MMA SRC #10, Attachment 2: Care Coordination and Transitions Policy and Procedure
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<tr>
<th>Subcontractor/Delegated Entity: N/A</th>
<th>SMMC MMA Contract 2014-2018</th>
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<tr>
<td>Policy Title: Coordination and Transition of Care Policy</td>
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<tr>
<td>Policy Number: CO.MCD.61.03.(B)(P).FL.MCC.FL.CMC</td>
<td>Contract Section (s): Statewide Medicaid Managed Care Managed Medical Assistance Contract 2014 – 2018: Amendment 1-11</td>
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<td>Effective Date: 7/1/14</td>
<td>Revision Date: 8/28/15, 2/2/17</td>
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**Signature Block** (all necessary Plan signatures are placed in this section)

Approved By: Board of Directors or other Authorized person

Signature: __________________________ Date: __________________________
Title: Steven L. Arnold, MD, Chief Medical Director

Approved By: Magellan Complete Care

Signature: __________________________ Date: __________________________
Title: Kerry McDonald, Chief Executive Officer

**POLICY:**

Section V. Covered Services
D. Coverage Provisions

2. Behavioral Health
Care Coordination and Transition of Care

a. For SMMC enrollees, behavioral health services will be provided to enrollees by other sources, including Medicare, and state-funded programs and services. Magellan shall coordinate with other entities, including MMA Managed Care Plans, Medicare plans, Medicare providers, and state-funded programs and services.

c. MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall provide a full range of medically necessary behavioral health services for enrollees as authorized under the Medicaid State Plan, the applicable federal waivers, and specified in the MMA Exhibit.

3. Managing Mixed Services

a. Magellan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. When a recipient is enrolled in both the LTC and MMA programs, the LTC case manager is primarily responsible for care coordination and case management to enrollees. Comprehensive LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an enrollee’s enrollment in an MMA Managed Care Plan.

b. Managed Care Plans shall provide non-emergency transportation (NET) mixed services to enrollees with both MMA benefits and LTC benefits as follows:

(1) MMA Managed Care Plans shall provide non-emergency transportation (NET) to all MMA services and MMA expanded benefits, except for over-the-counter (OTC) medication expanded benefits.

(2) LTC Managed Care Plans shall provide NET to all LTC services and LTC expanded benefits.

(3) Comprehensive LTC Managed Care Plans shall provide NET to enrollees with both MMA and LTC benefits, and MMA Managed Care Plans shall provide services and payment for expanded benefits when the enrollee exhausts the MMA expanded benefit through the LTC Plan.

c. Managed Care Plans shall coordinate with any other third party payor sources to ensure mixed services are not duplicative.

E. Care Coordination/Case Management


a. Magellan shall be responsible for care coordination and case management for all enrollees.

b. Magellan shall provide care coordination and case management to enrollees as specified in this Contract and with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit.
(2) Not Applicable

(3) Specialty MMA Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit and the applicable Specialty Plan Exhibit.

2. Transition of Care

a. Magellan shall develop and maintain transition of care policies and procedures that address all transitional care coordination/care management requirements and submit these policies and procedures for review and approval to the Agency. Transition of care policies and procedures shall include the following minimum functions:

(1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation or other service supports;

(2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. Transfer of medical/case records in compliance with HIPAA privacy and security rules;

(3) Documentation of referral services in enrollee medical/case records, including follow up resulting from the referral;

(4) Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management;

(5) Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and develop actions to reduce avoidable emergency room visits and potentially avoidable hospital admissions;

(6) Transitional care coordination/care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of enrollee and family caregiver needs, coordinating the patient’s discharge plan with the family and hospital provider team, collaborating with the hospital or institution’s care coordinator/case manager to implement the plan in the patient’s home and facilitating communication and the transition to community providers and services; and
(7) Ensuring that in the process of coordinating care, each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describing the requirements regarding the privacy of individually identifiable health information.

b. Magellan shall be responsible for coordination of care for new enrollees transitioning into the Plan.

c. Magellan shall be responsible for coordination of care for enrollees transitioning to another Managed Care Plan or delivery system and shall assist the new Managed Care Plan with obtaining the enrollee’s medical/case records.

d. Magellan shall implement a process to ensure records and information are shared and passed upon request to the new Managed Care Plan within thirty (30) days of an enrollee’s enrollment into the new Managed Care Plan.

3. Health Management

a. Magellan shall develop and maintain written policies and procedures that address components of effective health management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollee’s health care needs and effective action to promote quality of care.

b. Magellan shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success.

c. Magellan, through its QI plan, shall demonstrate specific interventions in its health management to better manage the care and promote healthier enrollee outcomes.

Section VII. Quality and Utilization Management

H. Continuity of Care in Enrollment

1. Magellan shall be responsible for coordination of care for new enrollees transitioning into the Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, Magellan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers. Magellan shall reimburse non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate.

3. MMA Managed Care Plans shall provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no
more than sixty (60) days after the effective date of enrollment. The following services may extend beyond the sixty (60) day continuity of care period, and Magellan shall continue the entire course of treatment with the recipient’s current provider as described below:

a. Prenatal and postpartum care – Magellan shall continue to pay for services provided by a pregnant woman’s current provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in Magellan’s network.

b. Transplant services (through the first year post-transplant) - Magellan shall continue to pay for services provided by the current provider for one year post-transplant, regardless of whether the provider is in Magellan’s network.

c. Oncology (Radiation and/or Chemotherapy services for the current round of treatment) - Magellan shall continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in Magellan’s network.

d. Full course of therapy Hepatitis C treatment drugs.

Section VIII. Administration and Management
A. Organizational Governance and Staffing

4. Care Coordination/Case Management Staff

Magellan shall have sufficient care coordination/case management staff, qualified by training, experience and certification/licensure to conduct Magellan’s care coordination/case management functions. See the LTC Exhibit for required case manager qualifications for enrollees with LTC benefits.

Exhibit II-A

Section V. Covered Services
A. Required MMA Benefits

3. Customized Benefits

e. Magellan shall send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid. Magellan shall send an exhaustion of benefits letter for any service restricted by a dollar amount. Magellan shall implement said letters upon the written approval of the Agency. The letter of notification include the following:

(1) A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by Magellan for a benefit

(2) A follow-up letter notifying the enrollee when he/she has reached seventy-five (75%) of any maximum annual dollar limit established by Magellan for a benefit; and
E. Care Coordination/Case Management

1. Behavioral Health Coverage and Coordination in Long-Term Care Settings

a. Magellan shall retain responsibility for provision of medically necessary behavioral health evaluation and treatment services to enrollees, regardless of setting, including in the community, a medical facility, an assisted-living facility, or a nursing facility. Provision of services in long-term care settings will require coordination with other entities including LTC Managed Care Plans and providers, Medicare plans and providers, and state-funded programs and services.

b. In cooperation with the administration and/or treatment providers associated with the other plans, settings or agencies, Magellan shall coordinate behavioral health services consistent with the care coordination requirements established in Section V.D.2. Specific responsibilities of Magellan as it relates to coordinating with other entities include:

(1) Psychiatric Evaluations and Treatment for Enrollees Applying for Nursing Facility Admission: Magellan shall, upon request from the DCF offices, promptly arrange for and authorize psychiatric evaluations for enrollees who are applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long-Term Care Services (CARES) workers, are thought to need behavioral health treatment. The examination shall be adequate to determine the need for “specialized treatment” under OBRA. Evaluations must be completed within five (5) business days from the time the request from the DCF office is received. Regulations have been interpreted by the state to permit any of the mental health professionals listed in s. 394.455, F.S., to make the observations preparatory to the evaluation, although a psychiatrist must sign such evaluations. Magellan will not be responsible for resident reviews as a result of a pre-admission screening and resident review (PASRR) evaluation. If the psychiatric evaluation of an enrollee indicates covered behavioral health services are medically necessary, and the enrollee is subsequently admitted to a nursing facility, Magellan will retain responsibility for provision or those behavioral health services to enrollee in the nursing facility.

(2) Assessment and Treatment of Mental Health Residents Who Reside in Assisted Living Facilities (ALFs) That Hold a Limited Mental Health License: Magellan shall develop and implement a plan to ensure compliance with s,
c. Magellan shall ensure that a cooperative agreement, as defined in s. 429.02, F.S., is developed by the ALF administrator and Magellan’s designated care coordinator/case manager for enrollees that are residents of an ALF and qualify as a mental health resident. Magellan must ensure that appropriate assessment services are provided to enrollees and that medically necessary behavioral health services, including psychiatric medication and access to drop-in centers and clubhouses, are available to all enrollees who meet criteria as a mental health resident and reside in this type of setting.

d. Magellan shall coordinate with other entities that provide behavioral health services, to ensure that a community living support plan is developed and updated for each enrollee who is a resident of an LMH-ALF. Magellan shall ensure the community living support plan is implemented as written.

e. Upon request from an ALF, Magellan shall provide procedures for the ALF to follow should an emergent condition arise with an enrollee that resides at the ALF.

2. **Enhanced Care Coordination for Enrollees under Age 21 Receiving Skilled Nursing Facility or Private Duty Nursing Services**

a. Magellan shall implement enhanced care coordination processes for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility or are receiving private duty nursing services in their family home or other community based setting.

b. Magellan shall maintain written protocols for the care coordination of enrollees, as described in sub-item a., above, which shall include:

   1. Magellan shall assign a care coordinator to all enrollees meeting the criteria described in sub-item a., above. Magellan shall maintain documentation of an enrollee or the enrollee’s authorized representative’s rejection of care coordination services.

   2. Magellan shall utilize care coordinators who possess the following qualifications:

      a. State of Florida licensed registered nurse with at least two (2) years of pediatric experience;

      b. State of Florida licensed practical nurse with four (4) years of pediatric experience; or

      c. Master’s degree in social work with at least one (1) year of related professional experience.

   3. Caseload Ratio Requirements

      a. Magellan shall ensure that care coordinator caseloads do not exceed a ratio of forty (40) enrollees to one care coordinator for enrollees receiving private duty nursing services in their family home or other setting.
community based setting and no more than a ratio of fifteen (15) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.

(b) Magellan may submit a request to the Agency to implement a mixed caseload of enrollees in the community and in nursing facilities. Magellan shall receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by Magellan and do not require authorization. Magellan shall submit any caseload exception requests to the Agency. The Agency may, at any time, revoke Magellan’s authorization to exceed caseload ratios.

(4) The care coordinator shall ensure the enrollee’s or enrollee’s authorized representative’s completion and signature of the Agency-approved Freedom of Choice Certification Form within seven (7) business days of the effective date of admission to a nursing facility and every six (6) months thereafter. Magellan shall maintain documentation in the enrollee’s record with the completed Freedom of Choice Certification Forms.

(5) Magellan shall ensure that the care coordinator maintains monthly (or more frequently, if needed) contact with the enrollee and the enrollee’s parent or legal guardian. The contact shall be face-to-face or telephonic. Magellan shall maintain documentation in the enrollee’s record of all contacts attempts. For successful contacts, Magellan shall include in the enrollee’s record a summary of the discussion, whether the Freedom of Choice form was discussed, and the choice of placement made by the enrollee or enrollee’s authorized representative.

(6) Magellan shall convene a multidisciplinary team (MDT) no later than sixty (60) days after enrollment into the plan, and every six (6) months thereafter, to provide a comprehensive review of the services and supports that the enrollee needs, and to authorize any Medicaid reimbursable services that are prescribed for the enrollee (e.g., private duty nursing, therapy services, etc.), and to complete the Freedom of Choice Certification Form with the enrollee or the enrollee’s authorized representative. Magellan shall convene an MDT meeting more frequently, if needed, based on any changes in the enrollee’s medical condition or a significant life change. The MDT meeting shall include at a minimum: the enrollee’s care coordinator, the enrollee (if able), the enrollee’s parent or legal guardian, and other health care professionals involved in that enrollee’s care. Magellan shall develop, update, and maintain, with input from the MDT attendees, a person–centered, individualized service plan that reflects the services and supports that the enrollee needs.

(7) Magellan shall convene an MDT meeting one year prior to an enrollee turning the age of twenty-one (21) to discuss the services and supports that
the enrollee will need after turning twenty-one (21). If the MDT recommends medically necessary services and supports for the enrollee at the time of turning twenty-one (21) years of age, and those services and supports are not covered by Medicaid, Magellan shall inform the enrollee or their authorized representative of any community programs or home and community based waiver options that may be able to meet the needs and make the necessary referrals, as needed.

c. Magellan shall maintain written protocols that address the transition/discharge planning process for enrollees who are receiving services in a skilled nursing facility. Magellan shall:

(1) Ensure that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing in a skilled nursing facility prior to enrollment in Magellan, Magellan shall begin the transition planning process upon enrollment in Magellan.

(2) Convene an MDT meeting focused specifically on transition planning to proactively consider placement alternatives and offer such opportunities to the enrollee and to the enrollee’s authorized representative. This transition planning meeting shall occur every three (3) months until the enrollee is transitioned home or to another community based setting.

(3) Develop a final written transition plan within thirty (30) days prior to discharge that includes all of the services and supports that the enrollee needs to successfully reside in the community.

(4) Maintain contact with the enrollee and the enrollee’s authorized representative at least two (2) times a month during the first six (6) months after discharge from the skilled nursing facility. If agreed to by the enrollee’s authorized representative, at least one of these contacts must be face-to-face. After this six (6) month transition period, Magellan shall continue to maintain monthly contact with the enrollee and the enrollee’s authorized representative.

4. Additional Care Coordination/Case Management Requirements

a. Magellan shall be responsible for the management and continuity of medical and behavioral health care for all enrollees.

b. Magellan shall maintain written care coordination/case management and continuity of care protocols that include the following minimum functions:

(1) Appropriate referral and scheduling assistance for enrollees needing specialty health care or transportation services, including those identified through CHCUP screenings.

(2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to WIC and Healthy Start) with assistance, as needed, by the Medicaid Area Office.
(3) Care coordination/case management follow-up services for children/adolescents whom Magellan identifies through blood screenings as having abnormal levels of lead.

(4) A mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs.

(5) An outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. Magellan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

(6) Documentation of referral services in enrollee medical/case records, including reports resulting from the referral.

(7) Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up.

(8) Coordination of hospital/institutional or residential treatment setting (including residential SIPP and TGC services) discharge planning that addresses post-discharge care, including but not limited to residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care, as appropriate. Coordination of aftercare services must begin at least thirty (30) days prior to discharge from a residential treatment setting (including SIPP and TGC services);

(9) Magellan shall report monthly on the enrollees receiving residential psychiatric treatment (e.g., SIPP services and comparable treatment settings), in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide;

(10) Magellan or designee shall develop a process to participate in interagency staffings (for example, DCF and DJJ) or school staffings that may result in the provision of behavioral health services to an enrolled child/adolescent. Magellan or designee shall participate in such staffings upon request.

(11) Sharing with other Managed Care Plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated; and

(12) Ensuring that in the process of coordinating care/case management, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

c. Magellan shall maintain written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:
(1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees.

(2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level.

(3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads.

(4) Specifying experience and educational requirements for case managers and case management support staff.

(5) Providing training and continuing education for case management staff.

(6) Using evidence based guidelines.

(7) Conducting comprehensive assessments that identify enrollee needs across multiple domains, including current health conditions, current providers, caregiver or other supports available, transportation barriers, medications, behavioral health conditions, and preferences for treatment.

(8) Developing treatment plans that incorporate the health risk issues identified during the assessment and incorporate the treatment preferences of the enrollee. The treatment plan shall contain goals that are outcome based and measurable and include the interventions and services to be provided to obtain goals. Interventions should include community service linkage, improving support services and lifestyle management as appropriate based on the enrollee’s identified issues. Treatment plans shall be updated at least every six (6) months when there are significant changes in enrollee’s condition.

(9) Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders.

(10) Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions.

(11) Interfacing with the enrollee’s PCP and/or specialists.

(12) Assessing enrollees for literacy levels and other hearing, vision or cognitive functions that may impact an enrollee’s ability to participate in his/her care and implementing interventions to address the limitations.

(13) Assessing enrollees for community, environmental or other supportive services needs and referring enrollees to get needed assistance.

(14) Facilitating enrollee preferences for treatment, including cultural preferences, and enrollee participation in treatment planning.

(15) Using best practices to increase enrollee engagement.

(16) Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up.
Coordination of hospital/institutional or residential treatment setting (including residential SIPP and TGC services) discharge planning that addresses post-discharge care, including but not limited to residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care, as appropriate. Coordination of aftercare services must begin at least thirty (30) days prior to discharge from a residential treatment setting (including SIPP and TGC services);

Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement;

Sharing with other managed care plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated; and

Ensuring that in the process of coordinating care/case management, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

d. Magellan shall work in coordination with the Department of Children and Families’ behavioral health managing entity to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services for enrollees, in accordance with s. 409.973(5), F.S.

e. Magellan shall coordinate and deliver behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address enrollee needs in accordance with s. 409.967(2)(d), F.S.

f. Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate behavioral health professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, Magellan shall have a mechanism in place to allow enrollees to directly access a behavioral health care specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

g. Magellan shall maintain written protocols for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. Magellan shall:

1. Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee’s needs for continuity in existing behavioral health therapeutic relationships;

2. Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including
behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement;

(3) Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees and enrollees with multiple agency involvement);

(4) Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting;

(5) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. Magellan shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management; and

(6) Upon the admission of an enrollee, Magellan shall make its best efforts to ensure the enrollee’s smooth transition to the next service or to the community and shall require that behavioral health care providers:

   (a) Assign a mental health case manager to oversee the care given to the enrollee;

   (b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and

   (c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.

h. Magellan and its QI plan shall demonstrate specific interventions in its behavioral health care coordination/case management to better manage behavioral health services and promote positive enrollee outcomes. Magellan’s written policies and procedures shall address components of effective behavioral health care coordination/case management including, but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee’s behavioral health needs, and effective action to promote quality of care; participation in the DCF planning process outlined in s. 394.75, F.S.; and the provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:

   (1) Have resided in a state mental health facility for at least six (6) of the past thirty-six (36) months;
(2) Reside in the community and have had two (2) or more admissions to a state mental health facility in the past thirty-six (36) months;

(3) Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;

(4) Have been diagnosed with a behavioral health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications; or.

(5) Have been identified as exceeding Magellan’s prescription limits as permitted under Section V, Covered Services.

If an enrollee makes a request for behavioral health services to Magellan, Magellan shall provide the enrollee with the name (or names) of qualified behavioral health care providers, and if requested, assist the enrollee with making an appointment with the provider that is within the required access times indicated in Section VI, Provider Network.

Magellan shall be responsible for the management and continuity of medical and behavioral health care for all enrollees.

i. Magellan shall ensure that appropriate resources are available to address the treatment of complex conditions that reflect both behavioral health and physical health involvement. The following conditions must be addressed:

   (1) Mental health disorders due to or involving a general medical condition, and
   (2) Eating disorders.

Magellan shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. Magellan’s provider network must include appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods.

DEFINITIONS:

*Care Coordination/Case Management* — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee's health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting.

*Medically Complex* — An individual who is medically fragile who may have multiple co-morbidities or be technologically dependent on medical apparatus or procedures to sustain life.
Mixed Services – Medicaid services listed in statute as covered by the LTC Managed Care Plan under s. 409.98, F.S., and the MMA Managed Care Plan under s. 409.973, F.S. These include the following services: home health and nursing care (intermittent and skilled nursing), hospice services, medical equipment and supplies (including durable medical equipment), therapy services (physical, occupational, respiratory and speech) and non-emergency transportation services.

PROCEDURE:
I. Transition/Coordination of Care
   A. Magellan Complete Care (MCC) assists all enrollees with care transitions in the following situations: when benefits are exhausted; when newly enrolled in MCC; for medically complex and medically fragile enrollees who are receiving services in a skilled nursing facility or who are receiving private duty nursing services in their family home or other community based setting, when transitioning from child to adult services; when transitioning from or coordinating with ongoing Long Term Care benefits; when transitioning between health plans or between levels of care; when a provider is terminated from the network; or when benefits are exhausted and non-covered services are needed from community agencies.

   B. Magellan Complete Care develops and maintains written care coordination/case management and continuity of care protocols for the following transition of care activities at a minimum:
      1. Support to the case manager, and to enrollees and caregivers as needed for referral and scheduling assistance for enrollees needing special health care, transportation or other service supports, including those identified through CHCUP screenings
      2. Determination of the need for non-covered services and referral of the enrollee for assessment to the appropriate service setting (to include referral to WIC and Healthy Start) with assistance from the Medicaid Area Office as needed.
      3. Ensuring direct access to specialists for enrollees with special health care needs appropriate to their conditions and identified needs
      4. Identification of every pregnant enrollee through care coordination/case management, outreach, claims analysis a health risk questionnaire and other strategies. MCC requires Magellan Complete Care’s participating providers to notify the plan of any enrollee who is identified as being pregnant.
      5. Ensuring the documentation of referrals in the enrollee medical/case records including follow up resulting from the referral
      6. Follow-up services for children/adolescents that are identified through blood screenings a having abnormal levels of lead.
      7. Ensuring compliance with the transfer of medical/case records according to HIPAA privacy and security rules to any new Managed Care Plan within thirty (30) days.
8. Monitoring enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management.

9. Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and potentially avoidable hospital admissions;

10. Care Coordination/care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of the enrollee and family caregiver needs, coordinating the patient’s discharge plan with the family and hospital provider team, collaborating with the hospital or institution’s care coordinator/case manager to implement the plan in the patient’s home and facilitation, communication and the transition to community providers and services.

11. Coordinating efforts and information with other health plans and service delivery systems as appropriate to ensure services are not duplicative, but support the enrollee in an efficient and effective manner.

C. Magellan Complete Care maintains written protocols to identify, assess and implement interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care by including at a minimum the following:

   1. Development and utilization of an identification and stratification algorithm to sort eligible enrollees by severity and risk level
   2. Utilization and development of interventions and frequency of touch for each severity and/or risk level
   3. Managing, monitoring and determining maximum caseloads for each case manager and support staff
   4. Providing training and continuing education for case management staff
   5. Using evidence based guidelines
   6. Conducting comprehensive assessments that identify enrollee needs across multiple domains, including current health conditions, current providers, caregiver or other supports available, transportation barriers, medications, behavioral health conditions, and preferences for treatment.
   7. Developing treatment plans that incorporate the health risk issues identified during the assessment and incorporate the treatment preferences of the enrollee. The treatment plan shall contain goals that are outcomes based and measurable and include the interventions and services to be provided to obtain goals. Interventions should include community service linkage, improving support services and lifestyle management as appropriate based on the enrollee’s identified issues. Treatment plans shall be updated at least every six (6) months when there are significant changes in enrollee’s condition.
8. Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders.
9. Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions.
10. Interfacing with the enrollee’s PCP and/or specialists.
11. Assessing enrollees for literacy levels and other hearing, vision or cognitive functions that may impact an enrollee’s ability to participate in his/her care and implementing interventions to address the limitations.
12. Assessing enrollees for community, environmental or other supportive services needs and referring enrollees to get needed assistance.
13. Facilitating enrollee preferences for treatment, including cultural preferences, and enrollee participation in treatment planning.
14. Using best practices to increase enrollee engagement.
15. Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up.
16. Coordination of hospital/institutional discharge planning that includes post-discharge care, including residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care, as appropriate.
17. Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement;
18. Sharing with other managed care plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.
19. Ensuring that in the process of coordinating care/case management, each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

D. For enrollees identified with special health care needs that require a course of treatment or regular care monitoring determined by an appropriate behavioral health professional, Magellan allows enrollees to directly access a behavioral health specialists through a standing referral or an approved number of visits as appropriate for the enrollee’s condition and needs

II. Care Coordination Teams/Case Management Staff

A. Magellan Complete Care designates Care Coordination Teams (CCT) comprised of care coordination/case management staff, qualified by training, experience and certification/licensure to carry out procedures required in care coordination, complex case management, and other related care management programs. The Care Coordination Team includes the enrollee or designated representative, the primary behavioral and medical treating providers, a Health Guide, and if indicated by the
member’s circumstances, an Integrated Care Case Manager. A clinical pharmacist, peer support specialist, and medical directors (with physical and behavioral health expertise) are also available to the CCT at all times.

B. Enhanced care coordination processes and staffing requirements are applied for medically complex and medically fragile enrollees under the age of 21 who are receiving services in a skilled nursing facility or who are receiving private duty nursing services in their family home or other community based setting.

C. Specialized complex case management also applies for individuals transitioning to or from long term care program services.

III. Continuity of Care in Enrollment

A. Magellan Complete Care provides coordination of care for new enrollees transitioning into Magellan Complete Care. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, Magellan Complete Care maintains responsibility for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers. Magellan Complete Care reimburses non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless the provider agrees to an alternative rate.

B. If transitioning from Magellan Complete Care, Magellan Complete Care provides continuation of approved services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment. (See Magellan’s Policy on New Enrollee Procedures for additional information)

C. If transitioning to Magellan Complete Care, the LTC Managed Care Plans provide continuation of LTC services until the enrollee receives an assessment, a plan of care is developed and services are arranged and authorized as required to address the long-term care needs of the enrollee. Magellan’s case managers and designees work with the LTC Plan, member, and providers to coordinate regarding the plan. In no case will the transition to Magellan Complete Care be more than sixty (60) calendar days after the effective date of enrollment.

D. Magellan Complete Care meets state required reporting requirements for nursing facility transition, including reporting schedules for case management and submission to the Agency on a quarterly basis; and

E. Ensuring that in the process of coordinating care, each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describing the requirements regarding the privacy of individually identifiable health information
IV. Coordination of a Member's Care Transition when Benefits are Exhausted

A. Health Services staff work closely with network providers in order to be prepared for a situation where benefit limits have been maximized and hence, reimbursement is no longer available. In accordance with accepted professional guidelines and standards for clinical practice, members in active treatment are never abandoned. Rather, appropriate policies are in place to support the safe transition of each member from one provider to another under a different benefit plan, private pay or publicly funded arrangement.

B. MCC sends an exhaustion of benefits letter to the member for any Customized Benefit Package service restricted by a dollar amount. The letters of notification include the following:

1. A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by Magellan Complete Care for a benefit;
2. A follow-up letter notifying the enrollee when he/she has reached seventy five (75%) of any maximum annual dollar limit established by Magellan Complete Care for a benefit; and
3. A final letter notifying the enrollee that he/she has reached the maximum limit for a benefit.

V. Managing Mixed Services

A. Magellan Complete Care provides case management and care coordination with other Managed Care Plans for enrollees with both Magellan Complete Care benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. Mixed Services include:

1. Assistive Care Services;
2. Home health and nursing care (intermittent and skilled nursing);
3. Hospice services;
4. Medical equipment and supplies (including durable medical equipment); and
5. Therapy services (physical, occupational, respiratory and speech).

B. Magellan Complete Care provides non-emergency transportation (NET) services to enrollees with both MMA benefits and LTC benefits as follows:

1. Magellan Complete Care provides NET for all Magellan Complete Care benefits.

Magellan Complete Care also provides case management and care coordination with other service delivery systems serving Magellan Complete Care enrollees like the agency, DCF, FL Assertive Community Teams and other public or private organizations to ensure
services are not duplicative but rather support the enrollee in an efficient and effective manner.

D. Behavioral Health Coverage and Coordination in Long-Term Care Settings

1. Magellan Complete Care provides medically necessary behavioral health evaluation and treatment services to enrollees, regardless of setting including in the community, a medical facility, an assisted-living facility, or a nursing facility. Magellan Complete Care coordinates with LTC Managed Care Plans and providers, Medicare plans and providers and state-funded programs and services. Responsibilities include:
   a) Arranging and paying for psychiatric evaluations within five (5) business days from the time the request is received from DCF for enrollees applying for admission to a nursing facility.
   b) If the results of the psychiatric evaluation indicates medically necessary covered behavioral health services, and the enrollee is admitted to the nursing facility, Magellan Complete Care will provide the behavioral health services to the enrollee in the nursing facility.

2. Magellan Complete Care ensures that enrollees residing in licensed Assisted Living Facilities (ALFs) that meet criteria as a mental health resident also have access to appropriate assessment services, medically necessary behavioral health services, including psychiatric medication and access to drop-in centers and clubhouses.
   a) Magellan Complete Care ensures the development of a community living support plan and that it is implemented as written and updated annually.
   b) If requested by the ALF, Magellan Complete Care provides emergency procedures for the ALF to follow for an enrollee that resides at the ALF if an emergent situation arises.

E. Enhanced Care Coordination for Enrollees under Age 21 Receiving Skilled Nursing facility or Private Duty Nursing Services

1. Magellan Complete Care has enhanced care coordination processes for medically complex and medically fragile enrollees under the age of 21 who are receiving services in a skilled nursing facility; or are receiving private duty nursing services in their family home or other community based setting.

2. The care coordination of medically complex and medically fragile enrollees includes:
   a) Assigning a care coordinator to all enrollees
   b) Maintaining documentation of an enrollee or their parent or legal guardian’s rejection of care coordination services.
   c) Care coordinators who possess the following qualifications:
i. State of Florida licensed registered nurse with at least two (2) years of pediatric experience;

ii. State of Florida licensed practical nurse with four (4) years of pediatric experience; or

iii. Master’s degree in social work with at least one (1) year of related professional experience.

3. Ensuring that care coordinator caseloads do not exceed a ratio of forty (40) enrollees to one care coordinator for enrollees receiving private duty nursing services in their family home or other community based setting and no more than a ratio of fifteen (15) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.

4. Ensuring that the care coordinator maintains monthly (or more frequently, if needed) contact with the enrollee and the enrollee’s parent or legal guardian. The contact shall be face-to-face or telephonic. Magellan Complete Care shall maintain documentation in the enrollee’s record of any contacts made, including whether such attempts were successful in reaching the enrollee or the parent or legal guardian.

5. Ensuring a multidisciplinary team (MDT) occurs every six (6) months to provide a comprehensive review of the services and supports that the enrollee needs and to authorize any Medicaid reimbursable services that are prescribed for the enrollee (e.g., private duty nursing, therapy services, etc.). The MDT shall meet more frequently, if needed, based on any changes in the enrollee’s medical condition. The MDT meeting shall include at a minimum: the enrollee’s care coordinator, the enrollee (if able), the enrollee’s parent or legal guardian, and other health care professionals involved in that enrollee’s care. The MDT shall also develop a person centered individualized service plan that reflects the services and supports that the enrollee needs.

6. Convening an MDT meeting one year prior to an enrollee turning the age of twenty-one (21) to discuss the services and supports that the enrollee will need after turning twenty-one (21). If the services are not covered by Magellan Complete Care, the enrollee or their representative will be educated on any community programs or home and community based waiver options that may be able to meet the needs and make the necessary referrals, as needed.

F. Magellan Complete Care addresses the transition/discharge planning process for medically complex and medically fragile enrollees who are receiving services in a skilled nursing facility. Magellan Complete Care process includes:

1. Ensuring that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing a skilled nursing
facility prior to enrollment in the plan, Magellan Complete Care shall begin the transition planning process upon enrollment in the plan.

2. Convening an MDT meeting focused specifically on transition planning to proactively consider placement alternatives and offer such opportunities to the enrollee and his or her parent or legal guardian. This transition planning meeting shall occur every three (3) months until the enrollee is transitioned home or to another community based setting.

3. Developing a final written transition plan within thirty (30) days prior to discharge, which includes all of the services and supports that the enrollee needs to successfully reside in the community.

4. Maintaining contact with the enrollee and their parent or legal guardian at least two (2) times a month during the first six (6) months after discharge from the skilled nursing facility. If agreed to by the parent or legal guardian, at least one of these contacts must be face-to-face. After this six (6) month transition period, Magellan Complete Care shall continue to maintain monthly contact with the enrollee and their parent or legal guardian.

VII. Planned and Unplanned Clinical Transitions in Care

A. MCC supports members in planned and unplanned transitions from one level of care or setting of service to another. In order to support coordination of services, MCC manages transitions in care by gathering, sharing, and acting upon and information about any unplanned hospital or emergency room visit of which it is notified.

B. The MCC Health Services Department develops a plan to transition the individual smoothly back into the community and to share information with the discharging organization, behavioral health provider and PCP in order to prevent any gaps in treatment that could result in a re-admission.

C. To facilitate timely and effective transitions from inpatient and long-term settings to the community, Magellan maintains collaborative relationships with hospital emergency departments, medical and psychiatric units of local hospitals, nursing homes, home care agencies, and long-term care and other applicable settings.

1. Discharge Planning and Coordination of Care:

   a) MCC maintains written protocols for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. MCC does the following:
i. Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee’s needs for continuity in existing behavioral health therapeutic relationships;

ii. Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement;

iii. Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees and enrollees with multiple agency involvement);

iv. Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting;

v. Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. Magellan Complete Care ensures that the behavioral health program clinician is duly qualified and licensed to provide medication management;

vi. Upon the admission of an enrollee, Magellan Complete Care makes its best efforts to ensure the enrollee’s smooth transition to the next service or to the community and shall require that behavioral health care providers:
   (a) Assign a mental health case manager to oversee the care given to the enrollee;
   (b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and
   (c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.

VIII. Care Coordination/Case Management and Health Management
A. Magellan Complete Care and its QI plan demonstrate specific interventions in its physical and behavioral health care coordination/case management to better manage services and promote positive enrollee outcomes. Magellan Complete Care’s written policies and procedures address components of effective care coordination/case management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollee’s behavioral health needs, and effective action to promote quality of care. Participation in the DCF planning process, where such exists (see s. 394.75, F.S.). The provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:

1. Have resided in a state mental health facility for at least six (6) of the past thirty-six (36) months;

2. Reside in the community and have had two (2) or more admissions to a state mental health facility in the past thirty-six (36) months;

3. Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;

4. Have been diagnosed with a mental health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications; or.

5. Have been identified as exceeding the Magellan Complete Care’s prescription limits as permitted under Section V, Covered Services.

B. If an enrollee makes a request for behavioral health services, Magellan Complete Care provides the enrollee with the name (or names) of qualified behavioral health care providers, and if requested, assist the enrollee with making an appointment with the provider that is within the required access times indicated in Section VI, Provider Network.

Magellan Complete Care is responsible for the management and continuity of medical and behavioral health care for all enrollees.

C. Magellan Complete Care ensures that appropriate resources are available to address the treatment of complex conditions that reflect both behavioral health and physical health involvement. The following conditions must be addressed:

1. Mental health disorders due to or involving a general medical condition, and
2. Eating disorders.
D. Magellan Complete Care develops a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. Magellan Complete Care’s provider network includes appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods.

E. Magellan Complete Care complies with requirements in the Managed Care Plan Report Guide

IX. Continuity of Care – Pharmacy

A. Magellan Complete Care assures enrollee access to medications during the transition of care period at a minimum through the following actions and interventions:

1. New members will receive on-going prescriptions without disruption
2. Pharmacy data will be used to identify and stratify members at high risk
3. Processes remain in place to assure safe use of medications
4. Problems will be solved in real time through coordination and communication with the member, the provider, the PBM and the retail pharmacy when applicable
5. No prior authorization will be required for the first 60 days or until the treatment plan is reviewed by the PCP or behavioral health provider.

Cross References:

Care Coordination and Complex Case Management Program Description
New Enrollee Procedures Policy
Treatment of Medically Complex Conditions Policy

Associated Forms & Attachments

None