



STATEWIDE OPERATIONAL PLAN

March 2007

This Statewide Operational Plan is a coordinated effort between the Department of Health, Division of Children's Medical Services; the Department of Children and Families; and the Agency for Health Care Administration. This document has been reviewed and approved by staff from the aforementioned agencies.



Additional copies may be obtained through: Division of Children's Medical Services Network, 4052 Bald Cypress Way, Bin AO6, Tallahassee, Florida, 32399-1707 (850) 245-4200 or Sun Com 205-4200.

REVISIONS TO CMAT OPERATIONAL PLAN

NOTE:

The Children's Multidisciplinary Assessment Team (CMAT) was formerly known as the Multiple Handicap Assessment Team (MHAT). The name was changed to the Children's Multidisciplinary Assessment Team by the 1997- 98 Florida Legislature.

UPDATE NO.	DATE ISSUED	MAJOR CHANGES
<i>New Operational Plan</i>	<i>May 1993</i>	
<i>96-1 Revised Plan</i>	<i>January 1996</i>	
<i>97-1 Revised Plan</i>	<i>December 1997</i>	
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<i>98-2 Replacement Pages</i>	<i>October 1998</i>	
<i>99-1 Revised Plan</i>	<i>July 1999</i>	
<i>00-1 Revised Plan</i>	<i>January 2000</i>	
<i>00-1 Revised Plan</i>	<i>December 2000</i>	
<i>02-1 Revised Plan</i>	<i>November 2002</i>	
<i>06-1 Revised Plan</i>	<i>March 2006</i>	<i>Recommendation changes due to Medicaid reform.</i>
<i>07-1 Revised Plan</i>	<i>March 2007</i>	<i>Recommendation and process changes due to Medicaid reform.</i>

DISTRIBUTION LIST

Each district / area will receive copies of the **CMAT Statewide Operational Plan** to be distributed to the following people:

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Children's Medical Service Medical Director (1)

Children's Medical Service Nursing Director (1)

Children's Medical Service Nursing Supervisor (1)

CMAT Medical Director (1)

CMAT Registered Nurse (1)

CMAT Social Worker (1)

Medicaid Service Authorization Nurse (1)

Children and Family Services (4)
Office of Family Safety Team Representative
Program Administrator for Foster Care
Operations Program Administrator
Program Specialist for Foster Care

CARES Unit Supervisor (1)
Department of Elder Affairs

Agency for Persons with Disabilities (2)
Agency for Persons with Disabilities Team Representative
Operations Program Administrator

Early Steps Team Representative (1)

Medical Foster Care Program Coordinator (1)

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Department of Children and Families, Office of Family Safety
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PREFACE

Title XIX of the Social Security Act established the Medicaid program in 1965 for the purpose of helping recipients of public assistance and other low-income persons to meet the costs of necessary medical care. Florida implemented the Medicaid program on January 1, 1970.

Between 1970 and 1989, Children's Medical Services and other programs from the Department of Health and Rehabilitative Services, including Developmental Disabilities, Children and Family Services, and Medicaid worked to develop a continuum of care for children with special health care needs. The continuum was to be family-centered and include developmental evaluation and intervention at birth, primary care, secondary and tertiary care, with special services for the medically complex or involved child to include medical foster care, nursing facility care, and in-home services. Alternative homes and facilities beyond a hospital or acute care setting were often more appropriate for a child with complex medical needs; however, funding for these various alternatives remained problematic.

As a result of the federal mandates inherent with the implementation of the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89), the Florida Medicaid program expanded the reimbursement for services to children with special health care needs. This expansion of "funded" services had a significant impact on services available to children with special health care needs. OBRA 89 provided for expanded in-home care for children through nursing and personal care, therapies, durable medical equipment, prescribed pediatric extended care, and other related services. In addition, children up to the age of 21 are entitled to medically necessary services identified and prescribed as a result of the Child Health Check-Up, (formerly known as EPSDT) regardless of whether the services are included in the state's Medicaid plan according to Title XIX of the Social Security Act (T1905-A).

Concurrent with the implementation of OBRA 89, Children's Medical Services was identified as the principal program responsible for coordinating the staffing of a departmental multi-disciplinary assessment team with the mission of determining appropriate levels of care and recommending long-term care services for children with complex medical needs and providing cost containment for high cost Medicaid reimbursable services. Late in 1991, Medicaid and Children's Medical Services jointly provided funding to establish the positions of a Registered Nurse (RN) and a Social Worker (SW) to function as designated members of a MHAT (Multiple Handicap Assessment Team) in each district. By 1995, the teams were fully functional statewide. In 1998, MHAT was renamed Children's Multidisciplinary Assessment Team (CMAT). Due to Medicaid reform, CMAT no longer provided utilization review for wheel chairs in 2004, private duty nursing in 2005 and pediatric prescribed extended care in 2006.

CHAPTER ONE ROLE OF THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM

INTER-AGENCY EFFORT

The Children's Multidisciplinary Assessment Team (CMAT) is an inter-agency coordinated effort of Medicaid in the Agency for Health Care Administration; Office of Family Safety in the Department of Children and Families; the Agency for Persons with Disabilities; and Children's Medical Services in the Department of Health. These entities have agreed to accept on-going CMAT responsibilities. The CMAT makes recommendations for medically necessary services for children birth to twenty-one who is medically complex or medically fragile (65C-30.001, FAC).

Children's Medical Services has lead responsibility to facilitate this collaboration, which is essential to respond to the needs of each child and family and to guarantee the efficiency and effectiveness of supports and services.

SERVICES UNDER THE REVIEW OF THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM

The CMAT makes recommendations for medically necessary services that are funded by Medicaid and may perform utilization reviews and make services recommendations for the Children's Medical Service's integrated care systems.

Medicaid Funded Services Requiring A CMAT Recommendation

The long-term care services funded by Medicaid for children birth to twenty-one that require a CMAT recommendation includes the following:

- services provided in Skilled Nursing Facilities (SNF);
- Medical Foster Care (MFC);
- level of care determinations for Model Waiver (MW) applicants; and,
- Continuity of Care considerations.

Medicaid reimbursement policy requires that the CMAT assess all Medicaid eligible children referred for the above referenced long-term care services. The primary purpose for CMAT is to assess the child, conduct multidisciplinary staffings and make medically necessary recommendations for these Medicaid funded services.

Children's Medical Services (CMS) Funded Services

- The Integrated Care Systems (ICS) providing utilization review for the Children's Medical Service's may request a CMAT staffing for a medical necessity recommendation on high cost, high volume, high risk or low volume services funded by this network; and,

CMS care coordinators may request a CMAT recommendation for high cost, high volume, high risk, or low volume services for CMS clients whose services are not paid for by Medicaid.

These requests can not impede the CMAT staff's ability to assess and conduct staffings for the Medicaid funded services that require a CMAT recommendation and will only be provided if the CMAT staff have sufficient time to conduct these staffings and they are authorized by the Regional Nursing Director.

SCOPE OF THE OPERATIONAL PLAN

The CMAT operational plan includes policies, procedures, and protocols from programs and staff of Children's Medical Services (CMS) in the Department of Health, the Agency for Persons with Disabilities, Office of Family Safety in the Department of Children and Families (DCF), and Medicaid in the Agency for Health Care Administration (AHCA).

REFERENCES

1. Chapter 391, Florida Statue, Children's Medical Services
2. Section 64C, Florida Administrative Code, Division of Children's Medical Services
3. Section 65C-30.001, Florida Administrative Code, Department of Children and Family Services
4. Section 59G-1, Florida Administrative Code, General Medicaid
5. Section 59A-4, Florida Administrative Code, Nursing Homes and Related Services, Medicaid
6. Section 59G-4.080, Florida Administrative Code, Child Health Check-up
7. Section 59G-4.200, 59G-4.290, 59G-189, Florida Administrative Code, Nursing Home Services, Skilled Nursing Services, Intermediate Care Services
8. Section 59-G4.197, Florida Administrative Code, Medical Foster Care
9. Section 59G-13.080(13), Florida Administrative Code, Home and Community-Based Services Waiver, Model Waiver
10. Medicaid: Provider General Handbook
11. Medicaid: Nursing Facility Services Coverage and Limitations Handbook
12. Medicaid: Medical Foster Care Coverage and Limitations Handbook
13. CFOP 175-20 Child Protection Teams and Sexual Abuse Treatment Programs
14. CFOP 175-23 Case Supervision in Initial Responses/Assessments Involving Shelter Care
15. HRSOP 175-26 Confidentiality of Children and Families Records
16. CFOP 175-34 Removal and Placement of Children
17. CFOP 175-40 Consent for Medical Screening, Examination, and Treatment of Children in Physical or Legal Custody of the Department
18. Section 65C-13.014, Florida Administrative Code, Entry into Foster Care
18. Section 65C-13.016, Florida Administrative Code, Health Care
19. Chapter 65-2, Florida Administrative Code, Rules of Practice and Procedure
20. CFOP 165-22 Integrated Public Assistance Policy
21. Chapter 42, subsection 483.100 – 483.138, Federal Code of Regulation (CFR), PASRR requirements
22. Chapter 400, Florida Statue, Nursing Homes

**CHAPTER TWO:
HEADQUARTERS AND SERVICE AREA RESPONSIBILITIES**

RESPONSIBILITIES OF PROGRAMS AND AGENCIES

Each agency's headquarters office participating in CMAT functions will designate a program or agency consultant as a CMAT liaison. This individual will have the knowledge and authority to make decisions on behalf of their program or agency regarding CMAT activities, including the provision of technical support and consultation on policy and programmatic issues. In addition, the agency's headquarters offices will maintain agreements with other programs or agencies regarding participation and the use of the CMAT.

Each agency will support the function of the CMAT by assigning an individual to be responsible for agency and program representation, coordination, and conflict resolution when necessary. Each Children's Medical Services Regional or Area Office Medical Director will appoint appropriate management staff to oversee the collaborative efforts and functioning of the regional CMAT(s) and to assist in scheduling visits by Central Office staff. The CMAT Medical Director, the Medicaid Field Office Manager and lead Community Based Care agency, or their designee, will designate the appropriate representatives to participate in applicable CMAT staffings for each service area.

The following sections delineate the responsibilities at the agency headquarters and local levels for each of the agencies involved.

DEPARTMENT OF HEALTH

Children's Medical Services

Central Office:

It is the responsibility of Children's Medical Services staff to maintain the CMAT Statewide Operational Plan; provide oversight and training required for CMAT functions; and provide statewide review for regional area office CMAT operations. Children's Medical Services will provide statewide medical direction and consultation to area office CMAT staff. Training for CMAT staff will be offered as needed. Additionally, Central Office staff will respond to requests for policy interpretation and clarification from area office CMAT staff, providers, families and other interested individuals.

Local Service Area:

Each CMS region within the State will have CMAT representation. The Children's Medical Services regional area office administration will:

- provide office space and supplies to the CMAT Registered Nurse (RN), Social Worker (SW) and Medical Director;
- recruit, hire and supervise the CMAT staff (RN, SW, and Medical Director);

- provide medical consultation and direction to the CMAT participants concerning the condition and expected long-term impact of the complex medical needs of individual children, information about family and health care dynamics, and the care and management options available;
- oversee and facilitate appropriate and correct billing for the CMAT Medical Director services;
- oversee assessments concerning the child and family including the CMAT nursing and psychosocial assessment information documented in the appropriate electronic medical record;
- request technical assistance or policy clarification from Central Office as needed, relating to the CMAT staff's specific roles and functions including participation in fair hearings; and,
- respond to, address and facilitate resolution of complaints regarding CMAT staffing recommendations.

Medical Foster Care Program

Central Office:

The MFC registered nurse and social worker will provide consultation on services for children from birth to 21 years of age in accordance with the MFC Operational Plan.

Local Service Area:

The MFC registered nurse (MFC RN) and / or social worker (MFC SW) is responsible for participating in all CMAT staffings for shelter / foster care children in their service area who are currently or who may be eligible to receive MFC Services. The MFC staff will assist in facilitating the provision of information about assessments completed for potentially eligible children.

Early Steps

Central Office:

Early Steps staff will provide consultation on services for children from birth to 3 years of age with identified developmental delays, best practice issues, observance of procedural safeguards, and appropriate Individualized Family Support planning for all Part C eligible children eligible as mandated by the Individuals with Disabilities Education Act (IDEA).

Local Service Area:

The Early Steps representative is responsible for participating in CMAT staffings for foster children in their service area who are currently or who are potentially eligible to be served by the Early Steps program. This representative will ensure that procedural safeguards are observed and that appropriate Individualized Family Support planning for all Part C eligible children occurs, as mandated by IDEA. They will assist in facilitating the provision of information about

evaluations and assessments completed for potentially eligible children when requested and when appropriate consent for release of information has been obtained.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

Headquarters:

Medicaid staff will provide consultation on Medicaid issues including funding requirements and policies affecting CMAT recommendations. Medicaid headquarters staff will provide program evaluation, monitoring, and oversight of Medicaid area office CMAT representative.

Local Service Area:

The Medicaid Service Authorization Registered Nurse Specialist (SA RNS) is responsible for participating in CMAT staffings for foster children in their service area, reviewing the Medicaid eligibility status of each child referred to CMAT and making a service authorization determination on all CMAT recommendations for children in their service area. In addition, the Medicaid SA RNS may request to participate in SNF, MW and Continuity of Care CMAT staffings. The Medicaid SA RNS will provide consultation to the CMAT regarding Medicaid reimbursement, including prior authorization requirements, service authorization requirements, and re-authorization requirements including eligibility time lines. The Medicaid SA RNS will submit the authorization information necessary for reimbursement of services. Medicaid staff will attend and participate in fair hearings related to CMAT recommendations.

DEPARTMENT OF CHILDREN AND FAMILIES

Office of Family Safety

Headquarters:

Department of Children and Families staff representatives are responsible for providing consultation on legal and program requirements, issues, and policies affecting CMAT recommendations. They will provide expertise and assistance in regards to dependency, permanency planning and reunification.

Local Service Area:

Each CMAT will have a representative from the Department of Children and Families, Community Based Care agencies or sheriff office's child protection investigation unit, who will have expertise in dependency programs. The representative will:

- assist the team in engaging the participation of Department of Children and Families and / or Community Based Care providers who are involved with the child;
- participate in CMAT staffings for foster children in their service area;

- assist the team in understanding the impact of family involvement and the rights of the family when the child is living outside the home;
- clarify legal custody issues for children staffed; and,
- encourage the Department of Children and Families and / or Community Based Care direct service staff, lead care coordinator, support coordinator or a representative knowledgeable about the child and family to attend the CMAT staffing.

AGENCY FOR PERSONS WITH DISABILITIES

Local Service Area:

The Agency for Person with Disabilities representative is responsible for participating in CMAT staffings for foster children in their service area who are currently or who are potentially eligible to be served by the Agency for Person with Disabilities program. The representative from the Agency for Persons with Disabilities will have expertise in disabilities programs. The representative will:

- assist the team in engaging the participation of Agency for Persons with Disabilities providers who are involved with the child;
- assist the team in understanding the impact of family involvement and the rights of the family when the child is an Agency for Persons with Disabilities client; and,
- encourage the Agency for Persons with Disabilities direct service staff, lead care coordinator, support coordinator or a representative knowledgeable about the child and family to attend the CMAT staffing.

INVOLVEMENT OF OTHER PROGRAMS AND AGENCIES

Inquiries related to the Institutional Care Program (ICP) for children requiring nursing facility services should be directed to the Department of Children and Families Economic Self-Sufficiency office. Inquires related to a child in a nursing facility requiring specialized mental health services, admission review, and / or screening, should be directed to the Department of Children & Families district Substance Abuse and Mental Health Program. The CMS Early Steps program should be contacted if a prospective nursing facility resident under the age of 3 appears to need specialized services due to mental retardation and related conditions. The Agency for Persons with Disabilities should be contacted if the child described above is 3 years of age or older.

LOCAL TEAM MEMBER RESPONSIBILITIES

Each designated CMAT representative will:

- support opportunities for parental participation and family-centered approaches to CMAT recommendations;

- regularly attend all CMAT staffings in their service area and arrange for an alternate when attendance is not feasible;
- maintain confidentiality of client information by following Health Insurance Portability and Accountability Act (HIPAA) rules and guidelines;
- advise the team regarding the eligibility of the child and family for services and about the appropriateness, availability, duration, and limits on possible supports and services in their program;
- communicate available information to CMAT members about the issues and policies which affect decisions and recommendations for care and management of the child's medical needs in the context of the family's circumstances, concerns, and priorities;
- facilitate access to reports and records concerning the child being staffed when proper consent is available;
- participate in collaborative decision-making and problem-solving strategies with other CMAT members for the purpose of recommending individualized services specific to the care and management of the complex medical needs of each child and with consideration given to medical necessity, cost efficiency, accessibility and timeliness;
- respond to district, service area, and statewide requests for information about CMAT coordination and staffings as well as raising the awareness of local staff regarding the team;
- respond to federal and state requirements pertinent to service recommendations;
- provide information from data base systems as requested;
- participate in training, evaluation, monitoring, and related follow-up activities to improve CMAT functions, activities, and outcomes; and,
- provide program commitments for resources, supports, and services such as equipment, services, MFC homes in the community, and other settings that may provide a place for the child to live and receive the most cost effective, least restrictive and most inclusive care.

<p style="text-align: center;">CHAPTER THREE: ELIGIBILITY AND REFERRAL PROCESS</p>

ELIGIBILITY

Medicaid Eligible Children

The CMAT may staff any Medicaid-eligible child less than 21 years of age who has a medically complex or medically fragile condition requiring continual medical, nursing, or health supervision and has medical documentation to support the need for long-term care services. A CMAT staffing can be requested under the following circumstances:

- The child is in shelter or foster care with special health care needs not meeting the criteria of medically complex or fragile;
- The child is being referred for a service that requires a CMAT staffing according to the Medicaid reimbursement criteria, such as:
 - Skilled Nursing Facility (SNF) placement;
 - Medical Foster Care (MFC);
 - Request to determine the medical necessity for the Model Waiver (MW) program; or,
 - Individual requests from Medicaid for Continuity of Care staffings.
- The child is being referred by the CMS integrated care system (ICS) providing utilization review for CMS clients for a medical necessity recommendation on high cost, high volume, high risk or low volume services as authorized by the Regional Nursing Director.

Non-Medicaid CMS Children

All non-Medicaid CMS children are eligible for a CMAT staffing if a medical necessity determination is requested and if authorized by the Regional Nursing Director.

Definition of Medically Necessary, Medically Complex, and Medically Fragile

Medically Necessary or Medical Necessity means that the medical or allied care, goods, or services furnished or ordered must

(a) Meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service. *Florida Administrative Code 59G-1.010(166)*

Medically complex means an individual who has chronic, debilitating diseases or conditions of one or more physiological or organ systems that make the individual dependent upon 24-hour a day medical, nursing, health supervision, or intervention. *Florida Administrative Code 59G-1.010(164)*

Medically fragile means an individual who is medically complex and technologically dependent on medical apparatus and / or procedures to sustain life. Examples are individuals who require total parenteral nutrition, are ventilator dependent, or are dependent on a heightened level of medical supervision to sustain life, and without such services are likely to expire without warning. *Florida Administrative Code 59G-1.010(165)*

WHO MAY REFER CHILDREN

Anyone may refer a child to the CMAT. Typical referral sources include the Department of Children and Families, Children's Medical Services care coordinators, hospital discharge staff, and families.

RELEASE OF INFORMATION REQUIRED TO PROCEED

Prior to initiating the assessment phase of the CMAT process, a signed Consent for Routine Release of Protected Health Information (CRI) DOH 3206 form (Attachment 1) and a signed CMS Network Consent for Evaluation and Treatment (CET) DOH/CMS 1074 form (Attachment 2) must be obtained. If the child is already a CMS client and a signed CRI and CET is present in the child's CMS record, the CMAT staff may place a copy of the original CRI and CET form in the client's CMAT administrative file. If the child is not a CMS client, the CMAT staff will obtain a signed CRI and CET form and place the original forms in the child's CMS record and may place a copy in the child's CMAT administrative file. For children in the custody of their parents, the parent or legal guardian must sign the consent forms to authorize the CMAT staff to obtain and release the confidential medical information necessary to conduct the assessment and subsequent CMAT staffing. In the event that the child's parent refuses to sign the CRI and CET forms, an assessment can not be conducted, a staffing cannot be held and the service will not be authorized. An exception to this policy may occur when the Medicaid SA RNS requests a Continuity of Care staffing (see the Continuity of Care Staffing section in Chapter 10). For children in shelter / foster care status, the Department of Children and Families, Community Based Care agency staff or sheriff's office and CMAT staff have equal responsibility to obtain

the CRI and CET forms, which will permit the CMAT staff to proceed with their information gathering process. The shelter order will often be dispositive regarding the issue of who can consent to release of information to CMAT. The Department of Children and Families, Community Based Care agency or sheriff's office will determine whether their staff or the family will sign the CRI and CET forms. When a referral is requested for MFC placement by an individual outside of the Department of Children and Families, Community Based Care agency or sheriff's office, the CMAT staff must consult with child's foster care staff regarding the custody status of the child, the staff person's interest in having the foster child staffed for a MFC placement and obtaining the signed CRI and CET forms. The Department of Children and Families, Community Based Care agency or sheriff's office staff will be responsible for providing the CMAT a copy of the signed shelter order.

An interagency cooperative agreement between the Agency for Health Care Administration, the Department of Health and the Department of Children and Families allows for the exchange of medical information between the agencies without a signed CRI form.

The Department of Children and Families or Community Based Care agency staff cannot sign a consent form for the release of psychiatric assessments or reports, drug and alcohol abuse treatment or child abuse information without a court order. In this instance, the Department of Children and Families or Community Based Care agency staff must obtain a court order to allow the CMAT staff to obtain necessary and relevant information. If the parental rights have been terminated and the child has been permanently committed to the state agency, the Department of Children and Families or Community Based Care staff may sign the release and provide a copy of the permanent commitment court order to the hospital, physician, or other authorized party.

Reproduction of documents or pictures of identifiable children who receive CMAT recommended services may not be used for any media presentation without the permission of the local CMS Medical Director and not until after a Public Information Release Form has been signed by the parent or legal guardian of a child. If a child has had parental rights terminated, the child's Department of Children and Families or Community Based Care agency staff must be consulted and agree that this use will not be detrimental to the child. All identifying information pertaining to the birth parents of an adopted child must be deleted from any copy of the medical file prior to release. Assessments must not state that the child is adopted or name individuals who will adopt a child.

REFERRAL CONTENT

When a child is identified as potentially in need of CMAT recommended services, the referral source will contact the local CMAT RN or SW and provide the information needed to contact the child's family / legal guardian. The CMAT staff will contact the child's family / legal guardian to obtain consents and the information needed to complete the CMAT Referral Form (Attachment 5) and CMAT Assessment. The RN / SW will work with the referral source to obtain any additional information necessary to determine the child's medical complexity and needs.

ELIGIBILITY FOR A STAFFING

All children referred to CMAT will have a CMAT staffing unless the CMAT Medical Director determines that the child is not eligible for a CMAT staffing. When determining that a child is not eligible for a CMAT staffing, the CMAT Medical Director will follow the procedures documented in the Denial of Staffing section of this chapter. All children who are referred to the CMAT from the Department of Children and Families or Community Based Care agency are eligible for a CMAT staffing and will be staffed within five calendar days of the referral or receipt of a signed CRI and CET forms, whichever is later, unless the CMAT Medical Director signs a CMAT Medical Director's Review: Denial of a CMAT Staffing form (Attachment 13). See Denial of Staffing section below.

TIMEFRAMES FOR CONDUCTING A CMAT STAFFING

The CMAT staff will schedule staffings for all referrals within 15 calendar days of the referral or receipt of a signed CRI and CET forms, whichever is later. All initial staffings will be held within 30 calendar days from receipt of a signed CRI and CET forms. There are two exceptions to this policy. Emergency staffing and staffing of children in shelter / foster care will be conducted within 5 calendar days of the referral or receipt of a signed CRI and CET forms, whichever is later (see Chapter 10 Staffing Categories and Timelines for more information). If the referral is made by an individual other than the child's foster care staff, emergency staffing will be conducted within 5 calendar days of the Children & Families or Community Based Care staff's agreement for a CMAT staffing and receipt of a signed CRI and CET forms. Secondly, if the parent or legal guardian of the child requests a delay in the staffing of their child, this request will be honored.

The CMAT staff will maintain a list of CMAT referrals to verify appropriate follow up of referrals and validity of referrals. This list can be maintained on the optional Quarterly CMAT Referral Log (Attachment 6) or by printing a monthly CMAT Referrals report in the CMS electronic medical record system. A copy of the referral log or referral report will be maintained in a CMAT programmatic administrative file.

DENIAL OF STAFFING

Not all children referred to the CMAT program for MFC, SNF, or MW services will be medically eligible to receive CMAT recommended services. If the CMAT RN and SW question the appropriateness of a referral, they will obtain and document abbreviated clinical and psychosocial assessment information, which will minimally include:

- a brief medical history;
- diagnosis;
- medication(s);
- clinical treatment(s);
- equipment;
- growth, if it is an affected condition; and
- Activities of Daily Living, if personal care needs are significant.

If the CMAT RN and SW suspect that the child may not have a medically complex or fragile condition and / or the child does not meet the requested long-term care service eligibility requirements as defined in Attachment 13 section 3B, they will provide the CMAT Medical Director a copy of the abbreviated assessment. The CMAT Medical Director will make the determination on whether or not the child meets the above listed eligibility requirements for a CMAT staffing. Should the CMAT Medical Director determine that there is not sufficient evidence that the child has a medically complex or fragile condition or the child does not meet the requested long-term care service eligibility requirements, s/he will complete and sign a CMAT Medical Director's Review: Denial of a CMAT Staffing form (Attachment 13). CMAT staff will mail the signed Denial of a CMAT Staffing form along with the Notice of Right to Appeal form (Attachment 14) to the child's parent / legal guardian within one business day of the receipt of the signed Denial of a CMAT Staffing form. The referral source will be copied on the Denial of Staffing form. A copy of the signed Denial of a CMAT Staffing form will be filed in the child's CMS record. A Record of Treatment (ROT) note will be completed documenting that the parent was mailed the Denial of a CMAT Staffing form, the Notice of Right to Appeal form, and that the referral will be closed.

CHAPTER FOUR: CMAT GOALS, STAFF, TEAM COMPOSITION AND TRAINING

GOALS

The primary goal of the CMAT process is to provide recommendations for medically necessary long-term care services for medically complex or medically fragile children. The staffing process used to make the medically necessary recommendation will be determined by the service being sought by the referring individual. If Medical Foster Care services will be considered, a full team staffing will occur as outlined in the Participation in Medical Foster Care CMAT Staffing section in Chapter 11. If Skilled Nursing Facility or Model Waiver services will be considered or if the ICS makes a request for a CMAT staffing, then a staffing conducted by CMAT staff will occur as outlined in the Participation in Skilled Nursing Facility, Model Waiver and Integrated Care System CMAT Staffing section in Chapter 11. Nursing and psychosocial information documented in the CMAT assessment and discussed at the CMAT staffings will provide the team with the information necessary to develop recommendations. The assessment will minimally include information obtained from the child's family, legal guardian and providers. Recommendations for services include the service type, duration of the service and the child's level of care or level of reimbursement.

A second goal of the CMAT process is to recommend the most cost efficient long-term care service that will meet the needs of the child. The CMAT aids in reducing costs and avoiding escalation of costs by not only recommending long-term care services that are medically necessary, but also by reducing the overall number and length of hospitalizations of medically complex children while meeting their medical needs, and avoiding placement in acute care settings for the provision of non-acute care.

CMAT STAFF

The CMAT staff will consist of a Medical Director, Registered Nurse and a Social Worker. Each CMS region will have at least one team of CMAT staff which will have designated service area(s) within their region. Large geographical regions or regions with a large population base may have more than one team of CMAT staff. The CMAT staff are responsible for facilitating a CMAT process for all clients in their designated service area.

MEDICAL FOSTER CARE AND CONTINUITY OF CARE STAFFING TEAM COMPOSITION

The CMAT will be comprised of the following team members for MFC and Continuity of Care staffings:

- the family or legal guardian;
- the **CMAT RN**;
- the **CMAT SW**;
- the **CMAT Medical Director**;
- the **Medicaid SA RNS**;
- the Children's Medical Services representative;

- the MFC staff representative;
- the Children and Families / Community Based Care representative;
- the Early Steps representative for children ages birth to three; or,
- the Agency for Persons with Disabilities Program representative for children age three to twenty-one years.

The team members in **bold** or their designee are considered core team members and their participation is required for each CMAT staffing.

Only representatives from other agencies that are coordinating or providing supports and services, including education, for the child may participate in the staffing. When requested by the family, Family Resource Specialists (Early Steps) and Family Health Partners (CMS) may also attend and contribute valuable information to the CMAT process.

A working knowledge of medical necessity, medically fragile, and medically complex definitions and the long-term care services available in the service area is required before regular team members may participate in the consensus building process. Additionally, only regular team members who have had the Level of Reimbursement Training (see following paragraph), may participate in the consensus building process, which culminates in recommending levels of care for those children being considered for MFC services. The exception to this policy is the family or legal guardian, neither of whom is required to have a working knowledge of the terms identified above or complete the Level of Reimbursement training.

Required Level of Reimbursement Training

All service area CMAT members including alternate or rotating members and MFC staff must complete the Validated Level of Reimbursement (LOR) training prior to participating in the recommendation and consensus-building phase of the CMAT staffing for children being considered for MFC services. The CMAT RN, SW and / or CMAT Supervisor, with the support of the CMAT Medical Director, will train all new team members on the LOR instrument within 30 days of the new member's assignment to the team. When new CMAT staff is hired, the remaining CMAT RN, SW or supervisor will train the CMAT staff within 30 days of employment. In the event that the RN, SW and supervisor positions are vacated and new staff members are hired, the local Nursing Director will arrange for staff to be trained in another service area.

Each team member and alternate member who completes the LOR training will sign the Validated Level of Reimbursement Training Attendance Form (Attachment 18) indicating completion of the training and the participant will receive a signed Certificate of Completion for Validated Level of Reimbursement Training (Attachment 19). The team members name, date they became a team member, the date the LOR training was completed and the trainer's name will be documented on the Validated Level of Reimbursement Training Log (Attachment 17). The trainers will not deviate from the training curriculum in any way.

SKILLED NURSING FACILITY, MODEL WAIVER and INTEGRATED CARE SYSTEM STAFFING TEAM COMPOSITION

The CMAT will be comprised of the following team members for SNF, MW or ICS staffings:

- the **CMAT RN**;
- the **CMAT SW**; and,
- the **CMAT Medical Director**.

The team members in **bold** or their designee are considered core team members and their participation is required for each CMAT staffing. The child's parents or legal guardian and the Medicaid SA RNS may participate in the SNF and MW staffings, at their request. When the Medicaid SA RNS participates in these staffings, he/she is a voting member of the team. An ICS representative may participate in the ICS staffings, at their request. Representatives from agencies that are providing and / or coordinating services may be contacted during the staffing process if additional information is needed to determine the medical necessity of the requested service.

A working knowledge of medical necessity, medically fragile, and medically complex definitions and the long-term care services available in the service area is required before the CMAT staff participate in the consensus building process.

CHAPTER FIVE: THE ROLE OF THE FAMILY IN THE CMAT PROCESS

SETTING THE STAGE FOR SUCCESS

The involvement of the family or legal guardian in the CMAT process for MFC, MW, SNF and continuity of care staffings is the foundation for building independence and the capacity of the family to meet their child's needs. CMAT members will practice family centered service planning by involving the family in each step of the CMAT process. The CMAT recognizes that the family is the constant force in a child's life, and that family input is critical to the success of any service plan.

In order for families to fully participate in the CMAT process, they must be informed of the reasons surrounding the establishment of the CMAT in Florida. The CMAT ensures that a thorough assessment and review of the children's medically complex needs occur for all eligible children and their families. CMAT also considers the medical necessity of recommendations that come about as a result of these assessments and reviews. Family members or legal guardians must be informed that all long-term care recommendations are based on the child's medical needs and the medical necessity for the service being considered.

Many families who come to the CMAT are facing a multitude of issues relating to the illness of their child. Often these families experience a wide variety of unpredictable emotions. Each family is unique and will react to the stress of their child's needs in their own way. The team is charged with assisting families with identifying resources and supports that will maximize their ability to care for their child. To ensure that the team is setting the stage for a successful partnership between the family or legal guardian and the CMAT, the following steps will be incorporated into the CMAT process:

- Upon referral, each family or legal guardian will receive information about his or her roles, responsibilities and opportunities in the CMAT process and the A Family Guide to CMAT (Attachment 3). Documentation that the family has received this information will be documented in a Record of Treatment (ROT) note.
- All efforts will be made to help the family or legal guardian understand how the CMAT works and its resources and limitations in helping their family. The family will be given the name and telephone number of the CMAT RN and SW to contact for more information and questions concerning the CMAT process.
- In the event that Medicaid services are terminated, denied, suspended, or reduced, families or legal guardians will receive a copy of the Notice of Right to Appeal (Attachment 14) and will receive a verbal explanation of their rights. Documentation that the family has received this information will be documented in the CMAT Staffing Summary or a ROT note.

If the child is in foster care, all efforts will be made to involve both the foster family and the biological family or legal guardian in the CMAT process in recognition of the role each will play in supporting the child. These efforts will be documented in a ROT note. If the child's parental rights have been terminated, the biological family will not be involved in the CMAT process

without agreement between the legal guardian (Department of Children and Families or Community Based Care agency) and the MFC foster parents. When there is disagreement about who may attend a particular staffing, the CMAT Medical Director will determine staffing participants.

PREPARING FOR TEAM STAFFINGS AND CONTACTS

Consistent with family centered service delivery, each family served by the CMAT will:

- be informed of the date, time, and location for the CMAT staffing at least 2 weeks prior to the staffing date;
- help identify individuals who can provide relevant information for the CMAT assessment and participants for MFC staffing;
- consult with lead care coordinator to receive the results and explanation of evaluations and tests that have been completed;
- be supported in identifying additional resources the family may need to participate in the CMAT staffing;
- be identified and supported as a member of the CMAT for MFC staffing;
- be provided a copy of the Family Guide to the CMAT process;
- have their concerns, priorities and resources addressed; and
- receive and review a copy of the completed CMAT assessment.

AT THE STAFFING

The family is encouraged to participate in the development of resources and care recommendations for their child. For MFC, SNF, or MW staffings, the family may participate in the staffing in person or via a telephone / video conference call. Participation of the family is critical to the success of the care recommendations.

The CMAT RN, SW and Medical Director, along with all other team members, will strive to ensure that the family;

- is comfortable;
- knows the names and roles of each person at the staffing;
- discusses their child's strengths and needs;
- is supported in sharing what they feel their child's needs are;
- identifies the care needs they will be responsible for; and,
- is comfortable that differences will be settled in a sensitive and impartial manner.

AFTER THE STAFFING

The real test of the effectiveness of the CMAT staffing is how well the desired outcomes are achieved. Families play a critical role in helping measure the progress towards outcomes and the effectiveness of efforts made on behalf of the child. The time period after the staffing is one of re-assessing changing needs, revising resources to meet those needs, and transition and education of the family. During this time the family will begin learning or enhancing skills associated with the care of their child, continue to share their concerns, priorities, and resources; and participate in the development of transition planning that will expand supports necessary for them to be involved in the care of their child to the fullest extent possible.

It is expected that the care needs of the child, the support and resource needs of the family, and the family's involvement in their child's care will fluctuate and change throughout the CMAT association with the family. The family is encouraged to maintain a sharing and open relationship with the CMAT to ensure that the resources they access are meeting their developing and changing needs.

OUTCOMES OF A FAMILY CENTERED APPROACH

Anticipated outcomes of a family centered approach include increased independence on the part of the family, increased accessibility to programs and services within the community and greater collaboration between families and their service providers. The ethnic, cultural, economic, racial, social, and religious diversity of families will be respected and considered in the development and provision of services. Programs will recognize and respect families as individuals who react and respond to situations and services based upon their own unique experiences.

<p style="text-align: center;">CHAPTER SIX: RESPONSIBILITIES AND ROLES OF THE CMAT REGISTERED NURSE (RN)</p>

MANAGEMENT OF REFERRALS

The CMAT RN has shared responsibility for the **referral / intake** of CMAT clients in their designated service area with the CMAT SW. The RN will consult with the SW and CMAT Medical Director as necessary to ensure that the child being referred to CMAT meets the CMAT staffing criteria (see Denial of Staffing section in Chapter 3). The CMAT RN will communicate results of referrals to the family and / or the referral source and will document these communications in a (ROT) note. Upon receipt of referral and consent forms, the CMAT RN will conduct or arrange for a clinical assessment interview with the family or legal guardian and child. Completion of the assessment process may require the CMAT RN to make home and / or hospital visits as well as to follow up with care coordinators in other programs and agencies. Other RN's may conduct these interviews or visits and contribute information to the CMAT RN.

Through interviews with the family and the nurse care coordinator, Department of Children & Families or Community Based Care staff or other care coordinators, the CMAT RN will assess the need for additional information concerning their child's medical condition, prognosis, services available in the local area, or other information necessary for presentation at the CMAT staffing. The CMAT RN may make appropriate recommendations for referrals directly for the family. An example of an appropriate referral would be to refer a failure to thrive child to a nutritionist.

COMPLETION OF CMAT ASSESSMENT

The primary role of the CMAT RN is to ensure the completion of a comprehensive clinical assessment for each child being staffed by CMAT. The clinical assessment information will be documented in the appropriate electronic medical record.

The purpose of the clinical assessment information is to provide current, accurate, and relevant medical information that will enable CMAT members to make informed decisions regarding recommendations for medically necessary services. A comprehensive assessment is the foundation from which informed recommendations are derived.

Written clinical assessment information must be completed in preparation for each staffing using the CMAT Assessment Worksheet (Attachment 8). Completion of the clinical assessment information requires obtaining, reviewing and summarizing medical information / assessments, reports, and recommendations as well as consulting with the family, the CMS nurse care coordinator, Department of Children & Families or Community Based Care staff, and other health care professionals involved with the child and family. The nursing information documented in the assessment must follow the instructions outlined in the CMAT Assessment Instruction Guide (Attachment 7).

The CMAT RN is responsible for ensuring that the clinical assessment information documented in the CMAT assessment is current, accurate, complete and within the scope of a CMAT assessment. The CMAT assessment must not be completed more than 15 days prior to the

CMAT staffing and must be made available for review by the CMAT Medical Director at least one day prior to the staffing, if requested by the physician.

Any additional, relevant clinical information becoming available after the completion of the assessment will be verbally provided to the team at the staffing and will be included in the Nursing Assessment Update section of the CMAT Staffing Summary Report (Attachment 10).

The CMAT clinical assessment information documented in the CMAT assessment will be made available to the other members of the CMAT, if applicable, for review prior to the staffing, upon request.

When a Child is Referred for MFC Placement

For children referred to CMAT from the Department of Children and Families or Community Based Care agency, the CMAT RN may occasionally request that the MFC RN complete the clinical information in the assessment in preparation for the emergency staffing. If the MFC RN is requested to complete the clinical sections of the assessment and they are not able to meet this request, the CMAT RN is ultimately responsible for ensuring that the assessment and emergency staffing is conducted within five calendar days of the signed consents or date of the referral, whichever is later. The Nursing Director will make the determination if the MFC RN will occasionally be available to complete the clinical sections of the assessment for initial and follow-up staffings, if requested by the CMAT RN. The CMAT RN is responsible for the final content of the clinical assessment information. The CMAT RN will update the assessment completed by the MFC RN, review the assessment to determine if the content is correct and appropriate, and sign off and date the assessment.

CMAT Staffing Summary Report

The CMAT RN is responsible for providing all clinical information necessary to complete a comprehensive CMAT Staffing Summary Report (Attachment 10). The area office can make the decision if the CMAT RN will assume the lead responsibility for completing the CMAT Staffing Summary Report. The CMAT Staffing Summary Report must be completed following the instructions outlined in CMAT Staffing Summary Report Instruction Guide (Attachment 9). The CMAT Supervisor will ensure that a comprehensive CMAT Staffing Summary Report is completed and disseminated within 10 calendar days of MFC and MW staffing. The summary for SNF staffings must be completed and disseminated to the Medicaid SA RNS within 3 working days. It is recommended that the CMAT Medical Director review the CMAT Staffing Summary Report before it is disseminated to ensure that there is an adequate documentation on the long-term care services discussed and a rationale statement for the service(s) recommended.

The stability statement given by the CMAT Medical Director during the CMAT staffing will be documented in the current stability statement section of the CMAT Staffing Summary Report.

The following information will be included in the Nursing Assessment Update section of the CMAT Staffing Summary Report:

- updated clinical information discussed during the staffing that was not documented in the assessment that would include changes in medical condition, medications, interventions etc.

The discussion section of the CMAT Staffing Summary Report will include information that is discussed at the staffing including pediatric and / or specialty consult information. Clinical and psychosocial information contained in the assessment will not be duplicated in the CMAT Staffing Summary Report.

The following information will be included in the discussion section of the CMAT Staffing Summary Report.

- all long-term care services discussed during the Consensus Building process; and,
- a rationale statement to support the medical necessity of the recommended service(s).

Family Centered Approach

A family-centered approach will be used in conducting the assessment. The CMAT RN and SW will utilize parental report coupled with professional assessment information. Assessment content should not be invasive or include sensitive areas that are not pertinent to the team's recommendation. Descriptions of parental involvement in domestic violence, mental health diagnosis or counseling, drug abuse or rehabilitation, parental HIV status, adoption or incarceration are not to be included in the assessment. If the parent is unable to care for the child due to the above mentioned social issues, the assessment will only document the impact these issues have on their ability to care for the child. If the parent is unable to care for the child because of a medical condition, the assessment will document the parent's symptomology and the impact of this condition on their ability to provide care to the child. Staff may include HIV status of the child only when identified on the CRI form.

When Information Is Not Available

The completion of an assessment must not be delayed because a particular individual is not available to provide information or a report is not available. The RN must make reasonable efforts to obtain the relevant information and document these efforts in a ROT note. When information is unavailable, the RN will state this fact in the CMAT assessment and indicate when it is reasonable to expect that the information will be obtained. Based on this information, the team will determine if a re-staffing should be held at a later time to consider the additional information.

Duplication of Information

The CMAT RN and SW will collaborate to ensure that their respective information documented in the assessment is neither duplicative nor conflicting.

ROLE AT STAFFING

During each child-specific staffing, the CMAT RN will present the significant clinical information from the current assessment as well as any information obtained since completing the

assessment, and will provide guidance regarding the significance, risks and impacts involved. As a team member, the RN will participate in making CMAT recommendations based on the most appropriate services that are medically necessary, regardless of service availability, and will participate in Level of Care or Level of Reimbursement determination.

ONGOING RESPONSIBILITIES OF THE CMAT REGISTERED NURSE

The CMAT RN should participate in periodic on-site visits at the child's home and / or other sites where care is provided for the purpose of assessing current medical needs for the child's upcoming staffing. The CMAT RN, in conjunction with the CMAT SW, will confirm and document all changes in the child's condition, including progress, needs or concerns of the child / family and schedule staffings as needed.

The CMAT RN will provide nursing expertise to the lead program or person responsible for coordination and care of the child. The CMAT RN may assist in evaluating the need for changes in any of the long-term care settings and with coordination of services including facilitation of the child's out-of-district services when necessary.

Collaboration with the CMS Care Coordinator

The CMAT RN will provide information regarding nursing care to the identified care coordinator, as appropriate, for CMAT eligible children. This assessment information may be used by the care coordinator for the development, initiation or update, and implementation of the Care Plan.

The CMAT RN will advise the CMS nurse care coordinator, Department of Children & Families or Community Based Care staff or other lead care coordinator of the expected discharge of a child from the CMAT. The CMAT RN will provide written information regarding the need for any transition services or other referrals to all relevant parties.

In the rare event that the child and family are not served by a state agency providing care coordination and a CMS **care coordinator has not been identified**, the CMAT RN and SW will collaborate to provide on-going assistance to the family until a care coordinator has been assigned or the family declines care coordination services.

CMAT REGISTERED NURSE PERFORMANCE STANDARDS

The following are the performance standards for the CMAT RN. Regional management may add standards to meet their regional CMAT needs.

The CMAT RN will:

- For initial CMAT staffing, reasonable effort should be made for the CMAT RN to personally visit each child referred to CMAT to visually assess the child's medical situation and to conduct a pre-staffing clinical assessment with the family and child. It is recommended that the CMAT RN personally visit each child scheduled for a follow-up staffing. Acquire the required medical information as prescribed in the CMAT assessment. Assist the family in understanding the information and its significance;

- Document clinical assessment information for each emergency, initial and follow-up CMAT staffing, utilizing the required format and providing the required content. The CMAT assessment information must be obtained within two weeks of the CMAT staffing and must be made available for review by the CMAT Medical Director at least one day prior to the staffing, if requested by the CMAT Medical Director. Assessments will provide a thorough and relevant clinical assessment written in clear and understandable language so that all participants, medical and non-medical, have the information needed to make informed recommendations. The CMAT RN is responsible for the clinical content of the assessment;
- Ensure that any collateral assessments, records, and information have been reviewed or obtained prior to the staffing. Follow-up as needed to ensure that current information is available to the team;
- Attend each staffing and present a synopsis of the clinical assessment information to the participants;
- Facilitate staffings as requested; and,
- Submit the PASRR Reporting Form (Attachment 27) by January 15 and July 15 of each calendar year.

In conjunction with the CMAT SW:

- The CMAT RN has shared responsibility for the referral / intake of CMAT clients with the CMAT SW. Receive referrals and gather the information necessary for determining a child's eligibility for a CMAT staffing in consultation with the SW and CMAT Medical Director. Notify the family and the referral source of the decision;
- Ensure completion (or participate in the production / completion of) and distribution of CMAT Staffing Summary Report within 10 calendar days for MFC and MW staffings and 3 working days for SNF staffings and other documents as required by the Operational Plan;
- Assume lead care coordination responsibilities until a lead care coordinator can be identified, including assessing emergency medical needs and ensuring the initiation of long-term care services;
- Maintain the child's CMS medical record and administrative file as indicated in Chapter 19 of this Plan;
- Maintain the child's ROT notes in the appropriate electronic medical record as indicated in Chapter 19 of this Plan;
- Assist families in obtaining services and coordinating service delivery between agencies to ensure continuity of care. Follow-up as needed to facilitate the child's receipt of needed services;

- Maintain documentation of contacts with families, providers and other professionals involved with the child in a ROT note;
- Communicate with the nurse care coordinator, the Department of Children & Families or Community Based Care staff or other care coordinators and family concerning the progress or status of the child; and,
- Assist with the coordination of out-of-area services (such as MFC or nursing facility services) and follow up as appropriate and as required.

CMAT REGISTERED NURSE ADMINISTRATIVE ACTIVITIES

Policy and Resource Development

- Review and maintain a copy of the current CMAT Statewide Operational Plan;
- Maintain copies of all policy and informational memos received regarding the CMAT, CMAT staff and other related issues;
- Research, develop and maintain a knowledge base regarding local and other resources that may assist the children and families served by the CMAT;
- Maintain documentation of the significant contacts with agencies, programs and the child's family in the ROT note section in the child's electronic medical record ;
- Participate in the telephone conference calls conducted by CMS Central Office staff; and,
- Distribute policy and practice memos, conference call summaries, training and conference information and other pertinent information to CMAT members, as appropriate.
- Participate in the CMAT Quality Improvement process.

Coordination / Facilitation / Collaboration

- Coordinate with the lead care coordinator, Medicaid, MFC, the Department of Children and Families or Community Base Care agencies, other Children's Medical Services components, other agencies involved with the CMAT and the families and children served by the team;
- Ensure that the CMAT Medical Director's participation is recorded in the client's ROT note, as appropriate;
- Provide information related to CMAT at meetings, conferences and workshops as requested; and,
- Serve as community nursing / medical resources liaison for the CMAT.

Training

- Participate in Level of Reimbursement training, and any other CMAT related training as requested by local management and / or by the Central Office. Participate in providing the Level of Reimbursement training to the area's CMAT members as outlined in the Required Level of Reimbursement Training section in Chapter 4. All participants who complete the Level of Reimbursement training must sign the Validated Level of Reimbursement Training Attendance Form (Attachment 18), the instructor of the training will add the participant's information to the Validated Level of Reimbursement Training Log (Attachment 17), and the participants will receive a signed certificate of completion (Attachment 19). These forms will be filed in the CMAT program administrative file; and,
- Obtain a working knowledge of the current Children's Multidisciplinary Assessment Team Statewide Operational Plan.

Management of CMAT Data

- Assist in the development, collection and review of CMAT data; and,
- Submit CMAT data and required reports to local management and CMS Central Office staff.

Program Monitoring

- Have a working knowledge of the CMAT Goals and Performance Measures and participate in self-monitoring of work products; and,
- Upon request, participate as a peer reviewer in program monitoring of another service area.

REPORTING CONCERNS

The CMAT RN may become aware of concerns that are beyond the purview of the CMAT program to address. The CMAT RN has a responsibility to report this information to the appropriate program or person responsible for handling such concerns.

If the family has complaints about a specific professional, the CMAT RN has a responsibility to report this information to the appropriate program or person responsible for handling such concerns. The nature of these complaints should not be made a part of the clinical or psychosocial assessment information unless it will directly affect the team's recommendation for the most appropriate services or the Level of Care / Level of Reimbursement. It is sufficient to document that the family is not satisfied with the service they are receiving and that their concerns are being addressed by the appropriate entity.

RESPONSIBILITY FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT

Information regarding suspected child abuse, sexual abuse or neglect that is shared with the CMAT staff must be reported to the Florida Abuse Hotline and to the CMAT supervisor. The abuse hot line number is **1-800-962-2873**.

The alleged information and the resultant actions should not be recorded in the CMAT Staffing Summary, but should be recorded in the client's ROT.

<p style="text-align: center;">CHAPTER SEVEN: RESPONSIBILITIES AND ROLES OF THE CMAT SOCIAL WORKER (SW)</p>
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MANAGEMENT OF REFERRALS

The CMAT SW has shared responsibility for the **referral / intake** of CMAT clients in their designate service area with the CMAT RN. The CMAT SW will consult with the CMAT RN and CMAT Medical Director as necessary to ensure that the child being referred to CMAT meets CMAT staffing criteria (see Denial of Staffing section in Chapter 3). Upon receipt of referral and consent forms, the CMAT SW will conduct or arrange for a psychosocial assessment interview with the family and / or referral source and will document these communications in a ROT note. Completion of the assessment process may require the CMAT SW to make home and / or hospital visits as well as to follow up with care coordinators in other programs and agencies. Other SW's may conduct these interviews or visits and contribute information to the CMAT SW.

During the assessment process, the CMAT SW will communicate with the family or legal guardian, the nurse care coordinator, Department of Children & Families or Community Based Care staff or other care coordinators as appropriate. It is the CMAT SW's role to provide the family or legal guardian with information explaining the CMAT process, what the family's role is in that process, and to educate the family about CMAT throughout the process. The CMAT SW will provide a copy of the A Family Guide to CMAT (Attachment 3) to each family served by the CMAT.

Through interviews with the family the nurse care coordinator, Department of Children & Families or Community Based Care staff or other care coordinators, the CMAT SW will assess the need for additional information concerning their child's development, personal care needs and social services available in the local area, or other information necessary for presentation at staffing. The CMAT SW may make appropriate recommendations for referrals directly for the family. An example of an appropriate referral would be to refer a child under the age of three to the Early Steps program to ensure that all potential needs are addressed as early as possible.

The CMAT SW will ensure that the family receives the results of all developmental evaluations and tests relevant to the child's upcoming staffing prior to the day of staffing. Families or legal guardians should not hear the results of evaluations or tests for the first time at the staffing.

If the family or legal guardian is unable to attend or participate in the staffing, the CMAT SW will report any issues, priorities, concerns, and plans that the family has asked to be shared at the staffing.

COMPLETION OF CMAT ASSESSMENT

The primary role of the CMAT SW is to ensure the completion of a comprehensive psychosocial assessment for each child to be staffed by CMAT. The psychosocial assessment information will be documented in the appropriate electronic medical record.

The purpose of the psychosocial assessment information is to provide current, accurate, complete and relevant psychosocial and Activities of Daily Living (ADL) information that will

enable CMAT members to make informed decisions regarding recommendations for long-term care services. A comprehensive assessment is the foundation from which informed recommendations are derived.

Written psychosocial assessment information must be completed in preparation for each staffing using the CMAT Assessment Worksheet (Attachment 8). Completion of the psychosocial assessment information requires obtaining, reviewing and summarizing social and developmental information, assessments, reports, and recommendations as well as consulting with the family, the nurse care coordinator, Department of Children & Families or Community Based Care staff, other care coordinators and other health care professionals. The psychosocial information documented in the assessment must follow the instructions outlined in the CMAT Assessment Instruction Guide (Attachment 7).

The CMAT SW is responsible for ensuring that the psychosocial assessment information is current, accurate and within the scope of a CMAT assessment. The CMAT assessment information must be obtained within two weeks of the CMAT staffing and must be made available for review by the CMAT Medical Director at least one day prior to the staffing, if requested by the CMAT Medical Director.

Any additional, relevant psychosocial or ADL information becoming available after the completion of the assessment will be verbally provided to the team by the SW at the staffing and will be included in the Psychosocial Assessment Updated section of the CMAT Staffing Summary Report (Attachment 10).

The CMAT psychosocial assessment information documented in the CMAT assessment will be made available to the other members of the CMAT for review prior to the staffing, upon request.

When a Child is Referred for MFC Placement

For children referred to CMAT from the Department of Children and Families or Community Based Care agency, the CMAT SW may occasionally request that the MFC SW complete the required psychosocial and ADL information in the assessment in preparation for the CMAT emergency staffing. If the MFC SW is requested to complete the psychosocial and ADL sections of the assessment and they are unable to meet this request, the CMAT SW is ultimately responsible for ensuring that the assessment and emergency staffing is conducted within five calendar days of the signed consents or date of the referral, which ever is later. The Nursing Director or designee will make the determination if the MFC SW will occasionally be available to complete the Psychosocial and Activities of Daily Living sections of the assessment for initial and follow-up staffings, if requested by the CMAT SW. The CMAT SW is responsible for the final content of the psychosocial assessment information. The CMAT SW will update the assessment completed by the MFC SW, review the assessment to determine if the content is correct and appropriate, and sign off and date the assessment.

CMAT Staffing Summary Report

The CMAT SW will assume lead responsibility for the completion of the CMAT Staffing Summary Report for each child staffed through CMAT; however, the area office can make the decision that the CMAT RN will assume the lead responsibility for completing this report. The

CMAT RN will provide all necessary medical information to the CMAT SW for inclusion in the summary. The CMAT SW is responsible for documenting or providing all the psychosocial information necessary to complete a comprehensive CMAT Staffing Summary Report. The CMAT Staffing Summary Report must be completed following the instructions outlined in CMAT Staffing Summary Report Instruction Guide (9). The CMAT Supervisor will ensure that a comprehensive CMAT Staffing Summary Report is completed and disseminated within 10 calendar days of MFC and MW staffing. The staffing summary for SNF staffings must be completed and disseminated to the Medicaid SA RNS within 3 working days. It is recommended that the CMAT Medical Director review the CMAT Staffing Summary Report before it is disseminated to ensure that there is an adequate documentation on the long-term care services discussed and a rationale statement for the service recommendations.

The stability statement given by the CMAT Medical Director during the CMAT staffing will be documented in the stability statement section of the CMAT Staffing Summary Report.

The following information will be included in the Psychosocial Assessment Update section of the CMAT Staffing Summary Report:

- new psychosocial information discussed at the staffing; and,
- new ADL information discussed at the staffing.

The discussion section of the CMAT Staffing Summary Report will include information that is discussed at the staffing. Clinical and psychosocial information contained in the assessment will not be duplicated in the CMAT Staffing Summary Report.

The following information will be included in the discussion section of the CMAT Staffing Summary Report.

- all the long-term care services discussed during the Consensus Building process; and,
- a rationale statement to support the service recommendations.

Family Centered Approach

A family-centered approach will be used in conducting the assessment. The CMAT SW will utilize parental report coupled with professional assessment information. Assessment content should not be invasive or include sensitive areas that are not pertinent to the team's recommendation. Descriptions of parental involvement in domestic violence, mental health diagnosis or counseling, drug abuse or rehabilitation, parental HIV status, adoption or incarceration are not to be included in the assessment. If the parent is unable to care for the child due to the above mentioned social issues, the assessment will only document the impact these issues have on their ability to care for the child. If the parent is unable to care for the child because of a medical condition, the assessment will document the parent's symptomology and the impact of this condition on their ability to provide care to the child. Staff may include HIV status of the child only when identified on the CRI form.

When Information Is Not Available

The completion of an assessment must not be delayed because a particular individual is not available to provide information or a report is not available. The CMAT SW must make reasonable efforts to obtain the relevant information and document those efforts in a ROT note. When information is unavailable, the SW will state this fact in the assessment and indicate when it is reasonable to expect that the information will be obtained. Based on this information, the team will determine if a re-staffing should be held at a later time to consider the additional information.

Duplication of Information

The CMAT SW and RN will collaborate to ensure that their respective information documented in the CMAT assessment is neither duplicative nor conflicting.

ROLE AT STAFFING

During each child-specific staffing, the CMAT SW will present the significant psychosocial and ADL information from the current CMAT assessment. Any additional information obtained since completing the assessment will be shared and clarification provided regarding the child's functional levels and the age appropriateness of the child's care needs. As a team member, the SW will participate in making CMAT recommendations based on the most appropriate services, which are medically necessary and cost effective, regardless of service availability, and will participate in Level of Care or Level of Reimbursement determinations.

ONGOING RESPONSIBILITIES OF THE CMAT SOCIAL WORKER

Between staffings, the CMAT SW will periodically confer with the family, care coordinator, or Department of Children & Families or Community Based Care staff or others involved with the child to obtain updated information about the child and family, the services being delivered, and any newly identified needs. These contacts will be documented in the client's ROT note.

Collaboration with the CMS Care Coordinator

The SW will advise the care coordinator of CMAT recommendations including expected discharge of a child from the CMAT and will provide written information regarding the need for any transition services or other referrals. The CMAT SW will assist the care coordinator by providing assessment information for the development, initiation or update, and implementation of the Care Plan.

In the rare event that the child and family are not served by a state agency providing care coordination and a CMS care coordinator has not been identified, the CMAT SW and RN will collaborate to provide on-going assistance to the family until a care coordinator has been assigned or the family declines care coordination services.

CMAT SOCIAL WORKER PERFORMANCE STANDARDS

The following are the performance standards for the CMAT SW. Local management may add standards to meet their regional CMAT needs.

The CMAT SW will:

- For initial CMAT staffing, reasonable effort should be made for the CMAT SW to personally visit each child referred to CMAT to visually assess the child's social, personal care and developmental situation and to conduct a pre-staffing psychosocial and ADL assessment with the family and child. It is recommended that the CMAT SW personally visit each child scheduled for a follow-up staffing. Acquire the required psychosocial and ADL information as prescribed in the CMAT assessment. Assist the family in understanding the information and its significance;
- Assist the family or legal guardian in understanding the CMAT process and their role, responsibilities and opportunities available through their relationship with CMAT;
- Document comprehensive psychosocial and ADL information for each emergency, initial and follow-up CMAT staffings, utilizing the required format and providing the required content. The CMAT assessment must not be completed more than 15 days prior to the CMAT staffing and must be made available for review by the CMAT Medical Director at least one day prior to the staffing, if requested by the CMAT Medical Director. The SW is responsible for the psychosocial and ADL content of the assessment. Assessments will be written in clear and understandable language so that all participants will have the information to make well-founded recommendations;
- Ensure that any collateral assessments, records, and information have been reviewed or obtained prior to the staffing. Follow up as needed to ensure that current information is available to the team;
- Prepare staffing agendas and invitation lists and letters for each staffing and ensure distribution (may be in conjunction with CMAT RN). Ensure that families or legal guardians and professionals are invited to attend the staffings at least two weeks prior to the staffing date to allow them enough time to plan to attend;
- Employ methods to encourage and facilitate parental attendance, which may include discussion on participation by telephone conference call or making arrangements for providing transportation. Document those efforts in the client's ROT note;
- Assure that all CMAT staffing participants involved with the family and child and relevant to the CMAT task are identified and invited to the staffing;
- Attend each staffing and present a synopsis of the psychosocial and ADL assessment information to the participants;
- Facilitate staffings as requested;

- Report any family issues, concerns, priorities and plans the family or legal guardian has asked to be shared with the team; and,
- Ensure completion (or participate in the production / completion of) and distribution of CMAT Staffing Summary Report and other documents as required by the Operational Plan within the time frames established.

In conjunction with the CMAT RN:

- The CMAT SW has shared responsibility for the referral / intake of CMAT clients with the CMAT RN. Receive referrals and gather the information necessary for determining a child's eligibility for a CMAT staffing in consultation with the RN and CMAT Medical Director;
- Assume lead care coordination responsibilities until a lead care coordinator can be identified, including assessing emergency psychosocial needs and ensuring the initiation of long-term care services;
- Assist families in obtaining services and coordinating service delivery between service providers to ensure continuity of care. Follow-up as needed to facilitate the child's receipt of needed services;
- Assist with the coordination of out-of-area services (such as MFC or nursing facility services) and follow-up as appropriate;
- Maintain documentation of contacts with families, providers and other professionals involved with the client in a ROT note in the client's electronic medical record;
- Communicate with the nurse care coordinator, Department of Children & Families or Community Based Care staff or other care coordinator and family concerning the progress or status of the child;
- Maintain the child's CMS medical record and administrative file as indicated in Chapter 19 of this plan;
- Maintain the child's ROT notes in the electronic medical record as indicated in Chapter 19 of this Plan; and,
- Ensure completion (or participate in the production / completion of) and distribution of CMAT Staffing Summary Report within 10 calendar days for MFC and MW staffings and within 3 working days for SNF staffings and other documents as required by the Operational Plan.

CMAT SOCIAL WORKER ADMINISTRATIVE ACTIVITIES

Policy and Resource Development, implementation and maintenance

- Review and maintain a copy of the current CMAT Statewide Operational Plan;

- Maintain copies of all policy and informational memos received regarding the CMAT, CMAT staff and other related issues;
- Research, develop and maintain a knowledge base regarding local and other resources that may assist the children and families served by the CMAT;
- Participate in the telephone conference calls conducted by CMS Central Office staff;
- Distribute policy and practice memos, conference call summaries, training and conference information and other pertinent information to CMAT members, as appropriate; and,
- Maintain documentation of the significant contact with agencies, programs, and family of the child in the child's ROT note.

Coordination / Facilitation / Collaboration

- Coordinate with MFC, Department of Children and Families or Community Based Care agency, Medicaid, other Children's Medical Services components, and other agencies involved with the CMAT or the families and children served by the team;
- Provide information related to CMAT at meetings, conferences and workshops as requested; and,
- Serve as the community social work liaison for the CMAT.

Training

- Participate in Level of Reimbursement training, and any other CMAT related training as requested by local management and / or by the Central Office. Participate in providing the Level of Reimbursement training to the area's CMAT members as outlined in the Required Level of Reimbursement Training section in Chapter 4. All participants who complete the Level of Reimbursement training must sign the Validate Level of Reimbursement Training Attendance Form (Attachment 18) and the instructor of the training will add the participant's information to the Validated Level of Reimbursement Training Log (Attachment 17). These forms will be file in the CMAT program administrative file; and,
- Obtain a working knowledge of the current Children's Multidisciplinary Assessment Team Statewide Operational Plan.

Management of CMAT Data

- Assist in the development, collection and review of CMAT data; and,
- Submit CMAT data and required reports to local management and CMS Central Office staff.

Monitoring

- Have a working knowledge of the CMAT Goals and Performance Measures and participate in self-monitoring of work products; and,
- Upon request, participate as a peer monitor in program monitoring of other service areas.

REPORTING CONCERNS

The CMAT SW may become aware of concerns that are beyond the purview of the CMAT program to address. The CMAT SW has a responsibility to report this information to the appropriate program or person responsible for handling such concerns.

If the family has complaints about a specific professional, the CMAT SW has a responsibility to report this information to the appropriate program or person responsible for handling such concerns. The nature of these complaints should not be made a part of the clinical or psychosocial assessment information unless it will directly affect the team's recommendation for the most appropriate services or the Level of Care / Level of Reimbursement. It is sufficient to say that the family is not satisfied with the service they are receiving and that their concerns are being addressed by the appropriate entity.

RESPONSIBILITY FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT

Information regarding suspected child abuse, sexual abuse or neglect that is shared with the CMAT staff must be reported to the Florida Abuse Hotline and the CMAT supervisor. The abuse hot line number is **1-800-962-2873**.

The alleged information and the resultant actions should not be recorded in the CMAT Staffing Summary, but should be recorded in the client's ROT.

<p style="text-align: center;">CHAPTER EIGHT: RESPONSIBILITIES AND ROLES OF THE CMAT MEDICAL DIRECTOR</p>
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ROLE OF THE CMAT MEDICAL DIRECTOR

The CMAT Medical Director is an integral member of CMAT. The CMAT Medical Director will ensure that nursing and psychosocial assessment information is comprehensive and complete and that this information is presented to the participants of the CMAT staffing in a manner that is family friendly. The CMAT Medical Director may choose to facilitate the CMAT consensus building process, or may delegate this role to another member of the CMAT.

RESPONSIBILITIES OF THE CMAT MEDICAL DIRECTOR

Prior to each CMAT staffing, the CMAT Medical Director may:

- Review the nursing and psychosocial assessment information of each child to be staffed prior to the staffing;
- Determine whether the nursing or psychosocial assessment information requires additional information;
- In the case of an incomplete assessment, determine whether it is necessary to consult with the child's primary care physician, visit the child at the hospital, or use other means for information gathering. Communicate necessary information to CMAT RN and / or SW prior to the date of staffing; and,
- If the incomplete assessment is not the result of physician information, return incomplete assessments to the appropriate CMAT staff member for completion prior to the date of staffing.

At the time of CMAT staffing, the CMAT Medical Director will:

- Participate in all CMAT staffings including emergency staffings. When the CMAT Medical Director is unable to participate in a staffing, s/he will arrange for a substitute physician who has been oriented, including Level of Reimbursement training for MFC recommendation, to the CMAT process or the CMAT staffing will need to be postponed;
- Encourage families or legal guardians to express their priorities, concerns and needs;
- Assume a facilitative role including guiding the team into making consensus decisions regarding the service and Level of Care / Level of Reimbursement or delegate this role to another member of the CMAT;
- Assign and present the appropriate Stability Statement for each child, using current Level of Reimbursement language. It is the sole responsibility of the CMAT Medical Director to determine the stability of the child to be staffed;

- Ensure that all relevant assessment information is presented to team members before beginning the recommendation-making portion of the staffing;
- Assist in obtaining information or clarification when there are questions from any team member regarding a child's condition, care needs or ordered services that could be clarified by contacting the child's primary physician;
- Provide clinical education and pediatric consultation, as needed, to assist the team in making the most appropriate long-term care recommendations;
- Clarify with the family the family's role in providing care to their child. Help the family to identify possible training needs; and,
- Present team members with information on the risks, potential risks, and medical care needs, and the possible impact of these risks on the child.

After each CMAT staffing, it is recommended that the CMAT Medical Director:

- review the CMAT Staffing Summary Report before it is disseminated to ensure that there is adequate documentation to justify the long-term care service recommendation.

When Eligibility for CMAT Staffing Is Questionable

In cases where eligibility for CMAT recommended services is questionable, the CMAT Medical Director will review the abbreviated nursing and psychosocial assessment information and determine eligibility for staffing. If the CMAT Medical Director determines that a child does not have a medically complex / fragile condition or does not meet the qualification criteria for the long-term care service and therefore is ineligible for a CMAT staffing, s/he will document this fact on the CMAT Medical Director's Review: Denial of a CMAT Staffing form (Attachment 13). See Chapter 3, Eligibility and Referral Process for additional information.

The copy of the CMAT Medical Director's Review: Denial of CMAT Staffing Form will be maintained in the child's CMS medical record. The original document will be sent to the parent or legal guardian along with the Notice of Right to Appeal form (Attachment 14).

Pediatric Consultation

The CMAT Medical Director will be accessible to answer questions from families or legal guardians, Department of Health, Department of Children and Families or Community Based Care and Medicaid staff as well as the CMAT RN or SW and any CMAT member regarding children needing long-term care medical services.

CMS Central Office Consultation

The Deputy Secretary for Children's Medical Services or his / her designee is a resource to CMAT Medical Directors, RN, and SW, concerning medical issues involving children referred to

CMAT, a CMAT client, or served or potentially served by any of the long-term care services for children.

Policy or operational guideline questions will be directed to the appropriate Children's Medical Services Central Office CMAT consultants. If local efforts to resolve family concerns or complaints regarding policy or operational guidelines are not successful, the family should be informed of the CMS area office complaint and grievance policy and procedure.

CMAT MEDICAL DIRECTOR ADMINISTRATIVE DUTIES

The CMAT Medical Director:

- Is familiar with and abides by the policies of the CMAT Statewide Operational Plan;
- Maintains a current copy of the CMAT Statewide Operational Plan;
- Reports concerns regarding Medicaid services to the Agency for Health Care Administration;
- Participates in Level of Reimbursement training and is available to participate in workshops, training, and related seminars, as appropriate;
- Participates as requested in Central Office monitoring of their local service area CMAT, technical assistance visits and quality assurance activities;
- Writes prescriptions for CMAT children only when he/she is the child's primary care physician;
- Assists in determining the plan for review and follow up activities based on the staffing outcomes;
- Discloses and avoids any actual or potential conflicts of interest in accordance with applicable Florida Statute and professional standards of conduct; and,
- The CMAT Medical Director can not concurrently serve as the MFC Medical Director to prevent the potential for conflict of interest.

RESPONSIBILITY FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT

Information regarding suspected child abuse, sexual abuse or neglect that is shared with the CMAT Medical Director must be reported to the Florida Abuse Hotline. The abuse hot line number is **1-800-962-2873**.

**CHAPTER NINE:
IDENTIFICATION, ROLES and RESPONSIBILITIES of CARE COORDINATOR**

IDENTIFICATION OF CARE COORDINATORS

The child and / or family may be involved with multiple agencies and have several care coordinators. The care coordinator from each program or agency involved with the child and family should be contacted by the CMAT staff. CMAT staff will work closely and collaboratively with the assigned care coordinator to ensure that the child's service needs as they relate to CMAT recommended services, are identified and addressed through the CMAT staffing process.

Before A Lead Care Coordinator Is Identified

If a care coordinator has not been identified, the CMAT SW and RN will temporarily fulfill the role of care coordinator for the purpose of initiating necessary CMAT activities, e.g., assist family in contacting an agency for services. CMAT staff may serve in this role until the initial staffing is held and a care coordinator is identified. For children in shelter / foster care, the Department of Children & Families or Community Based Care staff will be the lead care coordinator with a medical care coordinator assigned as needed. CMS clients residing in a nursing facility may have a CMS care coordinator in addition to a care coordinator affiliated with the nursing facility.

Collaboration between CMAT Staff and Care Coordinator

The care coordinator is a valuable resource to CMAT and will be asked to provide relevant assessment information in preparation for staffings. Changes in a child's care situation are inevitable and the CMAT staff must work closely with the identified care coordinator to ensure that information is kept current.

The care coordinator will notify the CMAT staff when the child is moved to a new MFC home, a regular foster home, or a different nursing facility. When it is necessary for a child to move from one facility, site or home environment to another, the care coordinator (typically a CMS care coordinator) will continue to make the necessary contacts and arrangements with the family or legal guardian as well as those individuals presently involved with the care of the child and those who will be assuming responsibility for care of the child. The care coordinator will coordinate the admission and associated paperwork with the CMAT RN in the service area into which the child will move.

When closure to CMAT long-term care services or staffings is contemplated, the care coordinator will be consulted to help identify other services or referrals needed for transition from CMAT to other services.

Responsibilities of the Care Coordinator during the CMAT Staffing

The care coordinator is a valuable resource for the family and the CMAT members and is encouraged to participate in their client's CMAT staffings. As a non-voting CMAT member, the

care coordinator can take an advocacy role for the family during the CMAT staffing to assist the family in expressing the needs of the child and the family's abilities to meet those needs.

Responsibilities for Care Coordination when the CMS Network Children in a SNF Require Services that are not Included in the Medicaid Per Diem Rate

CMS Network children residing in nursing / long-term care facilities, as recommended by the CMAT, will be assigned a CMS Network care coordinator when the child requires services that are not offered by the nursing / long-term care facility and are, therefore not included in the Medicaid per diem rate. Those children requiring additional services will be followed by a CMS Network care coordinator, who will assess the child in 6 months, review the plan of care and progress notes, collaborate with the nursing facility case manager to ensure appropriateness of care and maintain contact with the child's family. In addition, the CMS Network care coordinator will provide updated assessment information to the CMAT staff at least annually. The CMS care coordinator will keep the CMAT RN informed of all significant changes in the child's medical condition that could result in a Level of Care change. Note: Care coordination must be provided for all children, who are being transitioned and / or discharged from the nursing / long-term care facility as well as from the CMS Network. See Chapter 18 section Responsibilities of CMAT Staff and Care Coordinators for responsibilities on out of area placement.

Responsibilities for Care Coordination when the CMS Network Children in a SNF Require No Additional Services

The area office Nursing Director or designee may assign those children who require no additional services beyond the services offered by the nursing / long-term care facility and that are included in the facility's Medicaid per diem rate to the CMAT RN or to a CMS Network Care Coordinator. That responsibility will include assessing the child at least annually, reviewing the plan of care and progress notes, collaborate with the nursing facility case manager to ensure appropriateness of care and maintain contact with the child's family. The CMAT RN may call upon the CMS Network nursing supervisor for issues, which might require the participation of a CMS Network care coordinator. Note: Care coordination must be provided for all children / youth, who are being transitioned and / or discharged from the nursing / long-term care facility as well as from the CMS Network.

RESOURCE GUIDE FOR IDENTIFYING POTENTIAL CARE COORDINATORS

Child Specific Information	Care Coordinators
Substance exposed newborns without complex medical problems	County Public Health Department
Substance abused newborns with complex medical problems	Children's Medical Services, with County Public Health Departments having some case management responsibilities
Child known to Office of Family Safety with complex medical needs	Department of Children & Families or Community Based Care Staff with Children's Medical Services having "medical lead"
Child known to Department of Juvenile Justice with complex medical needs	Department of Juvenile Justice with Children's Medical Services having "medical lead"
Children receiving private case management services	Private case management provider
Child birth to 3 served by the Early Steps program	Early Steps Coordinator
Medically complex infants and children up to the age of 21 who qualify for Children's Medical Services, (includes children in nursing facilities if he/she requires additional services not covered in Medicaid per diem rate)	Children's Medical Services nurse care coordinator
Medically complex infants and children up to the age of 21 who qualify for Children's Medical Services, (includes children in nursing facilities in no additional services required over per diem rate)	CMAT RN or Children's Medical Services nurse care coordinator; as assigned by CMS Nursing Director
Child served by Agency for Persons with Disabilities (children age 3 and over)	Agency for Persons with Disabilities support coordinator
Children in Brain and Spinal Cord Injury Program through age 17	Brain and Spinal Cord Injury Program nurse care coordinator
Children 18 – 21 in Brain and Spinal Cord Injury Program	Vocational Rehabilitation care coordinator with medical overlay through Children's Medical Services or other appropriate programs
Child open to Children's Medical Services Primary Care Program	Primary Care nurse care coordinator
Child in Medical Foster Care	MFC RN and SW with Department of Children & Families or Community Based Care Staff

<p style="text-align: center;">CHAPTER TEN: STAFFING CATEGORIES AND TIMELINES</p>
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PURPOSE OF STAFFING

The primary purpose of the CMAT staffing is to make medically necessary recommendations by determining a client's eligibility for Medical Foster Care, Skilled Nursing Facility and Model Waiver services and making a Level of Care / Level of Reimbursement determination. Secondly, CMAT staffings may be held to make a medically necessary recommendation for high cost, high volume, high risk and / or low volume services for CMS clients. Nursing and psychosocial assessment information, interviews with the child's family and other service providers, multidisciplinary evaluations, and CMAT member's discussion at the time of staffing will provide the team with the information necessary to develop medical service recommendations. Medicaid is the regulatory authority for the CMAT program, and as such, has final authority for authorizing all service recommendations generated as a result of the CMAT process.

Family Participation in Staffing

CMAT staff will make every effort to facilitate the family's participation and attendance in all Medical Foster Care and Continuity of Care CMAT staffings. If transportation, employment or another barrier prevents participation by the family and arrangements cannot be made to remove this barrier, the family should be provided the opportunity to participate by telephone. CMAT staff will inform the child's family that they may participate in person or by telephone in all Skilled Nursing Facility and Model Waiver CMAT staffings. Documentation of activities undertaken by CMAT staff to facilitate family participation in the staffing will be included in the client's ROT.

TYPES OF STAFFINGS

There are six types of staffings; Emergency, Initial, Follow-up, Transition / Discharge, Reconsideration and Continuity of Care.

Emergency Staffings

An emergency staffing is held when it appears that the child requires the initiation of a CMAT recommended service or a change in the Level of Care / Level of Reimbursement of a previously recommended service prior to the next regularly scheduled staffing date. CMAT staff will respond to all requests for an emergency staffing by completing an assessment and the CMAT Medical Director will determine (a) whether a CMAT emergency staffing will be conducted or to deny the staffing using the Denial of Staffing process (see Denial of Staffing section in Chapter 3), and (b) if to wait for the next regularly scheduled staffing would be detrimental to the health or well being of the child, or would require the child to remain in the hospital longer than what would be considered medically necessary. The CMAT Medical Director will make the final determination regarding whether or not to conduct an emergency staffing based upon the information documented in the child's assessment and a ROT note will contain documentation of this decision. If it is determined that an emergency staffing is

necessary, it will be conducted within five calendar days of receipt of a signed CRI and CET forms or the date of the referral, whichever is later. (See the Reporting Changes in the Child's Clinical Condition and Social Factors and Emergency Admission and Follow-up section in Chapter 13 for the exception to conducting an emergency staffing within five calendar days.)

The CMAT RN and / or SW are responsible for coordinating the emergency staffing. The CMAT RN and SW will gather the needed clinical and psychosocial information to complete the CMAT assessment, obtaining as much of the information as possible prior to the time of staffing. Due to the urgent nature of the staffing, it may not always be possible to comprehensively complete the assessment. The minimal clinical and psychosocial information required for the emergency assessment includes the follows: child's diagnosis and current medical condition, medications, interventions / treatments, medical equipment, and personal care needs. Additional medical information may need to be obtained on an individual basis, e.g. growth data for a failure to thrive child.

The minimum required CMAT members for conducting an emergency staffing are the CMAT Medical Director, CMAT RN, CMAT SW, and the Medicaid SA RNS for Medical Foster Care services and the CMAT Medical Director, CMAT RN, and CMAT SW for Skilled Nursing Facility and Model Waiver services. The group may meet in person or by teleconference call, depending upon the urgency and complexity of the referral.

Upon completion of the emergency staffing, a CMAT Staffing Summary Report will be completed. The CMAT RN will ensure that required CMAT Staffing Summary Form is sent to Medicaid for authorization of funding purposes.

Emergency staffings are considered temporary staffings. Services recommended as a result of the emergency staffing are authorized for a limited time until an initial staffing can be conducted. The initial staffing will be scheduled within 15 calendar days and held within 30 calendar days of receipt of a signed CRI and CET forms or the date of the referral, whichever is later.

Children in Shelter / Foster Care Status

Children in shelter / foster care who are referred to CMAT will be treated as emergency referrals, and staffings will follow the timeframes for an emergency staffing. CMAT staff will review all referrals for foster care children immediately upon receipt of referral and verify that the Children and Families / Community Based Care staff is requesting a staffing. The CMAT RN or SW will schedule and coordinate a CMAT staffing to be held within five calendar days of the date of the referral, receipt of the signed CRI and CET forms, or the date the Children and Families / Community Based Care staff gave approval for a staffing (if the referral was made by an individual other than the Children and Families / Community Based Care staff), whichever is later.

If the CMAT staff determines that they are not able to schedule and convene a staffing within this timeframe, a written request will be sent to the MFC staff for the MFC staff to determine the foster child's eligibility for MFC services and a temporary Level of Reimbursement. This request will include the reason why a staffing cannot be convened by CMAT within the required timeframe and the CMAT supervisor must approve the request for MFC staff to make the eligibility and temporary Level of Reimbursement determination. The CMAT supervisor will

document this approval in the child's Record of Treatment. When MFC staff receives a request from the CMAT staff to determine the child's eligibility for MFC services and a temporary Level of Reimbursement, the protocol as delineated in the MFC Operational Plan will be followed. As per the plan, the MFC staff will obtain the signed necessary consent and release of information forms and obtain and document the child's clinical and psychosocial assessment information. The MFC Medical Director will determine the child's eligibility for MFC services and will make a temporary Level of Reimbursement determination based upon the assessment information. If the foster care child is recommended for MFC services, the MFC staff will notify CMAT regarding their recommendation and Level of Reimbursement determination. CMAT staff will then complete a CMAT Staffing Summary Report documenting that the MFC Medical Director determined that the client was eligible for MFC services and the temporary Level of Reimbursement determination. The CMAT staff will follow the procedure for planning an initial staffing within 30 calendar days in accordance with the CMAT Operational Plan. If the MFC staff is not available to determine the child's eligibility for MFC services and a temporary Level of Reimbursement, they will notify the CMAT in writing on the day the request was received and this notification will include the reason why they are not available to determine the child's eligibility for MFC services and make a Level of Reimbursement determination. CMAT staff is ultimately responsible for ensuring that the emergency staffing is conducted within five calendar days of the signed consents or date of the referral, whichever is later.

It is expected that the vast majority of foster care children referred will be staffed by CMAT within five calendar days from receipt of the CRI and CET forms or the date of the referral, whichever is later. It will only be under exceptional circumstances that the CMAT will request that the MFC staff determine the child's eligibility for MFC services and make a temporary Level of Reimbursement determination due to the inability of the CMAT staff to conduct an emergency staffing within the required timeframe.

Initial Staffings

An initial staffing occurs when a child is referred to the CMAT for eligibility determination and for service recommendations. Initial staffings are scheduled within 15 calendar days and held within 30 calendar days of receipt of a signed CRI and CET forms or the date of the referral, whichever is later. In preparation for the initial staffing, the CMAT RN and SW will work with the family or legal guardian to orient them to the CMAT process and obtain the clinical and psychosocial information for the client's CMAT assessment. At the time of the CMAT staffing, the CMAT RN and SW will present the assessment information and the team will employ the consensus building process to arrive at service recommendations and Level of Care / Level of Reimbursement.

Follow-Up Staffings

Each child served through the CMAT process will receive periodic follow-up staffings for the purpose of ensuring continued medical necessity of service recommendations. Follow-up staffings are scheduled at a minimum of every 6 months for MFC services and annually for Skilled Nursing Facility and Model Waiver services from the date of the initial or previous staffing and prior to the expiration of the previous service recommendation. It may be necessary to re-staff children on a more frequent basis in response to changes in medical needs and / or the ability of the caretaker to meet those medical needs. In these instances,

staffings will be convened prior to the six-month or annual interval. Possible reasons for more frequent staffings include:

- potential changes in the child's medical condition, stability, or psychosocial status which might cause a change in the Level of Care / Level of Reimbursement or services needed or changes which require additional planning;
- potential changes in recommended services or options including discharge or transition;
- potential / anticipated changes in eligibility for funding which might effect availability of services;
- concerns from the family or other involved person about the child or about the appropriateness of continuing care at the home or facility;
- court orders affecting a change in the child's placement and / or custody status that may affect eligibility for a long-term care service; and,
- review of recommended service for the child receiving services for observation and / or assessment during a specified time frame while other care options are explored.

In preparation for the follow-up staffing, the CMAT RN and SW will update the clinical and psychosocial information in the client's CMAT assessment. At the time of the CMAT staffing, the CMAT RN and SW will present the updated assessment information and the team will employ the consensus building process to arrive at service recommendations and Level of Care / Level of Reimbursement, when applicable.

Transition / Discharge Staffings

Children served by the CMAT will experience a series of transitions as they grow. Transition planning increases continuity of services, increases the likelihood of meeting the individual needs of the family, minimizes disruption of the family system, and promotes collaboration between programs serving the child and family. Sound discharge and transition planning begins when the child first enters CMS and is continued at the first meeting with the family.

When possible, transition and discharge planning will be initiated well in advance of the anticipated transition. Once it is learned that a transition is imminent, a transition or discharge staffing may be scheduled to assess, anticipate, and facilitate the child's transition. The child's parent or legal guardian will determine if a discharge staffing will be held.

In some instances, a transition / discharge staffing will naturally occur as an extension of a regularly scheduled follow-up staffing. During the course of a staffing, the CMAT members may determine that the child no longer meets criteria for CMAT recommended services. All recommendations involving the denial, decrease, suspension or termination of Medicaid services are subject to a Department of Children and Families, Office of Appeal Hearings, Fair Hearing. The family will be informed of their right to appeal when a CMAT recommended

service is denied, decreased, suspended or terminated following the Fair Hearing Process as outlined in Chapter 12 of this Plan.

The CMAT has final authority for "adverse determinations" when a disagreement arises with a provider about the decrease in the Level of Care / Level of Reimbursement recommendation due to changes in the child's degree of medical complexity. In such cases, the provider can request a reconsideration staffing if additional medical information is available. The recommendation at the reconsideration staffing is final and there is no appeal available to the service provider.

Reconsideration Staffings

When a parent, legal guardian or provider indicates that they are concerned about a recommendation of the team, CMAT staff should first try to discuss the concerns or objections the parent, legal guardian or provider has about the recommendation. It may be necessary for the CMAT Medical Director to consult with the child's primary care physician. If there is additional medical information that was not presented, or the parent, legal guardian or provider feels that the information presented did not accurately reflect their child's condition or needs, it may be beneficial to convene a reconsideration staffing on the next regularly scheduled CMAT staffing day.

The reconsideration staffing will follow the same guidelines as a regular CMAT staffing. The reconsideration staffing does not interfere with the right to a fair hearing or with the guidelines for fair hearing timelines. The parent or legal guardian may decline participation in a reconsideration staffing.

Continuity of Care Staffings

There may be occasions when the Medicaid SA RNS requests that the CMAT conduct a staffing for a client who is receiving a Medicaid funded service that is not normally under the review of the CMAT. The CMAT is responsible for conducting the staffing within the time frames identified for initial staffings (see above) and completing assessments as required for an initial staffing. The CMAT staff will inform the family of the referral from the SA RNS and encourage them to participate in the entire CMAT process, from education of the CMAT process to providing assessment information to participating in their child's CMAT staffing. If the child is not a CMS client, the CMAT staff is responsible for obtaining consents from the family. If the child is already a CMS client, consents to obtain assessment information should already be in the client's record.

There may be occasions when the Medicaid SA RNS requests a CMAT staffing and the child's parents refuse to participate in the CMAT process and the child is not a CMS client. Under these circumstances, the CMAT is responsible for conducting the CMAT staffing using the following procedures:

- The CMAT RN will inform the child's parents / legal guardian of the Medicaid SA RNS request for a staffing, explain the purpose of CMAT, encourage their participation in the CMAT process by providing assessment information and attendance at the staffing to

provide them an opportunity to clarify any issues on the child's behalf and to give them a voice at the CMAT staffing. These efforts will be documented in the child's ROT;

- The child will be entered into CMDS under program component 41, non-CMS client, to enable the CMAT staff to document the child specific information in the ROT note, assessment and CMAT Staffing Summary in the client's electronic medical record;
- The Medicaid SA RNS will provide the CMAT staff with all available clinical and psychosocial information, which will be documented in the child's CMAT assessment and discussed at the CMAT staffing;
- Any involved agencies or providers not under the interagency cooperative agreement may submit clinical and / or psychosocial information to the CMAT staff for inclusion in the CMAT assessment. The referring person or agency will be responsible for submitting this information to the CMAT staff; and,
- If the child's parents did not sign the consents for the CMAT to obtain and discuss information on the child's, only employees for the Department of Health, the Agency of Health Care Administration and the Department of Children & Families can participate in the CMAT staffing (see the Release of Information Required to Proceed section in Chapter 3).

TIMELINES FOR STAFFINGS

Timelines for staffings are as follows:

- Emergency Staffings will be scheduled and convened within five calendar days of receipt of signed CRI and CET forms or the date of the referral, whichever is later. Staffings held as a result of a change in the child's condition will follow the procedures identified the Reporting Changes in the Child's Clinical Condition and Social Factors and Emergency Admission and Follow-up section in Chapter 13. The CMAT Medical Director will determine the necessity of an emergency staffing;
- Staffings for children in shelter or foster care will be considered emergency staffings and will be scheduled and convened within five calendar days of receipt of signed CRI and CET forms or the date of the referral, whichever is later;
- Initial staffings and Continuity of Care staffings will be scheduled within 15 calendar days and held within 30 calendar days of receipt of signed CRI and CET forms or the date of the referral, whichever is later;
- Children will be scheduled for re-staffing as often as need dictates. Children will be staffed, at a minimum, every 6 months for Medical Foster Care services and annually for Skilled Nursing Facility and Model Waiver services and prior to the expiration of the previous service recommendation; and,
- Reconsideration staffing will be scheduled no later than the next regularly scheduled CMAT staffing.

CHILDREN WHO ARE HOSPITALIZED AT THE TIME OF THE REFERRAL

If a child is in the hospital when he/she is referred to CMAT and the hospital staff reports that the child will not be ready for discharge for several weeks, the process and timeframe for emergency and initial staffs are as follows:

- The CMAT RN and SW will assess the child's current medical condition and clinical care needs within five days of the referral or signed consents, whichever is later, and document the required information in an emergency assessment.
- CMAT Medical Director will review assessment information and make a preliminary determination on whether or not the child is eligible for the requested service within five days of the referral or signed consents, whichever is later. This determination will be based on whether or not the child's current medical condition meets the definition of medically complex or fragile and whether or not the requested service would be medically necessary. CMAT staff will inform the referral source of the client's preliminary eligibility determination for their planning purposes.
- The CMAT RN will maintain frequent communication with the hospital staff to determine if there is a change in the child's medical condition and an anticipated discharge date. This information will be documented in the client's ROT.
- The CMAT staff will update the assessment for the emergency staffing and conduct an emergency staffing in a timeframe that prevents the child from remaining in the hospital longer than when the client's attending physician determining the client is ready for discharge. A final eligibility determination for the requested service and a LOC determination will be made at this staffing.
- The initial staffing is due within 30 days from the date of the emergency staffing.

**CHAPTER ELEVEN:
THE STAFFING PROCESS**

CONFIDENTIALITY

Confidentiality at CMAT staffings must be honored by all attendees. All discussions that occur during the course of the CMAT staffing will remain confidential. Any anticipated discussion of confidential information should be discussed with the family prior to the staffing for MFC services so that the family may determine who will be present during the sharing of this information. Should the family invite other family members, friends, or caregivers to the staffing for MFC services, these individuals will be asked to sign the CMAT Staffing Attendance & Confidentiality Statement Form (Attachment 11).

A parent or legal guardian may request that a staffing participant be excluded from the staffing. When this occurs, CMAT staff will consider how the absence of this individual (and the information that this person would bring to the team) might impact the ability of the CMAT to determine medical need. As an example, a family member may request the exclusion of a specific provider from the staffing. However, this provider may have information that is critical in order to make an informed decision. In this instance, CMAT staff will inform the family of their decision to include this individual and the reasons for inclusion. CMAT staff will work with the family to exclude the individual from any highly confidential portion of the staffing, provided that this exclusion does not impact the ability of the team to determine the medical necessity of the child being staffed. The CMAT Medical Director has final authority regarding staffing participants and will ensure that all information required to make an informed decision is presented at the time of staffing.

In rare instances, information regarding child abuse or neglect and other confidential information may be shared with members of CMAT during the course of the staffing. Such information will be contributed by the Department of Children & Families or Community Based Care staff or their representative; or by the CMAT SW after consultation with the child's Children & Families or Community Based Care staff. Assessments and reports that have been prepared by other agencies for their own purposes and subsequently provided to the Department of Children & Families or Community Based Care agency can not be provided to CMAT by the Department of Children & Families or Community Based Care agency due to confidentiality requirements. These reports must be provided directly from the originating organization. Generally, the relevant psychosocial information will be summarized briefly in the assessment, contingent upon agreement by the Department of Children & Families or Community Based Care staff. This agreement to discuss relevant confidential information will be documented in a ROT note.

At the beginning of each CMAT staffing, the CMAT RN or SW will circulate the CMAT Staffing Attendance & Confidentiality Statement Form (Attachment 11) for every participant to sign indicating their participation in the staffing and that they agree to keep the information confidential. The CMAT RN or SW will also make a verbal statement that the information discussed at the staffing is confidential and must not be discussed outside of the staffing without written permission from the parent or legal guardian.

PARTICIPATION IN MEDICAL FOSTER CARE AND CONTINUITY OF CARE CMAT STAFFING

CMAT staffings for Continuity of Care and MFC services will be conducted with full CMAT members as outlined in the Medical Foster Care and Continuity of Care Staffing Team Composition section in Chapter 4. In area offices that have CMAT staff in their local service area (regional CMAT area office), the local full CMAT members will meet and conduct the staffings at the regional CMAT CMS office. Child specific individuals (child's foster care counselor, Guardian Ad Litem, and / or care coordinators) should be invited to participate in the CMAT staffings. In areas offices that do not have CMAT staff in their local service area, the CMAT Medical Director, RN and SW will conduct the staffing via videoconference from the regional CMAT area office. The remaining members of the full CMAT will be from the community where the child resides and will participate in the staffing via video conference from the CMS area office where the child resides. Child specific individuals (child's foster care counselor, Guardian Ad Litem, and / or care coordinators) may be invited to participate in the CMAT staffings and they may participate in the staffings at either the regional CMAT area office or the area office where the child resides.

The child's family is an important participant in a CMAT staffing for Continuity of Care and MFC services. The family's attendance at these staffings is always encouraged. The exception to this policy is when parental rights have been terminated.

Parents may designate another family member to attend for them when they cannot be present for the staffing of their child when the parent has documented that family member's name in the "I authorize release of the information below only to the following:" section of the Consent For Routine Release of Protected Health Information form. If the family is unable to attend the staffing, the CMAT staff will offer the family the option to participate via telephone or videoconference call. Efforts to involve and accommodate families as much as possible will be documented in the client's ROT.

When a family member cannot attend, either in person, or by telephone or videoconference, the CMAT SW has the lead responsibility for consulting with the family to learn what the family would like to have shared at the staffing. After the staffing, the CMAT SW will report the outcome of the staffing to the family.

PARTICIPATION IN SKILLED NURSING FACILITY, MODEL WAIVER, AND INTEGRATED CARE SYSTEM CMAT STAFFING

The CMAT Medical Director, RN and SW will conduct SNF, MW and ICS CMAT staffings for all clients in their assigned regional service area(s). Whenever possible, these staffings are to be held with all participants gathered at the regional CMAT area office.

For SNF and MW staffings, the child's parent or legal guardian should be invited to participate in the staffings. If the family is unable to attend the staffing, the CMAT staff will offer the family the option to participate via telephone or videoconference call. When the child's parent or legal guardian cannot participate in the staffing, the CMAT SW has the lead responsibility for consulting with the family to learn what the family would like to have shared at the staffing. After the staffing, the CMAT SW will report the outcome of the staffing to the family.

FACILITATION

The CMAT staff will locally determine who will facilitate the CMAT staffing. The facilitator may be the CMAT Medical Director, the RN, the SW or CMAT Nursing Supervisor or a combination of these individuals. The CMAT Medical Director will facilitate the staffing process when providing clarification, pediatric consultation, and other information as needed to the CMAT members. Prior to the consensus building process, the facilitator will ensure that all participants are given the opportunity to describe their view of the needs of the child. If the family is not able to participate in the staffing, the CMAT SW or RN will facilitate the family's presentation and discussion. After the participants have describe their views of the needs of their child and provide any up to date medical information and after the CMAT RN and SW have provide a synopsis of the clinical and psychosocial information, the CMAT Medical Director will provide a stability statement. The stability statement will be documented in the CMAT Staffing Summary Report.

THE PROCESS OF BUILDING CONSENSUS

After all of the clinical and psychosocial information has been discussed and the stability statement has been provided by the CMAT Medical Director, the team will determine if the child has a medically complex or fragile condition (for MFC, SNF and MW services only) and if the requested service is medically necessary. After the team discusses if the client meets these eligibility requirements for the requested service, the voting members will make their recommendation(s). At this time, the team facilitator will begin to test for consensus. This is the act of paraphrasing or summarizing what appears to be the conclusion that the group is reaching or the direction in which the group is moving. Reflecting the potential service recommendation back to the group will crystallize the recommendation and may lead to further clarification and discussion. The group facilitator will ask team members if there are any serious concerns or disagreements regarding the recommendation(s). Consensus means that all members consent to the recommendation reached by the group. Full consensus means substantial agreement, not complete unanimity or total satisfaction by every member. Nor does consensus mean that the majority rules. In the instance where the team is unable to reach consensus, the previous level of service will continue until the conflict has been resolved. In the case of initial staffings, the recommendation agreed upon by the majority of the team will be recommended during the period of conflict resolution. For an in-depth discussion of how to resolve conflicts, refer to Chapter 12, Fair Hearing Process.

PARTICIPATION IN THE CONSENSUS BUILDING PROCESS FOR MEDICAL FOSTER CARE AND CONTINUITY OF CARE STAFFINGS

The following individuals are full participants in the consensus building;

- the family or legal guardian;
- the young adult who is 18 years old or older;
- the CMAT RN;
- the CMAT SW;
- the CMAT Medical Director;
- the Medicaid Service Authorization RN;

- the Children's Medical Services representative;
- an MFC staff representative for staffings involving foster care children;
- a Department of Children & Families or Community Based Care representative;
- an Early Steps representative for children ages birth to three; and / or,
- an Agency for Persons with Disabilities Program representative for children age three to twenty-one.

Persons who may attend the staffing and provide the team with information, but who do not participate in the consensus decision-making or recommendation process for the child include:

- lead care coordinator and other care coordinators;
- child's Community Based Care foster care counselor;
- child's Guardian Ad Litem;
- family's legal representative, if requested by the family;
- family health partners;
- family resource specialists; and / or,
- child's hospital or community agency / provider social workers.

Vendors, providers of service, and others present at staffings will be advised that their presence at the staffing is for the purpose of providing information that will assist the CMAT members in making their recommendations. CMAT staff will work directly with providers of services to obtain the nursing and psychosocial information needed for the assessment including copies of nursing charting and other notations reflecting service delivery and outcomes. The provider of services may also provide additional nursing and or psychosocial information at the staffing that was not included in the assessment. All providers of services, except medical foster parents, shall be excused from the staffing after all assessment information is provided.

PARTICIPATION IN THE CONSENSUS BUILDING PROCESS FOR SKILLED NURSING FACILITY, MODEL WAIVER, AND INTEGRATED CARE SYSTEM STAFFINGS

The following individuals are full participants in the consensus building;

- the CMAT Medical Director;
- the CMAT RN;
- the CMAT SW;
- the family or legal guardian (except ICS staffing); and,
- the young adult who is 18 years old or older (except ICS staffing).

LEVELS OF CARE / REIMBURSEMENT

When recommending services that require a Level of Care or Level of Reimbursement determination, the team will use the corresponding Level of Care or Level of Reimbursement instrument. For MFC recommendations, the team will use the Validated Level of Reimbursement Tool (Attachment 16). See the Determining the Level of Reimbursement section in Chapter 15 for information on the process for using the Validated Level of Reimbursement Tool. For Skilled Nursing Facility recommendations, the team will use the Skilled Nursing Facility - Level of Care Guidelines (Attachment 23). See the Determining

Nursing Facility Level of Care section in Chapter 18 for information on using the Skilled Nursing Facility Level of Care Guidelines. For Model Waiver recommendations, the team will use the Model Waiver - Notification of Level of Care form (Attachment 21). See the Initial Level of Care Determination and Annual Level of Care Determination sections in Chapter 17 for information on using the Model Waiver Notification of Level of Care form.

EFFECTIVE DATE OF RECOMMENDATIONS

The effective date for team recommendations is the date of the staffing. In situations in which services have been denied, decreased, suspended or terminated, the effective date will be 10 calendar days from the date of the staffing to allow time for the family or legal guardian to request a fair hearing. See Chapter 12 Conflict Resolution, Reconsideration, and Fair Hearing Process for specific information regarding the fair hearing process and the effective date when a fair hearing is requested.

Recommendations for services may also be for some future date, to allow for transitions, anticipated surgeries, reunification of children in foster care and other events that impact planning. When the recommendation is for a future date, the effective date, duration of recommendation and the reason why the recommendation is for a future date will be documented in the discussion and recommendation sections of the CMAT Staffing Summary Report. CMAT cannot make retroactive recommendations. An exception can only be made with the approval of the Medicaid SA RNS.

WHEN CONSENSUS CANNOT BE REACHED

When all other members of the team reach consensus regarding service recommendations with the exception of one team member, the consensus recommendation will be accepted, noting the disputed point in the CMAT Staffing Summary Report. The disagreement of a single individual will not deter the team from moving forward with their recommendation. When the disagreement by a single individual is the Medicaid SA RNS, see the Conflicts Related to CMS and / or Medicaid Policy section in Chapter 12.

Disagreements regarding CMAT complex medical issues will first be addressed by mediation at the local level with the local CMS Area Office Medical Director for a resolution. If a mediated agreement has been obtained, this agreement will be presented to the CMAT core members as soon as possible for a final recommendation. If the issue has not been resolved, the issue will be referred to CMS Central Office CMAT staff and Medicaid Headquarters Nurse Consultant for resolution.

If the dispute involves a MFC eligibility or Level of Reimbursement determination, the local CMAT and MFC Medical Director will first attempt to reach consensus. If a resolution between the two Medical Directors has been obtained, the mediated agreement will be presented at a reconsideration staffing to the CMAT core members as soon as possible for a final recommendation. If resolution cannot be reached, the case will be forwarded to Area Office CMS Medical Director for mediation. If a resolution can not be reached the CMS Area Office Medical Director will contact the Deputy Secretary of CMS to mediate the concern. The resolution made by the CMS Area Office Medical Director or the Deputy Secretary of CMS will be presented to the CMAT core members as soon as possible for a final recommendation.

CONCERNS REGARDING QUALITY OF CARE

If during the course of the staffing, concerns are expressed regarding the quality of care of a Medicaid funded service, the individual with the concerns will be directed to share those concerns with the Agency for Health Care Administration. In their role of facilitating the exchange of information when concerns are identified, the CMAT staff must refer the information and / or the individual with the concerns to the responsible program or agency.

TRANSFER TO ANOTHER CMAT SERVICE AREA

When it becomes necessary for a child being served by CMAT to receive their recommended services in a new service area, the child's follow-up CMAT staffings, CMS care coordination services and medical records will be transferred to the service area where the child resides. If the child's family expresses an interest to participate in the CMAT staffings, they may participate in the staffing in person or via a telephone conference call. When it is anticipated that the child will move back to their originating service area, the child's CMAT staffings, CMS care coordination and medical records will be transferred back to the originating service area.

**CHAPTER TWELVE:
CONFLICT RESOLUTION, RECONSIDERATION, AND
FAIR HEARING PROCESS**

INTRODUCTION

CMAT is an administrative process that makes medical recommendations for Medicaid funded services. As such, CMAT is obligated to inform parents of their right to appeal a CMAT recommendation or the denial of a CMAT staffing at the time of any action that affects the child's receipt of services. According to **42 CFR 431.200 - .250**, each CMAT is required to inform the parents or legal guardians of the Fair Hearing Process. The CMAT Fair Hearing Process is the same process used for all Medicaid services that are **denied, suspended, reduced, terminated, or not acted upon promptly**. Medicaid provides fair hearing process information at the time that the individual applies for Medicaid eligibility. However, the fact that Medicaid has provided this information does **not** relieve the CMAT from their responsibility to notify the parent or legal guardian of the right to a fair hearing at the time of the action affecting the child's receipt of services.

What Constitutes a Request for a Fair Hearing?

A request for a fair hearing occurs when a family expresses a concern or does not agree with a CMAT recommendation and presents their non-concurrence in a clear oral or written statement, and when this concern / disagreement is a result of a Medicaid service being denied, suspended, reduced, terminated, or not acted upon promptly.

What Does Not Constitute a Request for a Fair Hearing?

Parents or legal guardians do not have the right to appeal the CMAT decision when a Medicaid service is denied, suspended, reduced, or terminated through a prescription written by the client's prescribing physician.

Who Can Appeal a CMAT Recommendation?

Parents or legal guardians of children may appeal, in a written or oral statement, to CMAT staff or other appropriate state agency representatives. Information regarding a Request for a Fair Hearing will be documented in a ROT note.

Who Cannot Appeal a CMAT Recommendation?

Providers do not have the right to appeal the recommendations of the CMAT. When a provider disagrees with a CMAT recommendation, the CMAT has final authority for decisions. Medical Foster Parents, as Medicaid providers, do not have the right to appeal CMAT recommendations.

Timelines for Notification to Family / Legal Guardian

The CMAT must notify the parent or legal guardian of the child that they have 10 calendar days to request a fair hearing from the date that they were informed a Medicaid funded service was

denied, suspended, reduced, or terminated a Medicaid funded service. To ensure that the family has every opportunity to appeal a decision, information regarding their right to appeal will be provided to the family in writing (Attachment 14), at the conclusion of the CMAT staffing. When the family did not participate in person in the staffing, this information will be sent to the family **via certified mail** and regular mail within one working day of the CMAT staffing. When the family did not participate in the staffing, the CMAT staff will call the family within one working day of the staffing to inform them of their right to appeal and that they will be sent information on their right to appeal **via certified mail** and regular mail within one working day of the CMAT staffing. A ROT note will be completed to document that the family or legal guardian was provided written notice of their right to appeal, whether in person or by certified and regular mail.

When a Child Resides in a Skilled Nursing Facility

For children residing in a Skilled Nursing Facility and for whom there is a decrease in a Level of Care recommendation, the CMAT must notify the parent or legal guardian of their right to appeal this action by following the process documented in the Timelines for Notification to Family / Legal Guardian section above.

For Medicaid eligible children transferred or discharged from a nursing facility by actions that are not a result of a CMAT staffing, it is the responsibility of the nursing facility to inform the child's parents or legal guardian of their right to appeal the decision to transfer or discharge the child.

When a Child Resides in a Medical Foster Home

For children residing in a medical foster home and for whom there is a decrease in a Level of Reimbursement recommendation, the CMAT must notify the parent or legal guardian of their right to appeal this action by following the process documented in the Timelines for Notification to Family / Legal Guardian section above.

When the medical foster child leaves the medical foster home due to a court order, the parent or legal guardian does not have the right to appeal the termination of the MFC service. Examples of when a child would be court ordered to leave a medical foster home would include reunification with their parents or a placement with a relative.

Continuation of Medicaid Services

A child is entitled to receive the Medicaid reimbursed service(s) at the previously recommended level when a request for a fair hearing is received from the child's parent or legal guardian before the date of the action (10 days after notice is given). These services remain in place until the hearing officer renders a decision regarding the appeal unless;

- It is determined at the hearing that the sole issue is one of Federal or State law or policy and when this occurs, CMAT will promptly inform the family of the recipient in writing that services are to be terminated or reduced pending the hearing decision.

When the 10 Day Advanced Notice is not Required

The Agency may mail a notice not later than the date of action if;

- The change in services is due to a physician's orders;
- The CMAT has factual information confirming the death of the child;
- The CMAT receives a clear **written** statement signed by the child's parent or legal guardian that the parent or legal guardian (1) no longer wants the services for their child; or, (2) that gives information which requires termination or reduction of assistance and the parent or legal guardian has indicated in writing that s/he understands that this reduction or termination must be the consequence of supplying such information. Example: the parent supplies documentation stating that they are no longer requesting a Medicaid funded skilled nursing facility placement for their child;
- The child has been admitted to an institution where s/he is ineligible under the Medicaid State plan for further services;
- The child's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address; or,
- The child has been accepted for Medicaid services by another local jurisdiction, State, territory, etc.

Handling the Request for a Fair Hearing

Parents or legal guardians may use the CMAT Request for a Fair Hearing form (Attachment 15) when making a request for a fair hearing and direct their CMAT staff to submit the CMAT Request for a Fair Hearing form to the Department of Children and Families. Parents may also directly submit the request form to:

Department of Children and Families
Office of Appeal Hearings,
Building 5, Room 203,
1317 Winewood Boulevard
Tallahassee, Florida, 32399-0700, FAX (850) 487-0662

The Request for a Fair Hearing form must be submitted to the Department of Children and Families within three (3) calendar days of receiving the form and a copy will be placed in the client's CMS medical record. The CMAT staff will include the name of a contact person to be notified of the scheduling of the hearing. Copies of the Request for a Fair Hearing form **must** be sent to the local Medicaid office Field Office Manager **and** to the CMAT Consultant at Children's Medical Services Central Office at BIN A06, 4052 Bald Cypress Way, Tallahassee, FL 32399-1707, FAX (850) 488-3813.

Timeframes for Requesting a Fair Hearing

Parents or legal guardians may request a hearing within 90 calendar days from the date that a Notice of Right to Appeal was hand delivered or mailed, via certified mail. When the notice is hand delivered to the parent or legal guardian of the child, the 90-day time period begins from the date of receipt. If mailed, the required time frames begin the date the parent or legal guardian signed the return receipt. The person mailing or hand delivering the notice will document this fact in the client's ROT. If the notice is hand delivered at the time of the CMAT staffing, the CMAT Staffing Summary Report will reflect this fact.

The 90-day time limitation does not apply when the CMAT fails to provide the required notification, fails to take action on a specific request, or denies a request without informing the person appealing the action. In these instances, the 90-day time period begins once the CMAT has complied with the requirements for notification.

Parental Rights to Records

In preparation for a hearing, the parents or legal guardians of a child have the right to request a copy of all of the information in the CMS medical record including CMAT documents. The parent or legal guardians of the child, or their legal representative, must be given an opportunity to examine, at a reasonable time before the date of the hearing and during the hearing, the content of the child's file. Parents have the right to examine all documents and records such as the Medicaid Service Authorization file to be used by the State or local agency at the hearing. Additionally, the Hearings Officer may ask the CMAT staff to send copies of relevant materials, and other policy information. A copy of the current CMAT Statewide Operational Plan will be provided by the local CMAT staff to the hearing officer prior to the hearing.

THE FAIR HEARING PROCESS

Oral evidence will be taken only under oath unless the parties affirm that the evidence they are presenting is true as represented. Each party will have the right to present evidence relevant to the issue, to bring witnesses, to cross-examine witnesses on any matter relevant to the issue, to challenge any witness regardless of which party first called him / her to testify, and to rebut the evidence presented against them through the introduction of rebuttal evidence or testimony.

The Hearing Officer will request a copy of all references to Florida Statutes, Florida Administrative Codes, Medicaid Handbooks, manuals, or operational plans regarding the issue. A copy must also be furnished to the parent or legal guardian. The proceeding must be recorded by a certified court reporter or recording instrument. Submissions of evidence subsequent to the hearing will be made directly to the Hearings Officer only with the consent of both parties. Otherwise, the submission must be made to the Hearings Officer with a copy sent to the other party for that party's response. The Hearings Officer will provide a time period for the submission of evidence and the response of the second party. If necessary, at the discretion of the Hearings Officer, the hearing can be reconvened to allow the second party to rebut the evidence.

When CMAT takes action to reduce or terminate services being received by the child, the burden of proof is with the CMAT. The party bearing the burden of proof presents its evidence

first at the hearing; and must establish its position by a preponderance of the evidence to the satisfaction of the Hearings Officer.

When the hearing involves medical issues, such as those concerning a diagnosis, an examining physician's report or a medical review team's decision, and if the Hearings Officer mandates it is necessary, and the child is Medicaid eligible, a medical assessment other than that of the person or persons involved in making the original decision will be obtained at the expense of the Agency for Health Care Administration and made a part of the record.

Orders issued by the Hearings Officers are Final Orders and must be implemented immediately by the CMAT and Medicaid of the Agency for Health Care Administration. The Final Order will be based on the evidence and other materials introduced at the hearing including the applicable laws, regulations, and rules or materials submitted after the hearing upon agreement of all parties. The Final Order will be rendered within 90 calendar days of the request of the hearing.

CMAT Staff Attendance and Role at Hearings

A CMAT staff member from the team that made the service recommendation will attend the administrative hearing. CMAT staff members are expected to provide testimony as to the team's basis for the recommendation, how the recommendation was reached, and what notification was provided. If a change was made to a CMAT service recommendation during the Medicaid SA nurse authorization process, a CMAT staff member is not required to attend the administrative hearing.

Medicaid staff will attend for the purpose of presenting evidence relevant to the issue under appeal and refer to the particular law, policy, operational plan or administrative rule, which was used in making the recommendation under appeal.

Failure to Appear

If the parent or legal guardian, without good cause, fails to appear or send an authorized representative to the hearing scheduled for them, such action is considered abandonment. The Hearings Officer will make a determination of whether or not good cause existed. If good cause is shown, the hearing will be reset.

When a Staffing is Due and a Fair Hearing Request is Pending

If a parent or legal guardian files an appeal and the follow-up staffing becomes due before the hearing decision is rendered, a special staffing will be held. The participants of this staffing will be the CMAT Medical Director, RN, SW and Medicaid SA RNS. They will review the nursing and psychosocial assessment information completed for this special staffing and determine if a regular follow-up staffing should be held. If the child's service needs are not changed to the degree that a change in type of service, Level of Care / Level of Reimbursement, or frequency or duration may be needed, then the participants of the special staffing will make a recommendation for the continuation of the current service at the current level. A CMAT Staffing Summary Report will be completed indicating that this was a special staffing due to an appeal having been filed and the required information will be documented. A copy will be provided to the Medicaid office.

However, if the participants of the special staffing believe that a change in the type of service, Level of Care / Reimbursement, or frequency or duration is needed, then a follow-up staffing will be held so that the increased service needs can be addressed. Once the hearing decision is rendered, the hearings officer's order takes precedence over any recommendation of the team. For example, the order may find that Medical Foster Care services should have been granted by the team and goes on to require Medical Foster Care services for three months following the hearing; that order will be followed. However, if the hearings officer does not order any specified level of service or time period, the recommendation of the special staffing or the follow-up staffing held as a result of the special staffing will then be followed until the next staffing is held. The same documentation required for any staffing would be completed.

CONFLICTS RELATED TO CMS AND / OR MEDICAID POLICY

Conflicts related to CMAT policy disagreements will be addressed to the Children's Medical Services Central Office and / or Medicaid Program Office CMAT liaison or the Department of Children and Families' Office of Family Safety Program Headquarters or the Agency for Persons with Disabilities Program Headquarters for appropriate resolution of the policy issue.

When CMAT can not reach full consensus due to the Medicaid SA RNS disagreeing with the rest of the team regarding a recommendation or a complex clinical issue, the disagreement will be addressed as follows:

- Within one business day of the CMAT staffing, the CMAT RN will provide the CMS Nursing Director and the Medicaid Field Office Manager (via the Medicaid SA RNS) with completed CMAT assessment and staffing summary form for the recommendation in question. Staffing summary form will include documentation to the effect that consensus was reached, the basis for the consensus, who was not in agreement and the basis for this disagreement.
- The local CMS Nursing Director, CMS Medical Director, and the Medicaid Field Office Manager will discuss, in attempt to reach a decision, the appropriateness of the service in question. If a mediated agreement has been obtained, this agreement will be presented at a reconsideration staffing to the CMAT core members as soon as possible for a final recommendation.
- If attempts by the local CMS and Medicaid management to resolve the discrepancy are unsuccessful, the CMS Nursing Director and Medicaid Field Office Manager will forward the appropriate information to the CMS Central Office CMAT RN Consultant and the Medicaid RN Consultant respectively. This information will then be presented to the Deputy Secretary for CMS and the Statewide Medicaid Physician Consultant who will consult to make a final determination of service authorization. When they reach agreement, their decision will be communicated to the CMAT staff who will document their decision to an addend CMAT Staffing Summary Report. Medicaid ultimately has the final authority to determine if they will reimburse a service.
- During the period of time in which service recommendation(s) are under review, CMAT recommended services will be authorized until such time as a review and determination is made to the contrary.

**CHAPTER THIRTEEN:
MEDICAL FOSTER CARE SERVICES (MFC)**

DESCRIPTION OF THE SERVICE

Florida's Medical Foster Care Program (MFC) is a coordinated effort between the Department of Health, the Department of Children and Families, and the Agency for Health Care Administration to provide family based care for medically complex children under age 21 who are in the custody of DCF either through voluntary placement or through a court order under foster care or shelter status. This program is considered to be less restrictive than receiving services in hospital or institutional settings. The program strives to enhance the quality of life and allow medically complex shelter or foster children to develop to their fullest potential regardless of their medical condition. The Department of Health MFC staff and the Department of Children and Families or Community Based Care foster care staff will work with the child's family to provide them training in caring for their child so that the child may be returned to their birth parents or relatives as soon as possible. When reunification with family is not possible, the programs will seek to facilitate services in an alternative permanent placement.

ELIGIBILITY

To be eligible for MFC services the child must be:

- Medicaid eligible;
- in the custody of the Department of Children and Families;
- a child with a medically complex or medically fragile condition under the age of 21;
- in danger of periodic or prolonged hospitalization or institutional placement without the intervention of MFC services in a MFC home; and,
- medically stable and not require acute hospital care, as determined by the MFC Medical Director.

Children who **may** be considered for MFC services may include, but are not limited to:

- children who, while they are medically stable, have high technological needs for therapies, treatments, equipment, continuous observation, monitoring (e.g., children with long-term tracheotomies, feeding gastrostomies, intermittent or continuous ventilator support), or requiring total parenteral nutrition;
- children recently hospitalized for a change in medical management, counseling or adaptation (e.g., the out-of-control diabetic or asthmatic child who can no longer be managed effectively at home);
- children recuperating from complicated surgery or accidents with a prolonged recovery period during which time skilled nursing and / or medical care is required;

- children in transition from tertiary centers to home care (e.g., children who are generally medically stable but their parents or caregivers require a setting in which to learn the technical and developmental aspects of their care management); or,
- children in the custody of the Department of Children and Families who may be “at risk” (e.g., failure to thrive, on an apnea monitor or other diagnoses and when the child may require complex medical interventions or has other medical problems or risk factors).

CHILDREN WITH PSYCHIATRIC OR BEHAVIORAL ISSUES

Children with psychiatric or behavioral problems who also have complex medical needs should be recommended for MFC services if their psychiatric or behavioral needs can be met in a medical home setting. It should also be recognized that special health care needs might have an impact on the behavioral and emotional health of children. At the CMAT staffing, if it is determined that the child's psychiatric or behavioral needs can not be met in a home setting; the CMAT will make a suggestion on the most appropriate setting that can meet the child's psychiatric or behavioral needs and the child's clinical needs. The team will also determine if other long-term care services are medically necessary. The CMAT staff will inform the child's Children & Families or Community Based Care staff of this information.

REFERRALS

The majority of referrals for MFC services will come to CMAT via the Department of Children and Families, Community Based Care agencies or Sheriff Department. However, a referral can come from the child's parent, legal guardian, or any individual involved with the child. The Department of Children and Families, Community Based Care agency or sheriff's office will determine whether their direct service staff or the family will sign the CRI and CET forms. When it is determined that the family is responsible for signing the consents, the Department of Children and Families, Community Based Care staff or sheriff's office and CMAT staff will have equal responsibility in obtaining the signed consents. The assessment process begins upon receipt of a signed CRI and CET forms or the date of the referral by Department of Children and Families or Community Based Care agency staff if the foster child is already a CMS client. If the referral came from an individual other than the Children & Families or Community Based Care staff, the CMAT staff will contact the child's Children & Families or Community Based Care staff to determine if they are interested in a CMAT staffing to determine eligibility for a medical foster care placement. CMAT will immediately inform MFC staff of a potential candidate for the MFC Program. Should a family wish to voluntarily place their child in MFC; the CMAT staff will refer the parents to the Office of Family Safety staff within the Department of Children and Families. The Office of Family Safety staff will advise the CMAT staff on the child's legal status.

If the child being referred for MFC services is already in a foster home, the Department of Children and Families or Community Based Care agency may request a staffing for possible MFC services. The decision to staff the child must originate from a request by the Department of Children and Families or Community Based Care agency. The CMAT cannot recommend moving the child from one foster home to a MFC home if the Department of Children and Families or Community Based Care agency is not willing to do so. If the CMAT staff has concerns regarding the care of the child in the current setting, this information should be shared with the CMS Nursing Director, the child's Children & Families or Community Based Care staff and their supervisor, and documented in the client's ROT.

COLLABORATION WITH MEDICAL FOSTER CARE STAFF

MFC staff are full participants in the CMAT staffing process, providing invaluable insight into the potential care needs of the child. One MFC team member can participate in the voting and Level of Reimbursement determination process when MFC services are being considered. The CMS Nursing Director has responsibility for making the decision on whether or not the MFC staff will be responsible for occasionally completing assessments for the CMAT staffing. CMAT staff remains responsible for the assessment content and for ensuring that the assessment has been completed.

If the CMAT recommends MFC services and the local MFC program indicates that there are no available MFC beds or that they cannot serve the child due to staffing limitations, the team will explore the other service options that can meet the needs of the child in their current setting or other appropriate setting. CMAT must not let availability of any services preclude their holding the staffing or making the most appropriate service recommendations.

If a placement is not available, MFC will place the child on a waiting list. The Department of Children and Families or Community Based Care agency may also consider placement of the child in a MFC program in another service area. It is the responsibility of the MFC program staff to work with the Department of Children and Families or Community Based Care agency in locating a MFC program in another service area that can meet the needs of the child. The Department of Children and Families or Community Based Care agency may elect to transfer the child to the service area where a MFC home is available.

If the Department of Children and Families or Community Based Care agency makes a determination to transfer a child, the location of subsequent CMAT staffings will generally be in the receiving service area. If the child's family and / or foster care staff expresses an interest to participate in the CMAT staffing, they may participate in person, or via a telephone conference call. When the CMAT staffings are transferred to the receiving area, the receiving area is responsible for coordinating the participation of the child's biological parents (if parental rights have not been terminated) and the child's foster care staff in future CMAT staffings. The process outlined in the Transfer to Another CMAT Service Area section in Chapter 11 will be followed when a foster child is transferred to another service area.

LEVEL OF REIMBURSEMENT USING THE VALIDATED TOOL

Only team members who have completed the Validated Level of Reimbursement Training may participate in determining a Level of Reimbursement for a MFC child. Upon completion of this training (within 30 days of becoming a member of the CMAT), the team member will sign the Validated Level of Reimbursement Training Attendance Form (Attachment 18) and the team member will be added to the Validated Level of Reimbursement Training Log (Attachment 17). The participant will receive a certificate of completion (Attachment 19). This documentation will be kept in a CMAT programmatic administrative file.

Determining the Level of Reimbursement

Each child considered for placement in a MFC home will receive a Level of Reimbursement determination using the criteria outlined in the Validated Level of Reimbursement Tool

(Attachment 16). The following steps will be used when determining the Level of Reimbursement:

- Each team member will be given a Validated Level of Reimbursement Tool;
- The CMAT Medical Director will provide the Stability of the Child in the Home Setting stability statement prior to the team members completing the tool. For each care component (2-5) on the tool, each team member will individually select the most appropriate category description (a, b c, d, or e).
- The team members will discuss and come to an initial consensus on the most appropriate category description (a, b c, d, or e) for each care component (2-5) and total the corresponding points of the care components to determine the Level of Reimbursement;
- The team members will review the definition of the initial Level of Reimbursement determination to ensure that the level describes the child's clinical condition and needs;
- The team members will reach final consensus on the on the most appropriate category description (a, b c, d, or e) for each care component and Level of Reimbursement for MFC services;
- The agreed upon category description and the recommended Level of Reimbursement will be documented on the child's Validated Level of Reimbursement Tool; and,
- The recommended Level of Reimbursement will be documented in the CMAT Staffing Summary Report.

A Validated Level of Reimbursement Tool documenting the agreed upon category description and recommended Level of Reimbursement will be kept in the child's CMS medical record and a copy can be kept in the child's administrative file. A copy of the CMAT Staffing Summary Report will be provided to the Medicaid SA RNS and the child's foster care staff within 10 calendar days of the CMAT staffing.

Stability of the Child in the Home Setting

It is the sole responsibility of the CMAT Medical Director to determine which Stability Statement on the Validated Level of Reimbursement Tool best describes the stability of the child based on the information documented in the child's CMAT assessment and discussed during the staffing.

Using the Stability Statement determined by the CMAT Medical Director, the CMAT members will determine the appropriate description of the remaining categories to determine the Level of Reimbursement.

Tolerance to Delay or Task Error

CMAT members will determine a child's tolerance to a delay or task error using the criteria as specified in the Validated Level of Reimbursement Tool.

Team members will consider the impact of a delay and the severity of consequences of a task error by the caregiver in meeting the child's medical needs, which includes interventions / treatments, observations, medication administration and appointments.

The following definitions will be used when determining the child's tolerance to a delay or task error:

- "Task error" refers to an unintentional act that deviates from standard procedure or protocol.
- "Delay" refers to an act or response that is performed later or slower than desired by standard procedure or protocol.
- "Loss of function" refers to deprivation of a capability or the stoppage of a normal or proper physiological activity.
- "Decrease in functioning" refers to degradation of a capability or the partial compromise of a normal or physiological activity.
- "Acute illness" refers to sudden or severe change in medical condition.
- "Decline in general health" refers to a gradual or progressive deterioration in medical condition.

Interventions

CMAT members will determine the complexity of required interventions using the criteria as specified in the Validated Level of Reimbursement Tool. A sample of interventions for categories A, B, C and D are provided on the tool to assist the team members in determining the complexity of the required interventions.

Observation, Assessment and Documentation

CMAT members will determine the required level of observation, assessment, and documentation to be performed using the criteria as specified in the Validated Level of Reimbursement Tool. The team members will determine if the amount and complexity of observation, assessment and documentation the caregiver must provide to the child requires greater amounts of time or special skills. Risk factors, special observations or precautions should be considered. Team members will select a description according to the frequency and predictability of the need for observation, assessment and documentation.

Personal Care

CMAT members will determine the required level of personal care to be performed using the criteria as specified in the Validated Level of Reimbursement Tool.

The team's consideration of personal care is based on factors related to the child's medical condition and a determination of whether this medical condition is preventing the child from

functioning at an age-appropriate level. If the child is not functioning at an age appropriate level, the team member must determine if meeting the child's personal care needs related to their medical condition requires more time, attention, or supervision on the part of the caregiver than would be necessary for a child who is developmentally on target.

LEVEL OF REIMBURSEMENT

Level of Reimbursement (LOR) is based on the child's medical condition and the frequency, duration and complexity of the care required in meeting the child's medical needs. There are three MFC Levels of Reimbursement: Level I, II and III. The LOR determines the rate at which a Medical Foster Parent will be reimbursed by Medicaid and ensures that the Medical Foster Parent is adequately reimbursed for the time and skill required in providing the child's care.

Level One (I)

The child is at risk for or is experiencing infrequent and predictable changes in medical needs. The child's medical needs require simple interventions, medical management, reliable observation, and documentation by a trained caregiver.

Level Two (II)

The child is experiencing frequent and predictable changes in medical needs or infrequent and unpredictable changes in medical needs. These needs can be met by a caregiver who is prepared to meet both anticipated and unanticipated events.

Level Three (III)

The child is experiencing frequent and unpredictable changes in medical needs. These needs can be met in the home setting by a caregiver who is prepared to intervene when the child experiences anticipated and unanticipated events.

WHEN CONSENSUS ON MFC ELIGIBILITY OR LEVEL OF REIMBURSEMENT CANNOT BE REACHED

If consensus on the child's eligibility for MFC services or Level of Reimbursement cannot be reached after a thorough discussion, the CMAT Medical Director will contact their Area Office or Regional CMS Medical Director for a recommendation. If the Area Office or Regional CMS Medical Director and the CMAT Medical Director come to an agreement on a Level of Reimbursement, the CMAT Medical Director will take the agreed upon Level of Reimbursement back to the CMAT for a final Level of Reimbursement determination. If their discussion does not resolve the problem, the CMAT staff will contact the statewide CMAT Consultants at CMS Central Office and the area office Medicaid SA RNS will contact the Medicaid MFC Program RN Consultant at Medicaid Headquarters. The CMAT consultants will request all of the available information and refer the matter for review and a recommendation by the Children's Medical Services Deputy Secretary or his / her designee. The Level of Reimbursement determination made by the Children's Medical Services Deputy Secretary or his designee and the Medicaid Medical Director will be communicated to the CMAT staff who will document their decision to an addendum CMAT Staffing Summary Report.

ROLE OF MFC MEDICAL DIRECTOR IN MFC PLACEMENT

Once the recommendation / referral for MFC services and Level of Reimbursement is established by the CMAT, the MFC Medical Director will consider the individual needs of each child and the capabilities of the MFC providers under his / her supervision to determine if MFC is the appropriate placement for this child. If the MFC Medical Director believes that the child cannot be safely served in a MFC home, the child will not be admitted to MFC and the MFC staff will notify the CMAT staff of the Medical Director decision. If the MFC Medical Director feels that the child is appropriate to receive MFC services, but there are no beds available in the service area, the MFC staff will consult with Department of Children and Families or Community Based Care staff to determine if the Department of Children and Families or Community Based Care staff is willing to transfer the child to another service area. If the Department of Children and Families or Community Based care staff is willing to transfer the child, the MFC staff will contact the other MFC programs to determine if a bed is available. If there is no MFC bed available, the referral source may request a re-staffing to consider alternative service provision.

RESPONSIBILITIES OF MFC STAFF TO THE CMAT

Once a child is admitted to MFC, the MFC nurse and social worker become that child's CMS care coordinators and the Department of Children & Families or Community Based Care staff remains the lead care coordinator. MFC staff is responsible for formulating and providing Medicaid the Plan of Care for MFC. MFC staff will advise the CMAT prior to the initiation of transition or discharge of all children served by CMAT to allow the CMAT staff to determine the need for a staffing, to facilitate planning, or to consider additional long-term care services for the child in the new setting.

Reporting Changes in the Child's Clinical Condition and Social Factors

The MFC staff is responsible for informing the CMAT staff in writing of changes in a child's clinical condition that could result in a change in the child's Level of Reimbursement, either an increase or decrease. When a change in the child's clinical condition could result in an increase in the child's Level of Reimbursement, the MFC staff will request that the CMAT staff conduct an emergency staffing. If the change in the child's clinical condition is significant, this significant change may necessitate the need for an urgent Level of Reimbursement determination. Examples of these significant changes include, but are not limited to, a new diagnosis or condition, new complex intervention(s) or treatment(s), or significant increase in health risk. In these urgent situations, the MFC staff will request the CMAT staff to conduct the emergency staffing within 48 hours. The MFC staff will document this request in the child's Record of Treatment. If the CMAT staff is not available to conduct an emergency staffing within 48 hours of the request, the CMAT staff, with the approval of the CMAT supervisor, will request that the MFC Medical Director make a temporary Level of Reimbursement determination. The CMAT supervisor will document their approval in the child's Record of Treatment. When MFC staff receives a request from the CMAT staff to determine a temporary Level of Reimbursement, the protocol as delineated in the MFC Operational Plan will be followed. The temporary Level of Reimbursement will remain in effect until the CMAT staff conducts the emergency staffing, within five days of the request for an emergency staffing by the MFC staff. In the rare event that the CMAT staff is not available to conduct the emergency staffing within five days of the request from MFC, with the approval of the CMAT supervisor, the temporary Level of Reimbursement

determination made by the MFC Medical Director will remain in effect until the CMAT staff can conduct a CMAT staffing. This CMAT staffing will be conducted as soon as possible, but no later than 30 days from the date the MFC staff requested an emergency staffing. If the MFC staff is not available to determine a temporary Level of Reimbursement, they will notify the CMAT on the day the request was received and this notification will include the reason why they are not available to determine the child's eligibility for MFC services and will make a Level of Reimbursement determination. CMAT staff is ultimately responsible for ensuring that the emergency staffing is conducted within five calendar days of the request from MFC staff for an emergency staff due to the child's change in clinical condition.

When a change in the child's clinical condition could result in a decrease in the child's Level of Reimbursement, the CMAT staff will conduct a CMAT staff as soon as possible, but no later than five days from the date they were informed of the change in the child's clinical condition. If the CMAT recommendation results in a decrease in the Level of Reimbursement or termination of MFC services, the services may continue at the previous level for 10 days in order to allow the biological parents or legal guardian the opportunity to request a fair hearing. If the child's foster care staff disagrees with the decrease in Level of Reimbursement or termination of MFC services, they may request a reconsideration staffing if additional medical information is available.

Additionally, the MFC staff is responsible for keeping the CMAT staff informed of social changes in children served in their program, for example, the transfer of the foster child into another MFC home. Upon receipt of such information, the CMAT Medical Director, RN and SW will determine if a follow-up staffing is required for the purpose of reassessing the needs of the child in light of the new circumstances.

MFC staff may discharge the child from the MFC program without a CMAT discharge staffing if it is court ordered or it is apparent that no long-term care service will be needed in the new setting. MFC staff will notify the CMAT staff of all unanticipated discharges by the following business day.

Emergency Admissions and Follow-up

When MFC staff receives a referral for a child after normal business hours and / or during weekend hours, an emergency admission can occur. The MFC nurse will obtain the required consents and assess the child's clinical and psychosocial needs. The MFC Medical Director will determine the child's eligibility for MFC services and a temporary Level of Reimbursement. MFC staff will inform CMAT of the emergency admission during the next business day. The Level of Reimbursement assigned by the MFC Medical Director will remain in effect until the CMAT holds an emergency staffing and make a final Level of Reimbursement determination. For exceptions to CMAT staff conducting the emergency staffing within five days, refer to the Children in Shelter / Foster Care Status section in Chapter 10. CMAT will conduct an initial staffing within 30 days of signed CRI and CET forms or the date of the referral, whichever is later. With the exception of the situation described above, all children referred for possible MFC services will be directly referred to CMAT for staffing.

At times, CMAT may receive a referral during business hours to staff a child who is in shelter or foster care status that has an urgent need for a medical foster home placement. The CMAT

staff will discuss with the child's Children and Families / Community Based Care staff the option of having the child admitted into the hospital for up to 48 hours for Medicaid Observation Services, as defined in the Medicaid Hospital Services Coverage and Limitation Handbook. In the event that the CMAT can not obtain the required consents, obtain the medically necessary information to complete the CMAT assessment and conduct an emergency CMAT staffing within 48 hours of the referral, the CMAT staff, with the CMAT supervisor's approval, will discuss with the MFC staff to determine if the MFC staff are available to determine the child's eligibility for MFC services and a temporary Level of Reimbursement. The CMAT supervisor will document this approval in the child's Record of Treatment. If the MFC staff is available to determine the child's eligibility for MFC services and a temporary Level of Reimbursement within 48 hours, the Level of Reimbursement assigned by MFC Medical Director will remain in effect until the CMAT conducts an emergency staffing and makes a final Level of Reimbursement determination. For exception to CMAT staff conducting the emergency staffing within five days, refer to the Children in Shelter / Foster Care Status section in Chapter 10. CMAT will follow-up their emergency staffing with an initial staffing within thirty days of the referral or the date of the signed CRI and CET forms, whichever is later. If the MFC staff is not available to process the referral for an emergency placement within 48 hours, the CMAT will conduct an emergency staffing as quickly as possible, but no later than five calendar days.

If the CMAT recommends an increase in the Level of Reimbursement that was determined by the MFC Medical Director the effective date of the new Level of Reimbursement is the date of the CMAT staffing. If the CMAT recommends a decrease from the previous Level of Reimbursement, the previous Level of Reimbursement will continue for 10 calendar days during which time the child's biological parents or legal guardian are notified of their right to a fair hearing. For exceptions to this policy, refer to the "When the 10 Day Notice is not Required" section in Chapter 12. If the CMAT determines that MFC is not the most appropriate service or the child does not meet a Level of Reimbursement, the child may be approved to remain for a maximum of 10 days in MFC placement to allow the biological parent or legal guardian to request a fair hearing.

Transition and Discharge Planning

Ideally, discharge planning begins upon admission to the MFC program. Whenever possible, prior to a child leaving the MFC program to reunify with their biological family, or transitioning to a relative, to an adoptive family or other setting, MFC staff will request a CMAT discharge staffing. This staffing will address the child's needs as they enter a new environment, assist in planning any needed transition into the new setting and to determine if any other services may be needed.

It is not always feasible to conduct a discharge staffing. The legal status of some children receiving services from the MFC program may change without advanced notice. If this happens, MFC staff will notify the CMAT of the child's discharge. The CMAT RN or SW will communicate this information to the rest of the CMAT members.

In some cases, biological or adoptive families may choose not to have a discharge staffing. In this instance, the CMAT will abide by their decision and the child will be closed to the CMAT program. Discharge staffings will be offered to all families, whenever it is possible to do so.

**CHAPTER FOURTEEN:
MODEL WAIVER ASSESSMENTS**

DESCRIPTION OF THE SERVICE

The Model Waiver, formerly known as the Katie Beckett Waiver, is a special Medicaid program approved by the Centers for Medicare and Medicaid Services and operated by the Florida Medicaid Home and Community-Based Services office and the Department of Health office of Children's Medical Services. The Economic Self-Sufficiency Program of the Department of Children and Families coordinates the eligibility determination upon receipt of a referral from the Medicaid Home and Community-Based Services office. Services that are offered in the Model Waiver may include in-home care that must not exceed the comparable Medicaid cost for hospital care. The intent of providing services under the Model Waiver Program is to delay or prevent institutionalization and prolonged hospitalization and allow eligible recipients to live at home in the community as opposed to placement in a hospital. Services provided under the Model Waiver Program include assistive technology and service evaluation; environmental accessibility adaptations and respite care.

ELIGIBILITY

The Model Waiver program serves a limited number of children: Pre-application criteria include the following seven elements. The child must:

- be under 21 years of age;
- have a diagnosis of a degenerative spinocerebellar disease which are generally identified in the 330-337 range of ICD9-CM diagnostic classifications;
- meet disability criteria for Social Security Disability;
- have a Level of Care determination of "at risk for hospital placement";
- be able to be maintained safely in the home using home and community based services;
- be cost effective. The total Medicaid cost of care in the home setting must not exceed the comparable aggregated Medicaid cost for hospital care for all Model Waiver recipients; and,
- not be eligible for Medicaid when the income and resources of their parent(s) are considered and would be eligible if the children's own income and resources are within Medicaid limits.

The area Medicaid office will take the lead in initially screening for the Model Waiver Program. If the child currently has Medicaid that makes him / her ineligible, the CMAT cannot staff the child for waiver services.

If it is determined during the screening process that the child is not eligible for the model waiver, it may be appropriate to offer the family a continuity of care staffing to see if the child is in need of other services and to aid in coordination of services.

REFERRALS

Referrals for Model Waiver services will primarily come from the local Medicaid SA RNS or from the AHCA Headquarters Model Waiver consultant. If the referral comes from the AHCA Headquarters Model Waiver consultant, the CMAT staff needs to notify the local Medicaid SA RNS of the referral. Occasionally, a referral may come directly from a child's parent or legal guardian. In these situations, the CMAT staff needs to obtain the child's diagnosis from the parent and determine if the parent has applied for and been denied Medicaid. If the child has a degenerative spinocerebellar diagnosis and Medicaid services have been denied, the child is eligible for a CMAT staffings. The AHCA Headquarters Model Waiver RN consultant and the local Medicaid SA RNS needs to be informed of the referral. If the parents have not applied for Medicaid, refer them to the Department of Children & Families Economic Services office to apply for Medicaid.

INITIAL LEVEL OF CARE DETERMINATION

The CMAT performs the initial Level of Care determination and documents the LOC on the Model Waiver - Notification of Level of Care, AHCA Form 5000-28 (Attachment 21).

The CMAT's LOC determination will verify:

- the individual is at risk for hospitalization, based on the recipient's medical history and current condition,
- the individual is disabled; and
- there is reasonable indication that the recipient may require hospital placement in the absence of home and community based services.

The recipient's primary care physician must indicate that the child is at risk of hospitalization by completing and signing Model Waiver Physician Referral and Request for Level of Care Determination, AHCA Form 5000-25 (Attachment 20). The recipient's CMS nurse care coordinator must complete the Recipient Plan of Care, AHCA Form 5000-27 (Attachment 22).

ANNUAL LEVEL OF CARE DETERMINATION

Level of Care re-determinations will take place every 12 months at a minimum.

CMAT will perform all Level of Care re-determinations and the client's primary care physician must concur with this re-determination. The client's CMS nurse care coordinator must complete and submit the Recipient Plan of Care form to the local Medicaid SA RNS and the AHCA Headquarters Model Waiver consultant every six months.

ASSESSMENTS

Clinical and psychosocial assessment information will be completed by the CMAT in preparation for the staffing. The clinical and psychosocial assessment information should include:

- clinical assessment information must include the child's specific degenerative spinocerebellar diagnosis;
- clinical assessment information must provide sufficient information that the child would be at risk of hospitalization if the home and community based services provided through the Model Waiver program were not provided;
- psychosocial assessment information must include a specific list of requested services and / or current services provided by the Model Waiver program and the family's insurance company. This list should include need for therapies, nursing services, assistive technology and service evaluation, environmental accessibility adaptations to the home and respite care;
- psychosocial assessment information must include a specific evaluation of the client's home that addresses environmental changes that would be considered during the CMAT staffing. This information can only be obtained through a home visit;
- information regarding the outcome of the child's application for Medicaid and the families health insurance; and,
- information regarding third party payers and benefits summaries for commercial health insurance policies particularly benefits summaries regarding hospital inpatient and home health care. Specifically document what services their insurance policy will pay for, including the frequency and duration, and the services that were denied.

ROLE OF THE TEAM

Model Waiver requests for eligible children will be staffed by the CMAT staff for the purpose of providing a pre-screening assessment, Level of Care determination and recommending medically necessary services to assist the office of Medicaid Home and Community-Based Services, Agency for Health Care Administration, in making the final determination of waiver eligibility. The CMAT's determination of Level of Care and recommendation of the duration and frequency of services that are medically necessary is provided to the Area Medicaid office for inclusion in the package of information that is to be sent to the Medicaid Home and Community-Based Services office in Tallahassee. The team's role after a child is enrolled as a recipient of the Model Waiver is to provide an annual Level of Care determination.

Due to the detailed information that needs to be discussed at the CMAT staffing, the child's parents and nurse care coordinator need to participate in the CMAT staffing. It is recommended that the local Medicaid SA nurse also participate in the staffing.

RECOMMENDATIONS

A child's qualification for the Model Waiver Program is determined using hospital placement and Level of Care criteria. CMAT will document a Level of Care determination that verifies that the individual is at risk of hospital placement without the provision of Model Waiver services on the Notification of Level of Care form (Attachment 21) and in the CMAT Staffing Summary.

Additionally, an individualized and specific list of services (assistive technology, environmental accessibility adaptations, nursing services, etc.) that the team determines are medically necessary and are practical must be documented in the CMAT Staffing Summary. The Notification of Level of Care form and CMAT Staffing Summary will be forwarded to the AHCA Headquarters Model Waiver consultant and local Medicaid SA nurse for service authorization.

The child's CMS nurse care coordinator and the AHCA Headquarters Model Waiver consultant will work together to obtain any required estimates for the cost of recommended services and the client's CMS nurse will provide care coordination for services approved by Medicaid.

REQUIRED FORMS

After the staffing has been conducted, the CMAT RN will ensure that the following required forms are provided to the Area Medicaid office:

- Model Waiver Physician Referral and Request for Level of Care Determination form (AHCA Form 5000-25), signed by the recipient's primary care physician (Attachment 20);
- CMAT Staffing Summary Report;
- CMAT Assessment;
- Model Waiver - Notification of Level of Care form (AHCA Form 5000-28) signed by either the CMAT Medical Director, RN, or SW (Attachment 21); and,
- Model Waiver - Recipient Plan of Care (AHCA Form 5000-27) completed by the client's CMS nurse care coordinator (Attachment 22).

**CHAPTER FIFTEEN:
SKILLED NURSING FACILITY SERVICES FOR CHILDREN**

DESCRIPTION OF THE SERVICE

Skilled Nursing Facilities (SNF) provide 24 hour a day nursing, rehabilitative and residential services to residents in order to maintain the highest levels of physical, mental and psychosocial well being. SNF services may be recommended for eligible clients when the CMAT or the family determines that a client's clinical needs can not be met by the family and other authorized nursing services. If the family or the Department of Children and Families / Community Based Care staff do not agree to this recommendation, or if the facility will not accept the child, it is the responsibility of the hospital where the child is residing to arrange alternative services with the legal guardians of the client.

A SNF may also be used for short periods of time when the caregiver is not available to provide the care of the child and the child meets nursing facility criteria. Examples of appropriate use of this service may be surgical recovery or periods of transition from the hospital to home while the caregiver learns the necessary skills to care for the child at home. A medically complex client may be placed in a skilled nursing facility for two weeks two times a year if the caregiver is unavailable to provide the care of the child. These brief stays require a CMAT staffing to determine a Level of Care.

Each skilled nursing facility receives a per diem rate based on the child's Level of Care, which is reassessed at least annually. The per diem rate includes room and board, nursing care, personal care, laundry, stock medical supplies, all therapies, and medically related case management services or social services. Although case management is provided through the facility, children who are Children's Medical Services clients may also receive oversight by a CMS nurse care coordinator. If a Medicaid eligible child does not already have a care coordinator, the necessary care coordination services will be provided by the CMAT RN and SW until another person is identified. When a child is scheduled for an initial or follow-up staffing for skilled nursing facility services, the parent will be informed that they can participate in the staffing in person or via a telephone conference call.

ELIGIBILITY AND REQUIREMENTS FOR SKILLED NURSING FACILITY PLACEMENT

To qualify for placement in a SNF, the applicant or recipient must require 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital. A signed Physician's Referral Form 3008 - Skilled Nursing Facility (Attachment 24), designating the need for nursing facility care is required for skilled nursing facility placement.

Medicaid reimburses SNFs for services provided to residents who have been determined to meet Medicaid Institutional Care Program (ICP) eligibility. It is the CMAT staff's responsibility to inform the client's family / legal guardian that an ICP application must be completed before a child is placed into a nursing care facility. In all cases, in order to receive reimbursement from Medicaid for nursing facility care, the facility must have received written notification from the Department of Children and Families approving the individuals for institutional care benefits.

Eligibility for ICP is determined using program-specific technical, financial and medical eligibility criteria. Applicants under 21 must have a Level of Care determined by the Department of Health, Children's Medical Services, Children's Multidisciplinary Assessment Team.

To officially register an ICP application on behalf of the applicant, the client's representative must file a Request for Assistance form at the Department of Children & Families Economic Self-Sufficiency office.

The CMAT RN or SW is responsible for submitting the following forms to ICP / Medicaid for clients placed in a skilled nursing facility:

- Physician's Referral Form 3008 - Skilled Nursing Facility (Attachment 24);
- Level I PASRR Screen form (Attachment 25);
- CMAT Assessment; and,
- CMAT Staffing Summary Report with recommendation for placement and Level of Care.

PRE-ADMISSION SCREEN AND RESIDENT REVIEW REQUIREMENTS

The federal government requires States to conduct Pre-Admission Screen and Resident Reviews (PASRR) for all residents in Medicaid certified nursing facilities. The purpose of PASRR is to ensure that nursing facility applicants and residents with mental illness or mental retardation are identified and admitted or allowed to remain in a nursing facility only if there is a verified need for nursing facility services. Additionally, if a need for specialized services is determined, federal guidelines require that such services be identified and provided.

The CMAT RN is responsible for submitting the PASRR Reporting Form (Attachment 27) to CMAT Nursing Consultant at the CMS Central Office by January 15 and July 15 of each calendar year.

Pre-Admission Screen for Residents Under Age 21

Pre-admission screen consists of a Level I screening (Attachment 25) to determine if there is a possibility that the client has a mental illness or mental retardation. If either condition is suspected, a referral must be made to the DCF district Substance Abuse and Mental Health Program Office to conduct a Level II evaluation (Attachment 26) for residents with suspected mental illness or related conditions and / or the Agency for Persons with Disabilities Program to conduct a Level II evaluation for residents with suspected mental retardation or related conditions.

CMAT conducts Level I pre-admission screenings for Medicaid-eligible residents under the age of 21 by completing the Level I PASRR Screen form (Attachment 25). The screenings are most frequently completed at the time of the Level of Care determination and must be completed prior to the resident's admission to the skilled nursing facility. An individual is subject to pre-admission screenings only once. All subsequent reviews will be categorized as "resident reviews". Following the directions on the Level I PASRR Screen form, if it is suspected that the client has mental retardation or a mental illness, then CMAT staff will refer the child to the CMS Early Steps (ES) Program (birth to age 3), or to the Agency for Persons with Disabilities (APD) or DCF district Substance Abuse and Mental Health Program (SAMH) (age 3-20), as appropriate, for a Level II screening and document this referral in their ROT. The Physicians

Referral Form 3008 - Skilled Nursing Facility (Attachment 24), can be used to help determine whether the child has been diagnosed for mental retardation or a mental illness but a review of all medical and psychosocial information should be used to determine if it is possible that the client has mental retardation or a mental illness.

When CMAT staff refer a client for a Level II screening, they are responsible for providing written notification (Attachment 28) of this referral to the client and the client's parents or legal guardian. This notification reports that it is suspected that the child may have a mental illness or mental retardation condition and the child is being referred to the State mental health or mental retardation authority for Level II screening.

The SAMH, APD or ES PASRR representatives are required to make specialized services determinations and inform the parent or legal representative, nursing facility, attending physician, discharging hospitals and CMAT, as applicable, in writing of their determination within an average of seven to nine working days of the referral. An individual is permitted admission to a SNF if CMAT determines medical eligibility and if the MI/MR authorities determine that the specialized services, if needed, can be provided in a skilled nursing facility setting.

Residents and applicants with a mental illness or mental retardation condition determined not to require skilled nursing facility care cannot be admitted to a SNF regardless of payment source.

DETERMINING SKILLED NURSING FACILITY LEVEL OF CARE

If CMAT recommends Skilled Nursing Facility services, the following Level of Care determination process must occur:

- Each CMAT staff member will be given a Skilled Nursing Facility - Level of Care Guidelines (Attachment 23) with the criteria for admission, examples of interventions and definitions for each level of care;
- Staff will individually review and determine the Level of Care according to the Level of Care definitions and interventions required to meet the child's needs;
- The staff will then share the results of their ratings; and,
- Staff will review the definitions of the suggested Level of Care to ensure that the level describes the child's medical needs and based upon these definitions, will reach consensus on the Level of Care.

Definitions of the SNF Level of Care

- **Intermediate II** is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall be ambulatory, with or without assistive devices; demonstrate independence in activities of daily living; and not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24 hour nursing supervision.

- **Intermediate I** is extensive health related care and service required by an individual who is incapacitated mentally or physically. To be classified as requiring Intermediate care services, the nursing or rehabilitation services must be ordered and remain under the supervision of a physician, be medically necessary and provided to an applicant whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals; required to be performed under the supervision of licensed professionals; necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant; required on a daily basis; reasonable and necessary to treatment of a specific documented medical disorder, disease or impairment; and consistent with the nature and severity of the individual's condition or disease state or stage.
- **Skilled** is defined as a chronic debilitating disease or condition of one or more physiological or organ systems that generally make the child dependent upon 24-hour a day medical, nursing, or health supervision or intervention. To be classified as requiring skilled nursing or rehabilitative services in the community or in a nursing facility, and must meet the following conditions: the recipient must require the type of medical, nursing or rehabilitative services ordered and remain under the supervision of a physician; be sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse, required to be performed by or under supervision of a registered nurse or other health care professional, required on a daily basis, be reasonable and necessary to the treatment of a specified documented illness or injury; and consistent with the nature and severity of the individual's condition or disease state or stage.
- **Medically Fragile** is defined as a condition where the child is technologically dependent requiring medical apparatus or procedure(s) to sustain life or require significantly more intense and continual professional nursing supervision and intervention to sustain life and who without the provision of such continuous services and observation, is likely to expire. The medically fragile classification is limited to medically complex clients whose age is birth through 20 years old.

ONGOING TEAM RESPONSIBILITIES

Following the initial staffing and placement in a nursing facility, the CMAT will evaluate the client's need for continued placement and determine if the initial Level of Care currently reflects that client's needs 6 months after placement. Follow-up staffings will occur at least **annually** from the initial staffing date unless there is a significant change in the client's clinical status or a requested is made to staff more frequently. The six-month after placement evaluation and the annual staffings will include the completion of the CMAT assessment.

If the facility determines that a resident no longer meets nursing facility eligibility or the current Level of Care, the facility must contact CMAT within two days of this determination and request a review for the continued need for placement in the facility or a Level of Care re-determination.

The initial and annual staffings will be conducted with the CMAT Medical Director, RN and SW. The client and their family can participate in the staffing in person or via a telephone conference call. During the six-month follow-up time period, the CMAT RN will contact the client's CMS nurse care coordinator to determine if there are any changes in clinical status of the child that

could change the child's Level of Care, thus necessitating a six-month follow-up staffing. If there are no significant changes in the child's clinical status from the previous staffing, the CMAT RN will document this in the client's ROT and a six-month follow-up staffing is not required. If a client no longer requires nursing facility services, a transition or discharge staffing will be held as appropriate.

If at any time the team or family becomes concerned regarding the quality of services provided by the nursing facility, the local Agency for Health Care Administration, Health Quality Assurance office, must be notified. If the CMS nurse care coordinator becomes concerned about the care the client is receiving, he or she must advise their supervisor.

RESPONSIBILITIES OF CMAT STAFF AND CARE COORDINATORS

Typically, the CMAT staff will document the clinical and psychosocial assessment information in the initial CMAT assessment. While completing the assessment, it is important to clarify with the family or legal guardian that they want the child to reside and receive services in a nursing facility. The family or legal guardian must be provided information to allow them to consider all of the options and make an informed choice regarding the type of available services and where the services will be received.

When the team recommends nursing facility services, the CMS nurse care coordinator (for children enrolled in the CMS Network), the Department of Children & Families or Community Based Care staff (for children enrolled in the CMS Network for whom the Department of Children and Families is the legal custodian), or the lead care coordinator (for children not currently served in the CMS Network) is responsible for arranging facility placement. If the nursing facility placement will be out of the family's service area, the child's follow-up CMAT staffings, CMS care coordination services and medical records will be transferred to the service area where the child resides.

For out of area placement, the CMS care coordinator must send complete information to the receiving area Nursing Director or their designee, at least 10 days prior to the child's placement in the facility, whenever possible. The CMS nurse care coordinator where the parents / guardian reside will transfer care coordination to their counterparts in the area where the child resides. When parental rights have been terminated for a child residing in a nursing facility in another service area, the nurse care coordinator and the CMAT staff in the area where the child resides will assume full responsibility for the care coordination and staffings of the child.

If the child is a CMS client, the nurse care coordinator will be expected to visit the child once every six-months. During those visits, the nurse care coordinator will review the child's plan of care and progress notes, collaborate with the nursing facility care coordinator to ensure appropriateness of care and maintain contact with the family. The nurse care coordinator will provide updated clinical information to the CMAT RN.

Planning these visits so that they occur prior to the next staffing will allow the CMS nurse care coordinator to provide current information for the assessment process and to respond to any questions that may arise at the staffing. Visits to the family home or legal guardian are not expected. However, contact with the family to discuss their continuing desire for their child to remain in the facility and to determine their level of satisfaction with the placement is required.

Although the CMS nurse care coordinator will be asked to provide input for the assessments, the responsibility for completion of the assessments remains with the CMAT staff. When the caseload allows, an annual visit by the CMAT RN and / or SW to see the child in the facility will provide an opportunity to obtain complete and up-to-date assessment information.

If the care coordinator or nursing facility staff determines that there has been a change in the child's degree of medical needs they will notify the CMAT staff. Upon notification, the CMAT staff will obtain updated clinical and psychosocial assessment information and conduct a CMAT staffing to make a service recommendation and re-determine the Level of Care, if applicable. The effective date of the resultant change is immediate if the team recommends a SNF at the same or a higher Level of Care and 10 calendar days after the CMAT staffing if the team recommends a lower Level of Care or determines that the client is no longer eligible for SNF services. This allows the required 10 calendar days for a request from the individual or their family for a fair hearing as described in the Timelines for requesting a Fair Hearing section in Chapter 12. The nursing facility does not have a right to appeal this determination.

If it is anticipated that the child will be discharged from the nursing facility back to the family home, a visit by a nurse care coordinator to the family home may be necessary to assess the need for services in that setting.

When the client turns 18 years of age, transition planning for the transfer of responsibility to the Comprehensive Assessment Review and Evaluations Services (CARES) Nursing Home Screening / Medical Eligibility Unit located in the district Department of Elder Affairs will occur. Official transfer occurs when the client turns 21 years of age if the individual is to remain in the nursing facility. The CMAT staff will transfer the necessary information to the CARES unit supervisor.

WHEN FACILITY CARE IS NO LONGER APPROPRIATE OR THE FACILITY DISCHARGES A CHILD

When it is no longer appropriate for a child to remain in the nursing facility or the facility wishes to discharge a child, it is the responsibility of the nursing facility and family to find a placement for the child. CMS will provide care coordination for all children who are being transitioned and / or discharged from the nursing / long-term care facility.

If it is necessary to consider alternative placement of a Medicaid or Department of Health sponsored child for any reason, CMAT must be notified so that a staffing can be held to determine how the client's needs could best be met. CMAT is responsible for recommending the appropriate service and Level of Care for the child, if applicable.

The nursing facility is obligated to locate and secure the type of SNF service recommended by the CMAT. All nursing facility residents, including children, are entitled to 30 days written notice prior to any proposed transfer of discharge to the resident as well as notification to the resident's parent or legal guardian. If an appeal is filed within 10 calendar days of the discharge notice, the nursing facility cannot discharge the individual until a final hearing decision has been made.

When a discharge or transfer is initiated by the nursing facility, the administrator of that facility must sign the notice of discharge or transfer. If the notice indicates a medical reason for transfer or discharge, it must be signed by the resident's attending physician or the Medical Director of the facility.

If the resident or representative receives a discharge notice and requests a hearing within ten days of receiving the notice, the facility may not transfer or discharge the resident. Medicaid continues to pay for the resident's care until the hearing decision has been rendered. The resident may also request a review of the notice of transfer or discharge by the local ombudsman.

The Department of Children and Families, Office of Appeals Hearings conducts all hearings. A decision must be rendered within 90 days of the request for a hearing. If the hearing decision is favorable for the resident, and the resident has already been discharged, the facility must re-admit the resident to the first available Medicaid bed.

EMERGENCY DETERMINATIONS DURING A NATURAL DISASTER OR MANDATORY EVACUATION

A child may be considered for temporary placement in a skilled nursing facility for the following reasons:

- when a mandatory evacuation has been issued in the child's geographic area and care in an area emergency shelter is deemed inappropriate due to a child's clinical condition; or,
- a natural or manmade disaster has occurred in the child's geographic area and the family home is no longer considered a safe environment for the child.

The CMAT should be notified by the CMS Care Coordinator or the nursing facility as soon as possible to determine an appropriate Level of Care for Medicaid reimbursement.

The CMAT Medical Director, CMAT RN, SW and the Medicaid SA RNS will conduct an emergency staffing for continuity of care. Every attempt should be made to conduct the staffing prior to the child being temporarily placed in the nursing facility. If the staffing can not be completed prior to placement, it should be completed as soon as possible after the placement. This staffing may be conducted by a telephone conference call. A follow-up staffing is not required unless the client's medical condition changes or the client needs placement beyond the temporary emergency period.

If the client is already receiving CMAT services and the assessment information is current, this assessment information can be used to set a temporary Level of Care. If the child is not an established CMAT client, the CMAT RN has the responsibility to obtain the assessment information required for an emergency staffing to determine the child's Level of Care. The Level of Care is temporary and will only cover the time period required for the child to be safely returned to their home.

<p style="text-align: center;">CHAPTER SIXTEEN: DOCUMENTATION AND ADMINISTRATIVE REQUIREMENTS</p>
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REFERRALS

A CMAT Referral Form (Attachment 5) will be completed for each child referred to CMAT. In addition, every child referred to CMAT will be documented on a Quarterly CMAT Referral Log (Attachment 6) or the CMAT Referral Report. The CMAT Referral Report obtains information from the Summary Staffing Form in the CMAT Staffing Summary. In addition, the CMAT referral date will be documented in the client's Header Form in the emergency or initial CMAT assessment.

CASE MANAGEMENT DATA SYSTEM

Each child referred to CMAT will be entered into the Case Management Data System (CMDS). Entering a child into CMDS will create a record for the child in the electronic medical record. If the child is a CMS client with a Status 20 in the Demographic File, the child must have an open Program Component 26 in the Registration File. If the child is in applicant status with CMS with a Status 10 in the Demographic File, the child must have an open Program Component 26 in the Registration File. If the child is a Non-CMS client, and is only receiving CMAT services from CMS, a demographic record must be entered into the CMDS with Status 20 in the Demographic File and an open Program Component 41 in the Registration File. When a child is discharged from CMAT services, Program Component 26 or 41 will be closed in the Registration File using the appropriate closure code. For any of these processes, complete a PIF for the data entry person or follow the established process for your area office.

SCHEDULING AND DOCUMENTING STAFFINGS

The scheduling of all CMAT staffings will be completed within the timeframes outlined in the Timelines for Staffing section in Chapter 10. Exceptions to the timeframes outlined in Chapter 10 may occur when the child's hospital stay is extended and / or when the parent or foster care staff requests that the scheduling of the staffing be postponed. A ROT note will reflect the specific situation that justifies the delay in scheduling the staffing.

When the parent or legal guardian cannot attend a CMAT staffing, the CMAT staff will implement alternative strategies for involving the family such as telephone conference call, video teleconferencing, or inviting a family member to represent the family. The child's family or legal guardian will be informed of the date, time and location for the CMAT staffing at least two weeks prior to the staffing date and other necessary participants, if applicable, will be invited to the staffing at least 10 calendar days in advance of the staffing. A ROT note will document the staff efforts in inviting the child's family or legal guardian and other necessary participants and to accommodate families when scheduling staffings.

A Quarterly CMAT Staffing Log (Attachment 12) is available for CMAT staff to track the children they staffed. This report will allow the CMAT staff to track service recommendations with service beginning and ending dates.

CLOSURE OF A REFERRAL WITHOUT A STAFFING

In rare instances, a referral source may withdraw a request for a CMAT staffing. For example, a representative of the Department of Children and Families, Community Based Care agency or the Sheriffs Department may refer a child to CMAT for consideration of MFC services and the child is subsequently placed in the home of a relative. In this instance, CMAT staff will ask the referring individual if they would like to have the child referred to CMS to determine if they are eligible for CMS care coordination services. The child will then be discharged from the CMAT through administrative closure.

DISTRIBUTION OF CMAT ASSESSMENT AND CMAT STAFFING SUMMARY REPORT

At the time of staffing, copies of the CMAT assessment will be given the participants in the staffings, including the child's family (unless parental rights have been terminated) or legal guardian, foster parent, all other team members in attendance, to the lead care coordinator and any co-lead care coordinators, as applicable.

For assessments conducted on children in shelter / foster care, all identifying information regarding the foster parents will be omitted from the assessment so that a copy can be sent or given to the biological parent. If the family, legal guardian, foster family or lead care coordinator are unable to attend the staffing, a copy of the assessment will be sent to them within 10 days of the staffing. Assessment information will be provided to team members not in attendance at the staffing, at the request of the team member.

A copy of the CMAT Staffing Summary Report will be sent to the family, care coordinators, any co-lead coordinators, and Medicaid representative within 10 calendar days for Continuity of Care, MFC and MW staffing and 3 working days for SNF staffings. If the child is receiving MFC services, a copy will be sent to the MFC parent and made available to the MFC staff. A copy of the staff summary report may be maintained in the child's CMS record and CMAT administrative file. Any team member may receive a copy of the staffing summary report, upon request.

NOTICE OF RIGHT TO APPEAL

When a child's Medicaid service is denied, suspended, terminated or reduced, the child's parent or legal guardian must be given a notice of their right to appeal at the time of the staffing (Attachment 14). In the event that the family is not present at the staffing, the notice must be mailed to the parent via certified mail and regular mail within one business day of the staffing. For further information regarding the fair hearing process, see Chapter 12 Conflict Resolution, Reconsideration, and Fairing Hearing Process.

TRANSITION OR DISCHARGE FROM A SERVICE

Children served by the CMAT will experience a series of transitions as they move from one service to another or one setting to another. Information gathered through the assessment process and discussions at the time of staffing provides team members with information necessary to provide for a smooth transition of services. Transition and discharge planning will be initiated well in advance of the anticipated discharge. This requires consistent consultations with the lead care coordinator, CMAT members, and staffing participants. Once a transition is

imminent, a transition or discharge staffing will be scheduled to assess, anticipate, and facilitate the child's transition.

CMS MEDICAL RECORD AND CMAT ADMINISTRATIVE FILE

Each child referred to CMAT, including Non-CMS clients, will have one official CMS medical record that will contain all pertinent information, including all CMAT documents, related to that child. The CMAT documents will be filed under a tab labeled CMAT with the most recent date information on top. The child's medical record is a legal document that must be maintained in compliance with the laws regarding medical records and confidentiality.

The CMAT information to be incorporated in the child's CMS medical record must contain the following:

- The signed CRI and CET forms by the parent or the Children and Families / Community Based Care staff for children in the department's custody;
- A dated CMAT Referral Form;
- CMAT Staffing Attendance Form(s);
- the CMAT Medical Director's Review: Denial of a CMAT Staffing form (Attachment 13), if applicable;
- other relevant reports and assessments utilized to help determine a recommendation that were not incorporated into the assessments;
- a copy of the completed Validated Level of Reimbursement Tool for children receiving MFC services;
- each area office will determine if a copy of the client's ROT notes, CMAT assessments and CMAT Staffing Summaries will be placed in the client's CMS medical record;
- copy of the Request for Hearing form;
- copy of notice(s) of right to appeal sent or hand delivered to the client's parent or legal guardian, as applicable when a Medicaid service is suspended, stopped, decreased, or denied;
- other correspondence; and,
- Medicaid eligibility information including the client's Medicaid number.

CMAT staff may maintain a working "client administrative file" for their current CMAT clients. This administrative file may contain copies of all documents needed for the CMAT staff to complete their responsibilities. The CMAT staff will be responsible for forwarding all CMAT related original documents or a copy if they don't have the original, to the appropriate person

(typically the child's assigned care coordinator) for it to be filed in the child's official CMS medical record.

CMAT staff will maintain a programmatic administrative file which will contain the quarterly referral log or monthly referral report; quarterly staffing log, if used; and validated Level of Reimbursement training log.

RECORDS MANAGEMENT

The maintenance, disposal, transfer, and storage of public records is regulated by Florida Statutes and Code of Federal Regulations. The CMAT RN and SW will be responsible for the maintenance of all client CMAT documentation, the maintenance of all data regarding team staffings, referrals, placements, and other data on staffings and their results.

CMAT administrative files will be "thinned" on an ongoing basis. Staff will remove all CMAT specific forms that are over one year old. The entire administrative file will be destroyed after the child is discharged from CMAT.

PASRR REPORTING REQUIREMENTS

Pre-Admission Screen and Resident Reviews (PASRR) federal reporting is required for all clients under the age of 21 years placed in a skilled nursing facility or resided in a skilled nursing facility for any portion of the reporting period. An individual PASRR Reporting Form (Attachment 27) must be completed for each client and are due to the program office by July 15th and January 15th of each fiscal year. The individual PASRR Reporting Forms may be faxed or emailed, using encryption, to the CMAT Nursing Consultant.

DOCUMENTATION OF CMAT ACTIVITIES

The documentation of all CMAT related activities, including assessments, staffing summaries and ROT notes, will be completed in the client's electronic medical record. ROT documentation will include the following activities:

- documentation of the CMAT RN and SW's contacts with the child, family and programs or agencies involved, and any changes in the child's status must be documented in a timely fashion;
- documentation of the discussion of scheduling and final date for staffings with the child's biological parents, unless contraindicated, and to the Department of Children & Families / Community Based Care staff or Agency for Persons with Disabilities staff, if appropriate; and,
- documentation of the CMAT Medical Director's activities which may include consulting with the child's primary or specialty physician; visits to see the child; providing medical consultation to the family, the lead care coordinator or others involved with the child.

Programmatic data for each child may be done by completing the Summary Form. This form is located in the CMAT Staffing Summary in the electronic medical record and is obtained by

selecting Summary in the CMAT Staffing Type drop down box. The information documented in the Summary can be used by the area offices in collection their data for the CMAT Goals and Performance Measures (see Chapter 20).

<p style="text-align: center;">CHAPTER SEVENTEEN: DATA COLLECTION AND ANALYSIS</p>

AREA OFFICE DATA COLLECTION ACTIVITIES

The CMS Area Offices are responsible for collecting the data to determine their achievement in obtaining the standards outlined in the most recent CMAT Goals and Performance Measures*. The area office will use the CMAT Data Collection Tool* to collect, analyze and report this data. The Area Office Nursing Director will determine who is responsible, typically the CMAT supervisor, for collecting the CMAT data on an ongoing basis throughout the quarter. The CMAT RN and SW will not be responsible for collecting the data for the CMAT program. The CMAT data collection process will consist of reviewing CMAT programmatic reports and client information documented in the electronic medical record, CMAT administrative forms, and observing CMAT staffings as outlined in the CMAT data collection tool. The Area Offices will be responsible submitting their data to the CMS Central Office CMAT Consultants by the due dates provided by Central Office staff.

The CMAT Nursing Supervisor will randomly select the required sample size each quarter for the data collection activity. This sample will include new CMAT referrals referred during the quarter, current CMAT clients that had a staffing during the quarter and clients that were discharged from CMAT during the quarter. Data will be collected for each performance measure indicator activity that applied to the client during the quarter. If the indicator activity did not occur for the child during the quarter, the indicator would be documented with an NA. The data will be collected on an ongoing basis as the indicator activity occurs. For example, when a selected client's CMAT staffing occurs, the individual collecting the data will complete the CMAT Data Collection tool for the indicators that address the CMAT staffing and the CMAT assessment that was conducted for that staffing. This will allow teams to identify potential problem areas early in the quarter which will enable them to make adjustments to improve their outcome. The instructions for using the CMAT Data Collection Tool will be provided to appropriate staff by the CMS Central Office CMAT consultant.

* The CMAT Goals and Performance Measures and the CMAT Data Collection Tool, including instructions, were not included in this operation plan due to the evolving nature of these documents and will be provided to each area office by the CMS Central Office CMAT Consultants.

AREA OFFICE ANALYSIS ACTIVITIES

The CMAT Nursing Supervisor, RN and SW are responsible for analyzing the data collected on an ongoing basis, as it is collected and after the data is compiled for submission to the CMAT Consultants. This analysis will examine if the team is meeting the standard and if there are areas for improvement for each indicator. For all indicators that are 5% points below the indicator standard, a Continuous Quality Improvement Plan* (CQIP) is required. The purpose of the Continuous Quality Improvement Plan is to facilitate continuous quality improvement by documenting the problematic areas and identifying if the root cause is a process problem or other causative factors, the determination of a corrective action plan and evaluation of the implementation plan. The instructions for using the CQIP will be provided to appropriate staff by

the CMS Central Office CMAT consultant. The due dates for the CQIP are documented in the CQIP instructions and the CQIP format must follow the procedures identified in the instructions.

* The CQIP format will be provided to the area offices by the CMS Central Office staff.

CMS CENTRAL OFFICE VALIDATION REVIEW AND TECHNICAL ASSISTANCE

Each CMAT will receive a validation review from the CMAT consultants on an annual basis. This review will consist of validating the results obtained from the area office quarterly data collection activity. This review may take the form of an on-site visit or via a desk review. CMAT area offices receiving a desk review will be required to send requested information to the CMAT consultants for review.

The CMAT consultants will collect data on the client's files that were reviewed by the area office during their quarterly data collection to validate the results that they obtained. The CMAT consultants will review the client's electronic medical record, CMAT administrative documents and interview the staff. When possible, the CMAT consultants will observe a CMAT staffing to determine if the data collected is consistent to the data reported by the area office. Observation of staffing may be accomplished either on-site or through video teleconference technology. Regardless of whether the review is an on-site or desk review, the consultants will use the most current CMAT Goal and Performance Measure Data Collection Tool to collect the data.

The CMAT consultants are responsible for providing technical assistance to each area office when the results of the area office data collection activity do not match the results obtained by the CMAT consultants. The purpose of this technical assistance is to ensure consistent statewide implementation of the CMAT program and data collection activity. The CMAT consultants will also review the CQIPs that are submitted by the area office and provide any needed assistance to help the area office improve the performance in a performance measure that is below the standard. Additional technical assistance on the implementation of the CMAT program will be provided to the area offices on an ongoing basis through e-mail and telephone correspondence and office visits, if requested by the area office.

The CMAT consultants will provide each CMS Area Office a written report on their findings in the validation review and any technical assistance provided as a result of the validation review. A hard copy of the CMAT report will be sent to the CMAT Medical Director. A copy of the report will be electronically submitted to the CMS Area Office Medical Director, CMS Area Office Nursing Director, CMS Regional Nursing Director, and the CMS Regional Medical Director. It is the responsibility of the CMS Area Office Nursing Director to insure that the CMAT RN and SW receive a copy of the report. It is the responsibility of the CMS Nursing Director to distribute the results of the CMAT review to the Office of Family Safety District Administrator, and the Medicaid Area Field Office Manager.

**CHAPTER EIGHTEEN:
CMS MANAGED CARE SERVICES**

DESCRIPTION OF THE SERVICE

Children's Medical Services (CMS) Network is a statewide managed care system that provides or contracts to provide health services to eligible children with special needs. The CMS Network ensures that children with chronic conditions are provided quality, comprehensive care to meet their unique needs. CMS Network has contracted with integrated care systems (ICS) to act as CMS provider service networks within specified geographic regions of the State.

ELIGIBILITY

All CMS client with a chronic condition or illness and a physician's order for high cost, high volume, high risk or low volume services are eligible for a CMAT staffing.

REFERRALS

CMS integrated care systems (ICS) and CMS care coordinators may refer CMS clients who are receiving or have a physician's order for a high cost, high volume, high risk or low volume services for CMAT review. The Regional Nursing Director will make the determination if the CMAT staff has sufficient time to conduct these staffings, as the CMAT staff's primary responsibility is to conduct CMAT staffings for the Medicaid services that require a CMAT staffing. If the decision is made that the CMAT staff does not have sufficient time to conduct a CMAT staffing, the individual requesting the staffing will be notified of this decision, a ROT note will be completed to document this notification and the referral will be closed.

RESPONSIBILITIES OF CMAT STAFF

The CMAT Medical Director, RN and SW are responsible for conducting a CMAT staffing to make a medical necessity recommendation for all ICS referred CMS clients that the Regional Nursing director authorized the team to staff. The CMAT staff is responsible for completing the client's up-to-date CMAT assessment and obtaining the client's medical records, as needed, to enable the CMAT staff to make a medically necessary recommendation. After the staffing, the CMAT staff will complete the CMAT Staffing Summary and forward a copy of this report to the referring individual. See chapter 11 for details on the staffing process.

RECOMMENDATIONS

Based upon review of the client's assessment information and discussion at the CMAT staffing, the CMAT will make a recommendation on whether or not the high cost, high volume, high risk or low volume services are medically necessary as ordered, the frequency or duration of the service should remain as ordered or be decreased or increased, recommend a less costly but equally effective service, or request additional information prior to make a recommendation.

Depending on the nature of the service, the team may determine that no follow-up staffing is required. If the team determines that a follow-up staffing would be beneficial, the team will

determine the duration of the recommendation and conduct a follow-up staffing prior to the end of the recommendation time period.

Attachments