DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

BRIDGET HOLTHUS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
Quality and Member Relations Improvement Section
P.O. Box 700190
Kapolei, Hawaii 96709-0190

March 3, 2017

MEMORANDUM

MEMO NO.
QI-1620
CTR-1603

TO: QUEST Integration (QI) Health Plans
Department of Health Early Intervention Program (DOHEIP)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: QI HEALTH PLAN AND DOHEIP COLLABORATION

The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to provide guidelines and role delineation for collaboration between DOHEIP and QI health plans.

QI health plans assure Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) services are provided to EPSDT eligible QI beneficiaries. DOHEIP provides a specific set of services to implement plans to support developmental goals for children 0-3 years of age. Both of these programs may provide concurrent services as long as services are not duplicated. In the event that DOHEIP is unable to fulfill a service request, the QI health plan will ensure all medically necessary services are provided for EPSDT eligible QI beneficiaries.

With family consent, these programs will share information to optimize identification and treatment of medical and developmental concerns through early childhood. Beginning January 1, 2017, QI health plans will perform a face to face health and functional assessment (HFA) for every child exiting the DOHEIP program before the age of 3. Please see Attachment B for a detailed delineation of roles, and expectations.

Attachment A provides a simple workflow outlining how and when information will be exchanged. Attachment B provides a detailed side by side role delineation of the DOHEIP Care Coordinator (CC) and the QI health plan Service Coordinator (SC).

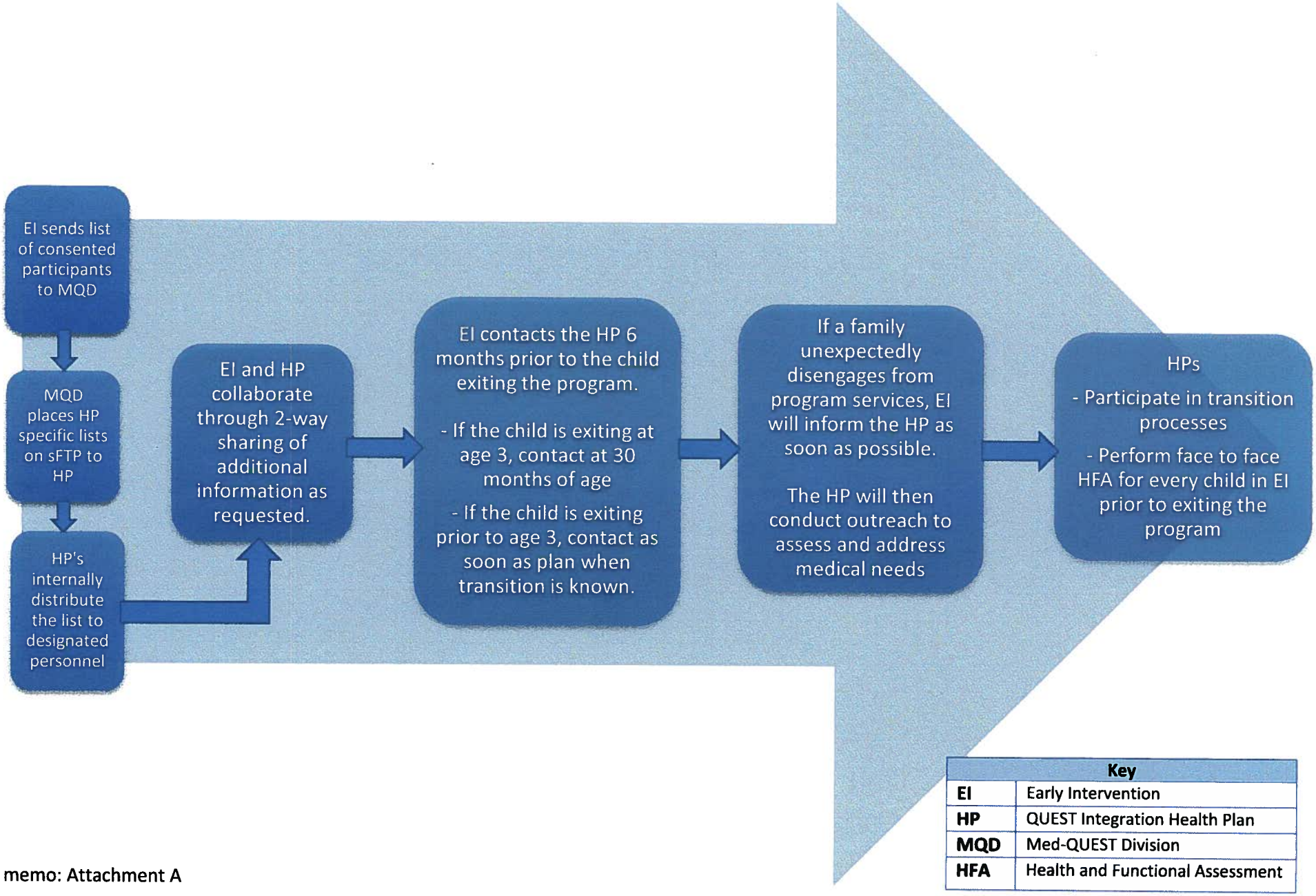
Please direct any questions to Sharon Thomas at 808-692-8161 or quest_integration@medicaid.dhs.state.hi.us.

Attachments:

Attachment A: Early Intervention (EI) and QUEST Integration health plan (hp) Collaboration flowchart
Attachment B: Early Intervention Section (EIS) and QUEST Integration (QI) Role Delineation of Care Coordinator (CC) and Service Coordinator (SC).

C: Department of Education (DOE)

Early Intervention (EI) and QUEST Integration health plan (HP) Collaboration flowchart



Key	
EI	Early Intervention
HP	QUEST Integration Health Plan
MQD	Med-QUEST Division
HFA	Health and Functional Assessment

QI memo: Attachment A

Early Intervention Section (EIS) and QUEST Integration (QI) Role Delineation of Care Coordinator (CC) and Service Coordinator (SC)

Function	EIS Care Coordinator	QI Health Plan Service Coordinator
General duties	• EIS has 20 Early Intervention (EI) programs statewide (3 State operated; 17 contracted agencies). The EI CC from these EI programs coordinate EI services to address developmental delays and objectives identified in the child's Individualized Family Support Plan (IFSP). Services on the IFSP may include: o Assistive Technology o Audiology o Care Coordination o Family Support/education o Health o Nursing (PHN) o Nutrition o Occupational therapy o Parent-to-parent support o Physical therapy o Psychological support o Speech and language therapy o Social work (counseling) o Specialized teaching o Transportation (accessing EI services) o Vision • EIS CC can call the HP as a community resource to support coordination of necessary services unrelated to developmental goals on the child's IFSP (i.e., connect with medical home for routine well child visit).	• QI health plans are responsible for providing health care services for QI beneficiaries. QI beneficiaries are health plan "members". Health plan SCs coordinate medical-related services (i.e., physician, hospital, home health, medication, transportation to medical appointments, etc.) for members with special health care needs (SHCN) or members receiving home and community based services (HCBS). • The QI health plan must: o Provide Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for children. o Find physicians or specialists, o Ensure the client has timely access to medically necessary Durable Medical Equipment (DME) and medical supplies, o Support client during a hospital discharge for new medications, home health, etc. o Coordinate provision of services related to acute medical diagnoses, o Coordinate provision of Speech Therapy/Occupational Therapy (ST/OT) for treatment of dysphagia, o Coordinate benefits with primary insurance to ensure that the member has medically necessary

Function	EIS Care Coordinator	QI Health Plan Service Coordinator
	• The EIS CC helps the family navigate the health care system by: o Referring the participant to their QI health plan for medical-related issues (i.e., physician, hospital, home health, etc.). o Making referrals to other Medicaid programs including, but not limited to QI, Dental Services, etc., • The EIS CC is the liaison to government programs [i.e., Department of Education (DOE), Child Welfare Services (CWS), etc.]	services to include medications, DME, transportation to medical appointments, access to specialists, etc., o Help the member navigate the health care system.
Setting for meetings with participant/ member	• IFSPs are typically conducted in the home. • EIS must invite SC to transition-related IFSP meetings and may invite SC to other IFSPs when appropriate with family consent.	• HFA and SP meetings are held either in the member's home or a location of the member's choice. • HP may invite EIS CC to Health and Functional Assessment (HFA) and Service Plan (SP) meetings when appropriate with family consent.
Initial assessment	• Conduct within 45 days from date of referral • Develops an IFSP with the IFSP team which includes the family and others that the family chose to invite. IFSP consists of various sections and is not limited to Outcomes, Objectives, and Strategies for the child and family.	• If identified for service coordination, HFA completed within 15 days. • Develops SP with the circle of support, based upon medical needs, short and long-term goals of the participant. • Prior to eligibility determination by EIS, HP to provide medically necessary and developmental services.
Ongoing assessments	• Evaluation completed annually to re-determine eligibility. • With signed consent, conduct additional assessments to gather more information, support service planning, etc	• Update every six months if identified as C-SHCN needing a SC. • Update every three months if the member is receiving HCBS.

Function	EIS Care Coordinator	QI Health Plan Service Coordinator

Service plan	• The IFSP consists of 8 sections that includes but is not limited to information about the family, child's present levels of development, outcomes, transition plan, summary of services, and other services.
	
	• Initial IFSP is developed within 45 days of referral
	
	• Reviewed every six months, at a minimum and updated annually.
	
	• Initial and Annual IFSP participants include:
	  o Family
	  o Others as requested by parent
	  o EI CC
	  o 1 EI Evaluator
	  o EI service provider(s)
	
	• 6-month and other Review IFSP
	  o Family
	  o EI CC
	  o Others as requested by parent
	
	• Also invited:
	  o PCP
	  o Specialists
	  o Health plan SC
	
	• With signed consent by family:
	  o EIS must provide IFSP to HP if requested.
	  o EIS CC will request SP as needed from HP.
		• Service plan is a broad roadmap of service delivery developed with the circle of support, based upon short and long-term medical needs of the participant.
		  o Developed with HFA which is done within 15 business days of referral or identifying that member needs a SC.
		  o Update with face to face reassessment within 10 days when significant events (e.g. hospitalization, change in medical needs, and loss of primary caregiver) occur in the life of a member or member's primary caregiver.
		  o Updated as needed or as level of care changes.
		
		• HP will request IFSP as needed from EIS CC.
		
		With family consent:
		  o HP must provide SP and HFA to EIS CC if requested
		
		• Update every six months if identified as Child with Special Health Care Needs (C-SHCN) needing a SC.
		
		• Update every three months if receiving HCBS.

Function	EIS Care Coordinator	QI Health Plan Service Coordinator
Approval of Services	• IFSP team, which includes the family, must determine the services and record in the Summary of Services section of the IFSP.	• QI health plan approves services that are: o Medically necessary o Coordinated with member's primary insurance o Part of the QI benefit package
NOTE:	• *QI health plan provides State Plan services before EIS carve out eligibility is determined.* • *QI health plan and EIS may provide concurrent services while a child is enrolled in EIS.* • *Services must not be duplicated.*	
Billing/Admin TCM: Who can bill?	• EI CC is reimbursable Primary Targeted Case Manager (TCM) for a child not receiving HCBS. • EI CC is non-reimbursable TCM for a child receiving HCBS.	• Non-reimbursable TCM for member not receiving HCBS • Primary TCM for member receiving HCBS
Program Exit – General	• EI CC will: o Begin transition planning from the Initial IFSP meeting and revisit the plan at each IFSP meeting. o Offer referrals o Notify QI HP SC of children who are exiting the EI program o Invite SC to transition conferences o Share transition plan with SC o Contact HP SC when the child is 30 months of age to inform of transition process and invite to planning meeting(s)	**For children exiting EI services:** • SC must coordinate communication with EIS CC to design transition of care and to learn supplemental information about the child and family for: o Routine transition as child turns 3 years old o Unexpected family disengagement from EIS o Child transitions prior to 3 year old o When SC cannot attend transition meeting • QI health plans must authorize continuation of medically necessary EI recommended services in place at the time of transition out of EI program. • SC must collaborate with circle of support to submit prior authorization for a seamless continuation of medically necessary services when the member transitions out of EI program. • QI health plan must contact EI program if a child is 30 months of age and contact from the EI program was not received.

Function	EIS Care Coordinator	QI Health Plan Service Coordinator
Program Exit – Under age 3	• If child is no longer eligible based on Multi-Disciplinary Evaluation (MDE), child exits EI program within 30 days from the time the evaluation. o At EI Eligibility Meeting, EI CC and service provider(s) share results, provides resources, and inform family that their child may be referred for a re-evaluation after 3 months should concerns arise. • EI CC will notify QI HP SC, as soon as possible, of children who have an IFSP and are exiting the EI program under age 3. • EI CC will contact HP SC if the family disengages or are lost to follow-up.	**For children exiting EI services:** • QI health plan must collaborate with EIS CC and the member's circle of support, including Primary Care Provider (PCP), to identify medically necessary services. • QI health plans must complete a face to face HFA before the member transitions out of the EIS program. • If unplanned exit or SC unable to attend, SC must coordinate communication with EIS CC to design transition of care and to learn supplemental information about the child and family.
Program Exit – at age 3	• EI services are provided up to age 3. • EI CC will contact HP SC when the child is 30 months of age to inform of transition process and invite to planning meeting(s)	**For children exiting EI services:** • QI health plans must complete a face to face HFA before the member transitions out of the EIS program.

Function	EIS Care Coordinator	QI Health Plan Service Coordinator
Care Integration	• EIS and EI CC must collaborate with HP and SC to optimize identification and treatment of medical and developmental concerns through early childhood. • EIS Administrative Office must submit a monthly data roster to MQD of all EI children who have signed consent to share information with QI HP: o Name o Medicaid ID o Program Name • With signed consent, EIS CC may request from QI HP: o HFA o SP o SC contact (share/learn additional information) o Refer for Service Coordination Program • Contact HP SC when the child is 30 months of age to inform of transition process and invite to planning meeting(s) • EI CC will notify QI HP SC, as soon as possible, of children who have an IFSP and are exiting the EI program under age 3.	• HP and SC must collaborate with EIS and EI CC to optimize identification and treatment of medical and developmental concerns through early childhood. • With family consent, the HP may request from EIS: o MDE o IFSP o CC contact (share/learn additional information) • HP to provide medically necessary and developmental services pending eligibility determination by EI. • HP to provide medically necessary services unrelated to developmental goals identified in EIS IFSP while member is enrolled in EI services. • In the event that a Department of Health Early Intervention Program (DOHEIP) is unable to fulfill a service request, the QI health plan will insure all medically necessary services are provided for EPSDT eligible QI beneficiaries. • QI health plans are expected to complete a face-to-face HFA with every family prior to a member transitioning out of EI services. • QI health plan SCs must participate in EI transition conferences and planning. • If unplanned exit or SC unable to attend transition conferences SC must coordinate communication with EIS CC to design transition of care and to learn supplemental information about the child and family.

Definitions:

Children with Special Health Care Needs (C-SHCN)	Any QI beneficiary under 21 years of age who has a chronic physical, developmental, behavioral, or emotional condition and who requires health and related services of a type or amount beyond that generally required by children.
Circle of Support	Circles of support are a group of family, friends and supportive workers who come together to give support and friendship to a person.
Early and Periodic Screening, Diagnostics, and Treatment (EPSDT)	"The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services." (The Center for Medicaid and CHIP Services (CMCS), 2016) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
Health and Functional Assessment (HFA)	An assessment performed by health plan service coordinators to determine the health and functional capability of the member and appropriate strategies and services to best meet identified needs. The HFA takes into consideration the health status, environment, available supports, medical history, and social history of each member.
Home and Community Based Services (HCBS)	Long-term services and supports provided to individuals in QI who meet nursing facility level of care to allow those individuals to remain in their home or community.
Medically necessary	A health intervention recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as further defined in HRS 432E-1.4.
Non-C-HCBS	Any QI beneficiary under 21 years of age who is not receiving HCBS. These beneficiaries may or may not have been identified as C-SHCN and also do not meet nursing facility level of care.
Targeted Case Manager	Engages recipient and may involve family members and other interested persons as appropriate to develop a comprehensive assessment which identifies the recipient's abilities, deficits, and needs as dictated by HAR §17-1738-27.

Acronyms:

CAMHD	Child and Adolescent Mental Health Division (part of DOH)
CC	Care Coordinator
C-HCBS	Children receiving home and community based services (Health plan)
C-SHCN	Children with Special Health Care Needs
CWS	Child Welfare Services (part of DHS)
DHS	Department of Human Services
DME	Durable Medical Equipment
DOE	Department of Education
DOH	Department of Health
EIS	Early Intervention Section (part of DOH)
EPSDT	Early and Periodic Screening, Diagnostics, and Treatment
HFA	Health and Functional Assessment
HP	Health Plan (AlohaCare, HMSA, Kaiser, 'Ohana, UHC)
IFSP	Individualized Family Support Plan
LTSS	Long-Term Services and Supports
MDE	Multi-Disciplinary Evaluation
MQD	Med-QUEST Division (part of DHS)
OT	Occupational Therapy
PA	Prior Authorization
PCP	Primary Care Physician
PHN	Public Health Nurse
QI	QUEST Integration (DHS/MQD health plan program)
SC	Service Coordinator
SP	Service Plan
ST	Speech Therapy
TCM	Targeted Case Manager

Point of Contact:

Early Intervention Services
Clayton Takemoto
Clayton.takemoto@health.hawaii.gov
P: 594-0034
F: 594-0015

Med-QUEST
Sharon Thomas
Sthomas2@dhs.hawaii.gov
P: 692-8161
F: 692-8087

AlohaCare
Val Gourley
vgourley@alohacare.org
P: 973-0573
F: 973-7374

HMSA
Chris Jamila
Chris_Jamila@hmsa.com
P: 948-5384
F: 944-5604

Kaiser
Jennifer Riel
Jennifer.k.riel@kp.org
P: 282-3334
F: 432-3615

'Ohana
Mona Brack
Mona.Brack@wellcare.com
P: 675-7373
F: 675-7398

United
Linda Taylor
linda_taylor12@uhc.com
P: 492-4196
F: 855-715-0514