

MCO Service Coordination in Nursing Facilities

The goals of managed care include an emphasis on preventive care, improved access to care, appropriate utilization of services, improved client and provider satisfaction, and improved health outcomes, quality of care, and cost-effectiveness. In the nursing facility (NF) context, managed care organization (MCO) service coordinators (SC) will partner with NF care coordinators and other NF staff to ensure members' care is holistically integrated and coordinated and find ways to avoid preventable hospital admissions, readmissions, and emergency room visits, resulting in shared savings to benefit both the NFs and MCOs, and most importantly the members themselves.

The MCO SC participates in person- and family-centered¹ service planning² with the NF staff, primary care provider, vendors, and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources. The MCO SC is strongly encouraged to participate with the individual, individual's family or representative, NF care coordinator/staff, and other members of the interdisciplinary team to provide input for the development of the NF plan of care, attending meetings and serving as a resource or advocate for the member. The MCO SC conducts a face-to-face visit with the NF resident at a minimum of quarterly, and more frequently as determined by the member's condition, situation, and level of care.

The MCO is responsible for:

- Coordinating services when a member transitions into a NF;
- Partnering with the member, family, NF care coordinator/staff and others in the development of a service plan, including services provided through the NF, add-on services, acute medical services, behavioral health services, and primary or specialty care. The approval of additional services outside of the NF daily unit rate is based on medical necessity and benefit structure;
- Participating in NF care planning meetings telephonically or in person, provided the member does not object;
- Comprehensively reviewing the member's service plan, including the NF plan of care, at least annually, or when there is a significant change in condition;
- Visiting members living in NFs in person at least quarterly. Visits should include, at a minimum, a review of the member's service plan and when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the person's service plan, and any other aspect of the member's life or situation that may need to be addressed;
- Assisting with the collection of applied income when a NF has documented unsuccessful efforts, per the state-mandated NF requirements;
- Cooperating with representatives of regulatory and investigating entities including DADS Regulatory Services, the LTC Ombudsman Program, DADS trust fund monitors, Adult Protective Services, the Office of the Inspector General, and law enforcement;
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) as described in UMCC Section 8.3.9.2. The quarterly in-person visits required of MCO SCs can include assessments required under the PII, and the MCO SC can serve as the designated point of contact for an individual referred to return to the community under PII;

¹ Information on person-centered practices can be found online at: <http://www.learningcommunity.us/> and <http://www.person-centered-practices.org/home.html>.

² For the purposes of this document, *service plan* is a comprehensive set of services and supports, including Medicaid-covered services, informal or family supports, and non-Medicaid community resources. The MCO SC is responsible for a member's service plan. A *NF plan of care* is the Medicaid-covered services provided in a NF. The NF is responsible for the NF plan of care but the NF plan of care may include add-on services authorized by the MCO. The NF plan of care is included in the MCO's service plan.

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- Coordinating with the NF discharge planning staff to plan discharge and transition from the NF;
- Notifying the NF within ten days of a change to the MCO's assigned service coordinator; and
- Returning a call from a NF within 24 hours after the call is placed by the NF.

The NF is responsible for:

- Inviting the MCO SC to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the MCO SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on MCO SC participation;
- Notifying the MCO SC within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home;
- Notifying the MCO SC if a member moves into hospice care;
- Notifying the MCO SC within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization;
- Coordinating with the MCO SC to plan discharge and transition from a NF;
- Notifying the MCO SC within one business day of an emergency room visit;
- Notifying the MCO SC within 72 hours of a member's death;
- Notifying the MCO SC of any other important circumstances such as the relocation of residents due to a natural disaster; and
- Providing the MCO SC access to the facility, NF staff, and members' medical information and records.