eQHealth 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.

The Florida operations office is located at 5802 Benjamin Center Drive, Suite 105, Tampa, FL 33634.

A branch office is located in the Miami/Dade area.

http://fl.eqhs.org
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 and/or personal care services.
An Introduction to Care Coordination
Care Coordination is a model of care that makes the Medicaid recipient the central focus of each component of the health care network.

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 a Care Coordinator.
To develop an enhanced, personalized program to evaluate and plan the needs of disabled, medically fragile and medically complex children receiving private duty nursing services and/or personal care services.
The Care Coordination for the pediatric population that will include a combination of:

- Telephone calls to recipients’ families;
- Recipient Assessment;
- Home visits; and
- Multidisciplinary team meetings.
Benefits of Care Coordination

- This program is guided by a Care Coordinator in conjunction with the recipient’s parent or guardian.
- The services to be provided are based on collaborative interaction between a Care Coordinator, the recipient’s parent or 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 or guardian receive additional education, referral to other resources and interaction they would not receive through the utilization review process.
- Home visits allow visual confirmation of the recipient’s condition, the home environment and additional information with which to identify appropriate services.
Meetings will include:
- eQHealth Care Coordinator
- Recipient
- Recipient parent or guardian
- Ordering physician or designee
- PPEC
- Other medical professionals (e.g. therapists)
- Home Health provider, when approved by the parent or legal guardian.

*Team meetings help to ensure alignment of the recipient’s needs and goals with the services provided.*
Children, under age 21 who require PDN and/or PCS services who are enrolled in the following Florida Medicaid programs:

- Fee for Service
- MediPass (including MediPass recipients in Simply Better Health Counties)
- Dually Eligible (Medicare/Medicaid, Commercial insurance/Medicaid)
- Medically Needy
- Children’s Medical Services (CMS)
- Consumer Directed Care Plus (CDC+) Recipients
Exclusions

Recipients who are:

- Members of a Medicaid HMO
- Members of a Medicaid Provider Service Network (PSN)
- Members of Children’s Medical Services (CMS):
  - Reform plans in Reform Counties
Care Coordination Process

PDN, PDN/PCS:
- All recipients currently receiving PDN or PDN/PCS services received Care Coordination enrollment letters the first week of April.
- All new recipients for whom PDN or PDN/PCS services are requested (on or after 4/1/13) receive Care Coordination enrollment letters upon receipt of the referral request.

PCS only:
- All recipients currently receiving PCS services received Care Coordination introductory letters the first week of April.
- All new recipients for whom PCS services are requested (on or after 4/1/13) receive Care Coordination introductory letters upon receipt of the referral request.

http://fl.eqhs.org
Initial Requests can be submitted by the:

- Physician
- Parent or guardian
- Hospital Discharge Planner
- Provider

Requests can be submitted by:

- Phone (parent/guardian and physicians)
- Fax (providers, discharge planners)
Once the request is received, the Care Coordinator will:

- Contact the family
- Complete an assessment
- Schedule a home or hospital visit
- Work with the multidisciplinary team to:
  - Determine the services needed
  - Develop a plan of care
  - Gather the required documentation
- Authorize the medically necessary services
- Identify additional needed resources
If a consensus cannot be reached among all parties during the Care Coordination multidisciplinary meeting, the case will be sent to an eQHealth physician reviewer for a decision.

A peer-to-peer consultation will be held with the recipient’s physician, if needed.
Initiated by the Care Coordinator 30-45 days prior to the end of the current authorization period.

The Care Coordinator:
- contacts the family;
- visit the 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;
- The Care Coordinator contacts the family, physician and other multidisciplinary team members as needed;
- The Care Coordination process is followed to completion.
Care Coordination Process
Requesting PDN or PDN/PCS

- Home Health providers do not enter PDN/PCS service requests in eQSuite.*

- All requests for PDN or PDN with PCS services follow the Care Coordination process.

*Home Health providers are able to view letters and reports in eQSuite.
## PDN, PDN/PCS Process

<table>
<thead>
<tr>
<th>Request</th>
<th>Submission Timeline</th>
<th>Response</th>
</tr>
</thead>
<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 and send a welcome letter within 5 days of the initial request for PDN services.</td>
</tr>
<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>
</tr>
<tr>
<td>Request for Continued Services</td>
<td>Initiated by the Care Coordinator prior to the end of the current approval</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>
</tr>
<tr>
<td>Modifications</td>
<td>As soon as the need is identified</td>
<td>Care Coordinator will contact the parent to discuss the need for a modification and follow up within 5 days of the request. Schedule multidisciplinary team meeting as needed.</td>
</tr>
</tbody>
</table>
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):

For recipients with PCS only:

- May be made by the recipient, parent/legal guardian, provider, or ordering physician.
- Providers may submit reconsideration requests in eQSuite.

For recipients with PDN or PDN/PCS:

- If consensus cannot be reached, a reconsideration may be requested by the recipient, parent/legal guardian or ordering physician.
- Reconsideration requests may submit reconsideration requests via phone, fax or mail.

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.
Required Supporting Documentation

- 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

➢ Email communications to providers (email blasts)

Nancy Calvert, Director, Provider Education & Outreach
ncalvert@eqhs.org
Questions and Answers

Thank-you for attending.

Your opinion is important to us. Please complete the survey that will appear on your screens at the end of the webinar.