INTRODUCTION TO CARE COORDINATION FOR PPEC PROVIDERS

April 2014

http://fl.eqhs.org
eQHealth Solutions is the Agency for Health Care Administration’s (AHCA) contracted quality improvement organization (QIO), responsible for the Comprehensive Medicaid Utilization Management Program for the State of Florida.
Currently, eQHealth authorizes certain Medicaid services:

- Acute and rehabilitation inpatient
- Home Health visits, Private Duty Nursing (PDN), and Personal Care Services (PCS)
- Therapies including Physical Therapy (PT) Occupational Therapy (OT) and Speech Language Pathology (SLP)
- Durable Medical Equipment (DME)
- Multispecialty services, including hearing, vision, chiropractic and physician services
- Dental services (partial dentures and orthodontics)
Beginning April 1, 2013, eQHealth Solutions implemented a care coordination program for children receiving private duty nursing (PDN) and/or personal care services (PCS).

On July 1, 2013 care coordination was expanded to include recipients receiving services in a skilled nursing facility (SNF).

On April 1, 2014, eQHealth Solutions implemented a care coordination program for children receiving Prescribed Pediatric Extended Care (PPEC) services.
Introduction to Care Coordination
Care coordination is a model of care that makes the Medicaid recipient the central focus of each component of their health care. The ratio of care coordinators to recipients is 1:40 for recipients with PDN/PCS/PPEC services and 1:15 for recipients in a nursing facility.

Care coordination identifies all of the providers involved in the care of a recipient, reaches out to each one, and then includes them in all aspects of care for that recipient.

At the center of the care coordination model is the recipient and the parent/legal guardian.
To develop an enhanced, personalized program to evaluate and plan the needs of disabled, medically fragile and medically complex children receiving PPEC services.
Care coordination for the pediatric population includes a combination of:

- Telephone calls to recipients’ families
- Recipient assessments
- Home, hospital, PPEC, or Nursing Facility (NF) visits
- Multidisciplinary Team Meetings (MTM) and Children’s Multidisciplinary Assessment Team (CMAT) staffings, if appropriate
Benefits of Care Coordination

- This program is guided by a Care Coordinator in conjunction with the recipient’s parent/legal guardian.

- The services to be provided are based on collaborative interaction between a Care Coordinator, the recipient’s parent/legal guardian, providers, the ordering physician, pediatricians, specialists and other medical professionals.

- Because all services for the recipient are coordinated, the recipient’s entire medical picture is available for consideration in determining the appropriate services.

- Through Care Coordination, the recipient and their parent/legal guardian receive additional education, referral to other resources and support and interaction they would not receive through the utilization review process.
Meetings will include:

- eQHealth Care Coordinator
- Managed Care Plan Case Manager, if applicable
- Recipient
- Recipient’s parent or legal guardian
- Ordering physician or designee
- PPEC provider, if applicable
- Home Health provider, if applicable
- Other medical professionals (e.g., therapists)

Team meetings help to ensure alignment of the recipient’s needs and goals with the services provided.
Care coordination is provided statewide for children, under age 21 who require PPEC services.
PPEC:

- All recipients currently receiving PPEC services received care coordination enrollment letters in April 2014.

- All *new* recipients for whom PPEC services are requested will be assigned a care coordinator and will be contacted upon enrollment.
Initial Requests can be submitted by the:

- Physician
- Parent/legal guardian
- Hospital Discharge Planner
- PPEC Provider

Requests can be submitted by:

- Phone (parent/legal guardian and physicians)
- Fax (PPEC providers and discharge planners)
- eQSuite (until May 31, 2014)
Care Coordination Process
Initial Request

Once the request is received, the Care Coordinator will:

- Contact the family
- Obtain an assessment from the PPEC
- Schedule a PPEC visit
- Work with the multidisciplinary team to:
  - Develop a plan of care
  - Gather the required documentation
- Authorize the medically necessary services
- Identify additional needed resources after MTM
If a consensus regarding services cannot be reached among all parties during the multidisciplinary team meeting, the request for services is sent to an eQHealth physician reviewer for a decision.

A peer-to-peer consultation will be held with the recipient’s physician, if needed.
Care Coordination Process
Continued Stay Request

Initiated by the Care Coordinator 30-45 days prior to the end of the current authorization period.

The Care Coordinator:
- contacts the family;
- visits the PPEC or home, if indicated
- schedules the multidisciplinary team meeting
If the recipient’s needs change during an authorization period:

- The request for a modification is submitted to the Care Coordinator by the PPEC;
- The Care Coordinator contacts the family, physician and other multidisciplinary team members if needed;
- The Care Coordination process is followed to completion.
Effective April 1, 2014, all new admissions to PPEC will follow the care coordination process

- Faxed request is the preferred method for requesting services.

Providers will continue to enter continued stays for children admitted to PPEC prior to 6/1/14.

- Effective June 1, 2014, all children receiving PPEC services will be in care coordination.
  - Providers will no longer enter authorization requests in eQSuite.*

*PPEC providers will be able to view letters and reports in eQSuite.
## Submission & Response Timelines

<table>
<thead>
<tr>
<th>Request</th>
<th>Submission Timeline</th>
<th>Response</th>
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<tbody>
<tr>
<td>Initial request for services</td>
<td>Prior to the initiation of services</td>
<td>Care Coordinator will make initial phone call attempt to the family within 5 days of the initial request for PPEC services.</td>
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<tr>
<td>Initial request for services for a recipient being discharged from inpatient care</td>
<td>Upon initiation of discharge planning (prior to discharge)</td>
<td>Care Coordinator will work with the hospital discharge planner prior to recipient leaving the hospital.</td>
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<tr>
<td>Request for Continued Services</td>
<td>Initiated by the Care Coordinator prior to the end of the current authorization period</td>
<td>Care Coordinator will make a phone call to the family and schedule a multidisciplinary team meeting 30 to 45 days prior to expiration of the current authorization period.</td>
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<tr>
<td>Modifications</td>
<td>As soon as the need is identified</td>
<td>Care Coordinator will contact the PPEC and the parent/legal guardian to discuss the need for a modification and follow up within 5 days of the request. Schedule multidisciplinary team meeting if needed.</td>
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</tbody>
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Retrospective reviews are only allowed for recipients who receive retroactive Medicaid eligibility.

Retrospective reviews should be requested for services provided during the time period in which the recipient has been determined to be eligible.

If services are currently being provided, submit an initial request for services instead of a retrospective review.
Requests for reconsideration of an adverse determination (a denial in full or part of the services requested):

- If consensus cannot be reached, a reconsideration may be requested by the recipient, parent/legal guardian, rendering provider or ordering physician.

- Physicians and parents/legal guardians may submit reconsideration requests via phone, fax or mail.

- Rendering providers may submit reconsideration requests via fax or eQSuite.

- Reconsideration requests must be submitted within 5 days of the adverse determination.
Recipients or their legal representatives may appeal an adverse determination by requesting a fair hearing.

The request must be submitted within 90 days from the date of the adverse notification letter by calling or writing:

- The local Medicaid area office; or
- Department of Children Families Office of Appeals and Hearings

To continue services at the current level, until the Fair Hearing decision, the request must be made within 10 days of the denial.
Supporting documentation is determined by AHCA policy and is required to substantiate the necessity of items or services.

Supporting documentation requirements are posted on [http://fl.eqhs.org](http://fl.eqhs.org).
Provider Communications and Resources

- **Customer Service:**
  855-444-3747
  Monday-Friday, from 8 a.m.-5 p.m. Eastern Time

- **Dedicated Florida Provider Website:**
  [http://fl.eqhs.org](http://fl.eqhs.org)

- Email communications to providers (blast emails)

Nancy Calvert, Director, Provider Education & Outreach

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Questions and Answers

Thank-you for attending.

Your opinion is important to us. Please complete the survey which will appear on your computer when the webinar ends.