Utilization Management Plan

2024-2025

Family Partnerships of Central Florida

Protecting Children, Strengthening Families, Changing Lives.

INTRODUCTION

Utilization Management (UM) ***n*** **1.** defined as a utilization analysis **2.** is a plan to track critical components of service utilization, approve services in a timely manner and monitor utilization with fiscal oversight.

FAMILY PARTNERSHIPS OF CENTRAL FLORIDA'S APPROACH

Utilization management (UM) is the foundation of Family Partnerships of Central Florida's (FPOCF) system of care. It is the process of coordinating, authorizing and monitoring services and placement for children and families on a continuum of care, from entry to exit. The process ensures a seamless service delivery system that maximizes resources, mitigates fragmentation and duplication, and builds upon natural supports to strengthen and sustain families long term.

The utilization review process involves ongoing communication and teamwork between and among clinical service and behavioral health coordinators, behavioral health specialists, case managers, multidisciplinary team (MDT) coordinators, family team conference members, attending members, and network and third-party providers. The type of service delivered determines the frequency of internal reviews.

DEFINITIONS

Multidisciplinary Team (MDT) Staffings

FPOCF implemented MDT staffings to ensure all voices within the team are heard and input is provided regarding decisions made about the children and families we serve.

This process is family-focused to help minimize the trauma children in care can experience from placement changes, educational needs, separation of siblings, and other factors. It is designed to ensure timely intervention in the least intrusive manner.

The MDT process is collaborative and involves shared input from all team members, including but not limited to, the child (as age appropriate), foster parents, caregivers, providers and others who play significant roles in a child's life. The MDT staffing is facilitated by MDT coordinators — trained, strength-based, family-focused facilitators — who use a proactive approach to ensure the best outcomes for our children.

MDTs are required for the following:

- Any change of placement — emergency or planned
- Separation of siblings
- Human trafficking incidents
- Educational transitions
- Reunifications
- Emergency staffings
- Reinstatement of parental rights

During the MDT, the team completes a comprehensive clinical review to assess the current placement needs for children as identified and ensure adequate services and support based on a review of progress notes, provider feedback and information provided.

Family Team Conferencing (FTC)

The family team conference is part of the wraparound process, which holistically brings people together from different areas of the family's life. With help from a care coordinator, people who serve as resources within the family (natural supports) work together, coordinate activities and blend their perspectives of the family's situation to create desired change and help strengthen children, families and communities.

This family-centered approach empowers the family to decide when they would like to schedule their FTC meetings — as often as weekly or as infrequently as every 90 days. Life circumstances occur outside of the FTC, and family members might decide they want to hold an unscheduled FTC. The family and team members can determine at any time that an FTC is needed to discuss new circumstances or information that warrants additional planning.

And to ensure voice and choice, the family is encouraged to actively participate in making decisions about services and supports based on the family needs, including what services have been tried in the past, expected results of services and supports, how the design of the services and supports utilized meet their needs, how services will be delivered, expected duration of services, possible alternatives for services, and how services will be evaluated, as well any other information requested by the family.

The FTC includes family members, friends, care managers and other members of the community who may have a relationship with the family, such as teachers, clergy and coaches. This team is created to provide the family with the necessary support to ensure the ownership and success of their care plan.

UM Guidelines

The UM process links children and families with the appropriate level of service within the following service guidelines. Services are:

- Customized to meet identified needs.
- Delivered in the least restrictive placement possible.
- Family-centered, youth-driven and consumer-focused.
- Community-based and as close to home as possible.
- Culturally sensitive and competent.

Integrated UM

UM has been integrated into each aspect of the system of care to ensure services are flexible, responsive and customized to the needs of the children and family.

The out-of-home care manager monitors placement decisions and the use of crisis intervention services daily to ensure appropriate services are in place. If crisis services are initiated, the out-of-home care specialist requests an MDT for follow-up and continuity of service provisions. The FTC or MDT staffing reviews the appropriateness and effectiveness of services being delivered for ongoing authorization. This is also reviewed as part of the quarterly case record review and other quality assurance reviews. The following questions are addressed during these reviews:

- Have the conditions requiring intervention been reduced or eliminated?
- Is the child thriving in the current placement?
- When formal therapy is being provided, have treatment goals been met?
- Is the initial permanency plan still appropriate?

FPOCF conducts a monthly review of the operational and financial performance of purchased services. This review also includes a performance review of the FPOCF contracted providers and eligibility to monitor funds to serve the population. The FPOCF management and leadership team continuously monitors these processes to ensure that the intended results are achieved.

CORE COMPONENTS

Type	Review	Management
Prospective (Prior to interventions/ treatment/ service)	**Prospective Review** Review of assessments and evaluations	**Prior Authorization** Prior authorization of service based on need and appropriateness of care conducted by the out-of-home care specialists at time of initial referral and by clinical services coordinators after development and any revision of case plans
Concurrent (During interventions/treatment/ service)	**Concurrent Review** • Review progress reports, treatment/service plan reviews • Review high utilization patterns	**Re-authorization** Level of care and step-down reviews/staffing with clinical services coordinators and case management agencies **High Intensity Reviews** MDT review of high utilizers and placements with an extended length of stay (exceeding the targets)
Retrospective (After interventions/ treatment/service)	**Retrospective Review** Review sample of case record – entry to discharge	**Program Integrity Reviews** Did the services provided have adequate documentation? **Quality of Care Reviews** Were services provided appropriate? **Best Practice Reviews** What were the results of the interventions?

SERVICE UTILIZATION AND AUTHORIZATION

The clinical services coordinators authorize services agreed upon at the FTC, standing team conference or MDT and advise the providers of the duration, frequency and specific needs of the consumer.

The clinical services coordinators notify providers of the schedule for the upcoming utilization review, which should occur minimally prior to the completion of a second 12-week authorization period for ongoing services. The family team or MDT may identify the appropriate provider, who is contacted by the clinical services coordinator and/or an assigned member of the family team to initiate services. The clinical services coordinator then submits an authorization form to the provider through the UM system.

The clinical services coordinator reviews all service requests within three business days of receipt from the care manager. MDT staffings are held for youth who display high behavioral or

emotional needs, are in high-end placements or are at risk of disrupting their placements, as well as youth funded through Substance Abuse and Mental Health (SAMH) funds.

The clinical services coordinator maintains the database of all authorizations through Mindshare. This ensures that the team has knowledge of real-time service availability and activity. Each network provider submits a monthly invoice to the FPOCF designated staff member through the utilization review system, detailing units actualized for all authorizations. If there is under-utilization for services authorized weekly, authorizations for those sessions will no longer be available and will be deleted in Argos and Mindshare to allow those dollars to be made available for future authorizations. Each FPOCF contracted provider is required to make and report on community linkages secured on behalf of the family. It is critical that providers create community linkages to support and sustain the child and family beyond discharge.

Referrals made to third-party reimbursable partner agencies are tracked in Mindshare by the clinical services coordinator and reviewed and reported monthly to monitor partner agencies receiving third-party referrals from FPOCF and oversee trends associated with service delivery.

Service Authorization Procedure

The initial service authorization and re-authorization occur through Argos and Mindshare, web-based, interactive databases. Within these systems, the clinical services coordinator authorizes a service, with duration and frequency of service dictated by unit of service delivery. The service authorization is electronically submitted to the provider through this automated system, which provides confirmation that the provider received the service authorization.

Services are started no later than one to two days from the authorization date. After initial contact is made by the provider, progress notes are entered into Mindshare and Argos and monitoring takes place through the receipt and review of provider progress reports, contacts and participation in the family team or MDT process. Within the first two weeks of service delivery, the service provider verifies that the service is appropriate. If there are any complaints or challenges identified in service delivery or with the child and family served, every effort is made for expeditious resolution at the lowest level possible.

FPOCF clinical services coordinators tailor the type and frequency of services according to the family's need, level of acuity, risk and intensity of service provision required. Flexible resources and the use of in-home supports are inclusive of the following:

1. In home support services are offered on a continuum service array to meet the evolving needs of families in complex situations. These support services are designed to assist families in times of stress or acute crisis.
2. Clinical services coordinators use a range of supportive and therapeutic services that are customized and individualized to the unique culture and strengths of a child and/or family.

3. In-home services are designed to alleviate family stress and address child safety risk factors, promote parental competence and protective capacities, and enable families to access resources and natural support networks to achieve long-term sustainability.
4. In-home services are family-focused, community- and home-based, and designed to support families to alleviate crises that may lead to out-of-home placement for children.
5. Families receiving in-home support services may be birth families, pre-adoptive families or relative, non-relative and fictive kin caregiver families. The goals of these family-focused services are to:

    a. Maintain children safely in their own home.
    b. Support and strengthen the family unit for family preservation.
    c. Assist families in obtaining services and support in a culturally sensitive manner.
    d. Maintain or stabilize placements.
    e. Create natural supports and linkages that will sustain the family upon discharge.

6. All referrals for in-home support services are made through the clinical services coordinator, who prioritizes the referrals based on need, availability of the service and funding source. Any service that has been court-ordered is reviewed for clinical necessity and authorized. If the service is not clinically indicated, the clinical services coordinator discusses with the case manager the next steps to engage all parties and apprise the court accordingly (in conjunction with Children's Legal Services). The chief legal officer also assists with issues that need to be discussed with the judiciary in Circuits 9 and 18.

Eligibility for In-home Support Services (all criteria must be met)

1. The case manager making the referral to the clinical services coordinator must have discussed the support services with the family, and at least one parent or other primary care giver must indicate that he or she is willing and able to participate. Families are given the opportunity to have a voice and choice regarding the providers to which they are referred.
2. When a service is requested, there should be a reasonable likelihood the service will result in the expected outcome so the family will benefit from the service.
3. Families have the capacity to participate and are expected to benefit from community or home-based services.
4. Without provision of the service, the child is at risk of removal/placement disruption.
5. Alternate, less intensive intervention strategies have been tried without success or were considered but determined not to be in the best interest of the family or child/adolescent.

Continued Review of Criteria

1. At each family team meeting or MDT, service provision is reassessed and at any critical juncture (defined as a major change in the individual or family status). Since this process is ongoing, it continues throughout the duration of service delivery.
2. In-home support services are authorized in increments not to exceed 12 weeks per authorization. This ensures that the services are tailored to meet the current and emerging needs of families.
3. Agreement of the FTC or MDT team members may extend the service duration.
4. Reviews are held at a minimum of every 12 weeks to review service delivery prior to the subsequent authorization period.
5. There are measurable goals and outcomes outlined to the provider.
6. On an ongoing basis and at a minimum of monthly, the clinical services coordinator and case manager review and assess service plan implementation, the family's progress toward achieving goals, desired outcomes, and the continuing appropriateness of service goals.

Termination of Service Criteria

1. The child and/or family's documented goals and objectives have been met.
2. The child and/or family are not making progress toward the initially stated goals and there is no reasonable expectation of progress.
3. The child and/or family, guardian, and/or custodian are not vested in achieving the stated goals, despite the provider's attempts to address noncompliance issues.
4. The provider is not successfully engaged with the family in the process.

Clinical Services Coordinators, Case Managers and In-Home Support Services Provider Roles

1. Clinical services coordinators, case managers and providers always treat families with dignity and respect while coordinating visits to the home. Barriers to successful engagement are considered and responded to. The assigned case manager and family regularly review progress toward achieving goals and desired outcomes and discuss the continued appropriateness of service goals.
2. Service providers exercise vigilance in observing children, ensuring they are seen as often as indicated on the service referral, that they are free of injury and that the home appears free of hazards. Service providers also identify safety risk factors and document the outcome of interactions in the Argos or Mindshare system. Providers are mandatory reporters — required to file a child abuse report when abuse is observed or reported to them, in accordance with Florida Statute 39.201's mandatory reporting laws.

Referral for Services

FPOCF adheres to the principles of wraparound in all aspects of engagement and interaction with children and families served. Not every child may be actively engaged in the wraparound process; however, through the clinical services coordinators, case managers and utilization of the Argos and Mindshare referral systems, the team monitors the services the family receives and reviews notes that have been entered by the provider.

The clinical and/or UM team attends the initial case transfer staffing to review the child and family strengths and offers insight and recommendations regarding services to ensure strength- and needs-based planning are taking place. Clinical services coordinators refer children and their families for appropriate services based on individual needs. These referrals are based on professional and ethical determinations of the family's needs and include the family's voice and choice to every extent possible.

1. Referrals for services occur as a direct result of recommendations made within an MDT staffing or FTC.
2. If a child or family member has Medicaid, the clinical services coordinator will identify a provider that bills the insurers directly. The coordinator will ask the identified case manager to ascertain if a child or adult has Medicaid. All referrals for services are checked by the designated staff member to determine their Medicaid coverage. All referrals for Medicaid-funded services are tracked. If a child or family member does not have Medicaid and a referral is made to a provider, the service is provided through purchased services. In cases of substance abuse treatment or batterer's intervention programs, the client may be responsible for full or partial payment.
3. The clinical services coordinator monitors all referrals to ensure the family is receiving the service as authorized and maintains regular communication with the provider to assess the family's participation and progress made regarding the service delivered.
4. In cases requiring transition of services, every effort will be made to ensure the service being transitioned is linked to a new provider of the same clinical orientation and expertise with cultural competence.
5. As part of the continuous quality improvement process, clinical services coordinators ask families to rate their satisfaction with the service referral process, including availability of appropriate services and information regarding how helpful the services were/are to the family as part of the FTC process.
6. If a child enters licensed out-of-home care (LOHC) and requires enhanced placement and supports immediately, the bypass referral process can be utilized. If a child enters LOHC and requires enhancement and supports, bypass referrals to all appropriate and available services must be completed within three business days of placement. This may include, but is not limited to, mentor or behavior buddy support to maintain supervision and safety. The out-of-home care specialist coordinates and discusses with the clinical services coordinators to ensure appropriate services are identified. Upon determination that a service is warranted, the case manager submits the request to the clinical services coordinator to complete the service request in Mindshare.

Flex Support Provider

After receiving the service request, the provider assigns the appropriate personnel and initiates services. Services authorized are based on the identified needs of the family and focus on the identified tasks within the care plan and/or case plan goals. The provider must contact the clinical services coordinator to update the care plan. This modification will be completed following consultation with the clinical services coordinators or behavioral health coordinators at the MDT and the care coordinator at the FTC.

Weekly/Monthly Reports

The provider completes a weekly progress report in the utilization review system for the identified family, unless the provider's contract calls for monthly submission of reports.

Over-Utilization

If the provider encounters a crisis that warrants immediate utilization above the current authorized number of units, the provider will address the crisis. Immediately following the crisis (within 24 hours), the provider will provide a written request for additional units to the clinical services coordinator, including a summary of the crisis for review of the request.

Informal Supports

During the provision of services, the provider will work with the family to link them to informal resources within the community to continue supporting the family following closure. This work should occur each time the provider meets with the family and must be documented in the weekly/monthly note. This is a critical piece in developing long-term family sustainability and for families to remain free of formal system involvement.

Utilization Review, FTC, MDT Staffings

During on-going MDT staffing or FTC, the clinical services coordinator, provider, family and team members meet to review progress. At that time, the team determines if services will be re-authorized, terminated or modified. This step is critical to ensure that services are appropriate and clinically indicated.

Other Processes to Identify Referrals for Services

The Comprehensive Behavioral Health Assessment (CBHA), an in-depth and detailed assessment of children in the child welfare system who enter out-of-home care placement, can be utilized for early engagement in services. The child's social, emotional, behavioral and developmental functioning is evaluated, as well as needs and strengths. A CBHA referral is completed for any child who is a victim of abuse, neglect and abandonment. Once the assessment is completed, the behavioral health coordinator (and/or clinical services coordinator) provides the completed CBHA recommendations and concerns for the child to the clinical services coordinator, case manager, case manager supervisor and Guardian Ad Litem (GAL) program. The behavioral health coordinator (and/or clinical services coordinator) conducts staffings with the case manager and GAL biweekly to ensure all CBHAs are reviewed,

and all recommendations are followed. The behavioral health coordinator (and/or clinical services coordinator) assesses services to ensure they are meeting the needs of the child and determines if the case needs to be escalated or flagged for a high-end MDT.

RETROSPECTIVE UTILIZATION REVIEW

A retrospective utilization review (UR) occurs, at minimum, prior to the completion of a second 12-week authorization or, at minimum, every quarter as part of the UR process completed by clinical services coordinators. This review is used to evaluate the effectiveness of services used by diverse groups of children and families and recommend changes based on findings. The clinical services coordinators share responsibility for conducting the retrospective review.

Elements of the discharge and retrospective reviews include evidence that:

- Services delivered were clinically indicated.
- Clients benefited as expected from services.
- Discharges and after-care planning were initiated early in the case.
- Progress toward discharge was regularly documented.
- The discharge summary reflects the child's and family's condition at time of discharge.
- The discharge summary reflects adequate after-care support, with transition planning and linkages to community resources as necessary and appropriate.

In addition to the URs, a review of cases that required multiple services and/or services that were provided over an extended time should also occur at minimum of every 90 days. This type of review includes the clinical services coordinator, case manager and service providers. This team is also responsible for reviewing cases of high service utilization, considering utilization data, progress notes, CBHAs, psychological or psychiatric reports, and other factors, to recommend and implement changes in services as needed.

The Mobile Response Team (MRT) is available 24 hours per day, seven days a week through FPOCF, CARES and Devereux. All case management agencies are also on-call 24 hours a day, seven days a week for assistance. In addition, families can contact 211 for additional referrals and service-related issues. All services and program referrals are conducted with the intent of providing the least restrictive and most appropriate service that meets the needs and preferences of the child and family being served. MRT is coordinated through 211 for the tri-counties.

If a care manager determines there is an immediate need for a service authorization and no time to schedule an FTC or MDT staffing, the care manager may request the authorization from the clinical services coordinator at the earliest point possible after identifying the need.

AUTHORIZATION THRESHOLDS

Clinical services coordinators cannot authorize any amount that exceeds one-twelfth of the total monthly annual budget allocation based on an average of a 60% utilization from the funding sources of family support, family preservation, time-limited reunification, other client services and 100/806 Diagnostic and Evaluation Funds (for non-Medicaid funded children service). It should also be noted that funding through other client services is a funding of last resort. Any request that exceeds this threshold must be approved by the placement and behavioral health administrator or designee.

LICENSED AND NON-LICENSED PLACEMENTS

Children entering licensed out-of-home care must be placed within four hours of completion of the Comprehensive Placement Assessment. When the child protective investigator (CPI) has determined the child must be removed from his/her home and there is no immediate or appropriate relative or non-relative caregiver available for placement, the CPI requests placement services and supports from FPOCF out-of-home placement specialists (during both normal business hours and after hours through an on-call line for placement identification after the removal episode).

The out-of-home placement specialists and/or behavioral health coordinators provide authorizations for all licensed placements. These decisions are based on placement protocols and service guidelines to ensure that children are placed appropriately. All enhanced placement requests, including double bed rates, one-to-one service and others, must be approved by a senior director or other designee.

For each child in out-of-home care placement and each child and family receiving services, the appropriateness of the placement and services are reviewed at the FTC or MDT staffings, as well as internally through the UM process. The objective of the utilization review is to ensure optimal quality care in the most effective manner through appropriate allocation of system of care resources. The necessity of services and overall utilization of all services is reviewed on an ongoing basis through a variety of mechanisms.

HIGH-END MULTI-DISCIPLINARY TEAM MEETINGS (HLOC MDTS)

These involve the review of children in licensed out-of-home care to determine the need for both an increased and decreased (step-down) level of care. Recommendations are based on medical-necessity criteria and are intended to provide guidance for other service options if specialized therapeutic foster care (STFC), specialized therapeutic group home (STGH) care, qualified residential treatment program (QRTP) and/or sub-acute inpatient psychiatric program (SIPP) are not recommended. These children must be under the jurisdiction of Brevard, Orange, Osceola or Seminole County.

The core team members who participate in the HLOC MDT include, but are not limited to, behavioral health coordinator or designee, out-of-home care specialist, nurse care manager, mental health targeted case manager if assigned, therapist if assigned, dependency care manger, and the Sunshine Health Plan representative if applicable. Staffings are held within 60 days from being placed and every 90 days thereafter for children who are in STFC, QRTP, STGC or SIPP levels of care. Requests for HLOC MDTs are submitted to the behavioral health coordinator or designee.

If the Qualified Evaluator (QE) determines the child needs treatment in a residential treatment center upon completion of a suitability assessment, and the decision to place is made in accordance with this recommendation, the assigned child welfare professional will immediately notify Children's Legal Services (CLS).

1. Upon notification, the CLS attorney files a motion for placement of the child with the court and notifies the child's GAL, attorney and all other parties.
2. This motion includes a statement explaining why the child is suitable for this placement, why less restrictive alternatives are not appropriate, the goals of treatment and the written findings of the QE. This motion also states whether all parties, including the child, agree with the decision.
3. CLS ensures that the court sets the matter for a status hearing within 48 hours, excluding weekends and holidays, and provides timely notice of the date, time and place of the hearing to all parties and participants, except the child, who will be notified of the date, time and place of the hearing by his or her attorney or GAL.
4. If, at the status hearing, any party disagrees with the recommended placement, the matter will be heard by the court within 10 business days.
5. If the motion to place the child into residential treatment is approved by the court, the assigned child welfare professional, FPOCF out-of-home care staff, will coordinate placement of the child in accordance with local protocol.

Any child requiring placement in an STFC Level I or Level II is reviewed and approved by the HLOC MDT to determine medical necessity criteria, including admission criteria. Children in these placements are reviewed at a minimum every 30 days to determine ongoing medical necessity criteria (continuing-stay criteria). The HLOC MDT assesses whether the child requires STFC or less intensive services. Once approved the behavioral health coordinator collaborates with the identified provider to obtain authorization for funding.

ACTIVITIES AND PURPOSE

Utilization Management Activity	Purpose
Quarterly Quality Service Review	Review the appropriateness and effectiveness of services delivered.
Monthly Review of Purchased Services	Review operational and financial/fiscal performance of purchased services.
High Utilization Services Reviews	Review families with multiple services, services provided for extended period and costly service delivery.
Submit Service Requests from CMA Within Three Days of Receipt	Ensure services are clinically appropriate and prioritize service referrals based on need, availability of service and funding source. If court ordered authorize immediately
Prospective Utilization Review	Prior to authorization of service, based on need and appropriateness at time of initial referral, and after development and any revision of case plans.
Concurrent Utilization Review	Prior to reauthorization of service to review progress reports, treatment plans and high utilization patterns.
Retrospective Utilization Review	After interventions/treatment and services. Ensures clinical integrity to evaluate quality of service and best practice reviews, asking: Did services provided have adequate documentation? Were services provided appropriate? What were the results of the interventions? Review occurs minimally prior to second 12-week authorization.
Track Medicaid Funded Referrals	Referrals made to third-party reimbursable partner agencies are tracked in Mindshare; reviewed and reported monthly to monitor partner agencies receiving third-party referrals from FPOCF and to oversee trends associated with service delivery.
Collaborative Review of Service Delivery	On an ongoing basis and at a minimum of monthly, the clinical services coordinator and behavioral health specialist review and assess service plan implementation, family's progress toward achieving goals, desired outcomes, and the continuing appropriateness of service goals.
Distribute the CBHA, Recommendations and Concerns for the Child to the CCC, CM, CMS and GAL Program	The behavioral health coordinator conducts staffing with the CM and GAL biweekly to ensure all CBHAs are reviewed and all recommendations are being followed. The behavioral health coordinator consults with the clinical services coordinators to assess services to ensure they are meeting the needs of the child and/or if the case needs to be escalated or flagged for a high-end MDT

Distribute Satisfaction Survey to Families	As part of the continuous quality improvement process, families rate their satisfaction with the service referral process, including availability of appropriate services and information regarding how helpful the services were/are to the family
High Utilization Placement Review	Any child with a double rate or daily rate standard exceeding the high utilization threshold is reviewed every 30 days to evaluate if the level of care is still required, ensure appropriate services are in place to help support and stabilize child, and determine when to step down to least restrictive level indicated based on treatment plan.
Enhanced Service Provision for Children Entering LOHC Who Require Enhancement and Supports for Stabilization.	Coordinate service provision and discuss with clinical services coordinator to ensure appropriate services are identified and authorized. Engage licensed placement.
Trauma Screening After a Child's Removal from Home Within 21 Days of Removal	FPOCF and DCF CPIs complete trauma screening using the Pediatric ACES and Related Life Screener (PEARLS). As indicated appropriate and necessary by the screening, refer the child to services and interventions.
Daily OOHC Meeting	Daily huddle of the OOHC team to assess needs, discuss upcoming placement moves, assign tasks and evaluate any on-call placements, including disruptions and unplanned moves that occurred the day prior. In addition, the OOHC manager reviews ongoing tasks, assigns a champion for children as needed and ensures communication occurs with the behavioral health team as needed for service implementation.
Monthly Licensing Meeting	The director of licensing facilitates a meeting that includes all licensing staff, out-of-home care and behavioral health team members. This forum provides the opportunity to discuss any needs in the home, review homes that may need additional support due to the behaviors being displayed in the home, discussion of overcapacity waivers, and homes on hold.
Weekly Behavioral Health Meeting	Team meeting that includes the behavioral health coordinators, MDT coordinators and clinical services specialists to review all youth, in all levels of care, that have escalated and/or been flagged due to increased needs for services or supports, Baker Acts, high-end placements, and others. This forum facilitates a comprehensive review that supports the youth and families remaining in the current level of care and/or ensures all services/supports are in place for a successful transition for those youth deemed ready to step down.

Monthly OOHC Reviews	The team completes a comprehensive clinical review to assess the current placement needs for youth as they are identified and ensure adequate services and supports are in place, based on a review of progress notes, provider feedback and information provided by the OOHC team.

DENIAL OF SERVICE (SUNSHINE FUNDED LEVELS OF CARE)

The team members that may participate in the HLOC MDT process include the behavioral health coordinator, out-of-home care specialist, substance abuse and mental health (SAMH) representative, independent living specialist, targeted case manager, therapist, and child welfare care manager. All decisions are made by a majority consensus vote. If a team member disagrees, a follow-up HLOC MDT will be scheduled within 30 days to re-review the case and come to a resolution. All decisions made by FPOCF's clinical team are recommendations only. Final approval for placement and funding is made by the clinical services coordinator and UM program manager. If a member of the child's treatment team disagrees with the decision made by the Sunshine Health Plan, he or she is advised to follow the Sunshine right to appeal process.

Appeal of Sunshine/Decisions Process

Final approval for placement and funding is from the Sunshine clinical care manager.

Operational Issue or Concern

Issues or concerns of an operational nature from Sunshine Health subcontractors or vendors are shared with Sunshine Health's child welfare program leadership to seek resolution. These issues can be member-specific or general in nature, but they are not considered to be complaints. While they may identify concerns about processes or operations, they are not reported due to member dissatisfaction.

Complaint

Any oral or written expression of dissatisfaction by an enrollee submitted to the Child Welfare Specialty Plan or to a state agency and resolved by close of business the following business day. A complaint is a subcomponent of the grievance system. Complaints that are not resolved within 24 hours become grievances (unless the complaint is from a network provider).

Grievance

An expression of dissatisfaction by or on behalf of an enrollee or a provider to the Sunshine

Health Child Welfare Specialty Plan or the Agency for Health Care Administration (AHCA). This expression of dissatisfaction may be filed either verbally or in writing and may be made directly to Sunshine Health and/or the FPOCF client relations specialist. Complaints that are not resolved within 24 hours become grievances (unless the complaint is from a network provider).

Grievance Procedure and Grievance System

An organized process for addressing enrollees' grievances, including the system for reviewing and resolving enrollee grievances or appeals. Components must include a grievance process, an appeal process and access to the Medicaid fair hearing.

Member Complaints, Grievances and Appeals

- Sunshine Health does not delegate member complaints, grievances or appeals.
- A complaint is any oral or written expression of dissatisfaction by a member submitted to the health plan or a state agency, such as AHCA. It must be resolved within one business day following receipt or managed as a grievance.
- A grievance is an expression of dissatisfaction about any matter other than an adverse decision to a prior authorization request.
- An appeal is a request to review an adverse decision as a result of a prior authorization request. Members can request an appeal by phone, in person or in writing. If a member is not happy with Sunshine Health's appeal decision, they can request a Medicaid Fair Hearing (confidential and proprietary information).

Additional information is available on the complaints, grievances and appeals page at SunshineHealth.com.

Complaints and grievances shall be reported to Sunshine Health within 24 hours of learning of the complaint or grievance.

1. Sunshine Health may receive information related to a potential complaint, grievance or quality of care issue from an enrollee, a treatment provider or FPOCF on behalf of an enrollee.
2. FPOCF will immediately notify the Sunshine Health child welfare director of a complaint or grievance that is reported by:

    a. An enrollee.
    b. FPOCF on behalf of an enrollee.
    c. A parent, guardian or caregiver on behalf of an enrollee.
    d. A provider, either on behalf of an enrollee or due to a specific provider dispute.

3. Within 24 hours of receiving a complaint, grievance or quality of care issue, a FPOCF designee immediately submits the report and attached documentation directly to

Sunshine Health via email through Sunshine Health's secure and monitored notification mailbox, as well as to Sunshine Health's Leadership:

a. SUN_PQI@centene.com (complaint)
b. cwsp_notifications@centene.com (complaint and grievance)

4. Complaints will be reported to Sunshine Health both as described above and in a format, frequency and process established by Sunshine Health.
5. Sunshine Health's quality improvement department is responsible for investigating the potential quality of care issue, complaint or grievance and taking appropriate action.
6. Sunshine Health must clearly communicate whether the appeal is standard or expedited and give the appropriate deadline at the time of the request.
7. The regional coordinator is responsible for monitoring compliance with procedures related to the reporting requirements as part of the quarterly community-based care lead agency monitoring process.

CONCURRENT UTILIZATION REVIEWS OF CHILDREN IN QRTP, STGH, STFC

All children residing in QRTP, STGC and SIPP levels of care are reviewed through an HLOC MDT a minimum of every three months in coordination with the suitability assessment requirements.

All children residing in STFC are reviewed at the HLOC MDT a minimum of every 30 days, unless agreed upon at the previous staffing. All clinical review staffing dates, purpose and outcomes are maintained in FSFN.

REVIEWED BY:

Philip J. Scarpelli
PRESIDENT and CEO

Family Partnerships of Central Florida
BREVARD | ORANGE | OSCEOLA | SEMINOLE

Signature _____ Date August 30, 2024

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