their HARP enrollment.
Behavioral Health Case Management Team	Members in any LOB (excluding HARP) who meet BH criteria and agree to program participation	Provide short-term, telephonic case management services. Develop and monitor person-centered care plans, coordinate member's care, and link members to community support resources and Health Home Case Management services. BH also has a designated inpatient and outpatient utilization management team.
Children's Health Medicaid Managed Care (CH-MMC)	Medicaid members under the age of 21	Person Centered Care Planning, linkage to Health Home Services, C-YES: Children and Youth Evaluation Service, coordination of care for physical and BH needs, engaging natural supports into care process, connection to concrete services like benefits and community resources, Transitions of Care after hospitalization for psychiatric or substance-use related reasons and utilization management services.
Integrated Foster Care Management Team	Members under 21 enrolled in Voluntary Foster Care Agencies or Local Department of Social Services (LDSS) Foster Care	Ensures access to health care services necessary to promote positive long term health outcomes and to satisfy mandatory assessments and screenings as required by NYS OCFS; initial health screening followed by care planning led by Child Advocate, Nurse Care Manager, or BH Care Manager as appropriate; discharge planning; transition of care planning for members entering or leaving foster care; linkage to health home services; coordination of care.
Medically Fragile Child Team	Members under the age of 21	Provides comprehensive telephonic case management for members from birth through age 20. Multiple specialties within the program are designed to help support the most vulnerable and acute members, such as pediatric transplant, HIV, neonatal home discharge, and all post-discharge rehabilitation stays. Members are assigned a registered Nurse Case Manager who provides person-centered care. Referrals are made from internal and external sources. The Nurse Case Manager provides service through an interdisciplinary team approach to ensure the member's needs and services are being completely met. The focus is on SSI Pediatric members who need DME, Private Duty Nursing (PDN), Consumer Directed Personal Assistance Services (CDPAS), and Community Services. The goal is to collaborate with Health Home Care Managers to ensure connectivity to all available community-based services so there are no gaps in care.