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Letter Attachment
Coordination of Care for Children, Youth, and Young Adults in Nursing Facilities – Roles, Functions, and Responsibilities of Care Coordinators

The purpose of this document is to outline the roles, functions, and responsibilities of both the Medicaid Managed Care Plan Care Coordinators and the Nursing Facility Care Coordinators providing care coordination to children who are Medicaid enrollees residing in Nursing Facilities. For the purpose of this document, and in accordance with the definitions outlined in the Order of Injunction (Document 1171) entered in *United States v. Florida*, 12-60460-CV (S.D. Fla.), children are defined as "NF Children" which are individuals who live in Nursing Facilities, have complex Medical Needs and either (1) are under 30 years of age and began living in a Nursing Facility before reaching 21 years of age, or (2) are under 21 years of age.

If an enrollee is enrolled in both a Medicaid Managed Medical Assistance (MMA) Program and a Long-Term Care (LTC) Managed Care Program, the Medicaid managed care plan must identify the Lead Care Coordinator that will be responsible for the roles, functions, and responsibilities outlined for the Medicaid Managed Care Plan Care Coordinator. Each Nursing Facility must identify the individual(s) that will serve as their Facility's Care Coordinator.

Medicaid Managed Care Plan Care Coordinator

Roles

Medicaid Managed Care Plan Care Coordinator Roles:

- Primary Care Coordinator for the enrollee's health plan benefits and associated needs
- Primary Care Coordinator for the enrollee's transition from the Nursing Facility to the community
- Convener and participant in the Transition Planning Process
- Convener and participant in multidisciplinary team meetings
- Participant in all enrollee's Children's Multidisciplinary Assessment Team (CMAT) staffing (for enrollees in LTC, the Care Coordinator will ensure the completion of the level of care, in accordance with contract requirements).

Functions

Medicaid Managed Care Plan Care Coordinators provide the following:

- Coordination of Care for all benefits covered through the Managed Care Plan, and any additional services and supports needed both while in the nursing facility and upon discharge.
- Facilitation of each enrollee's Transition Planning Process
- A minimum of two face-to-face visits and two telephone contacts each month with the enrollee and parent/guardian/authorized representative. Care Coordinators must make at least three contact attempts to reach the enrollee. At least two attempts must be by telephone on different days at different times. Care Coordinators will communicate with

the Nursing Facility if the enrollee and parent/guardian cannot be reached after at least three contact attempts.
- Facilitation of semi-annual multidisciplinary team meetings
- Assessment and annual reassessment that assesses the needs, preferences, and goals of the enrollee to inform the development of the enrollee's Care Plan (for enrollees in LTC, the assessment will be completed on the Agency-required forms and the LTC supplemental form).
- Care Plan development, maintenance, monthly review, quarterly revision, and annual update (for enrollees in LTC, the person-centered plan of care must be in accordance with 59G-4.192, Florida Administrative Code, and 42 CFR 441.301(c)(2)).

Responsibilities

Medicaid Managed Care Plan Care Coordinators are responsible for:

- Ensuring that the Nursing Facility Care Coordinator has access to the managed care plan's secure Provider Portal for information-sharing related to the enrollee's health.
- Ensuring they keep their own access up to date on their organization's secure Provider Portal for information-sharing related to the enrollee's health.
- Initiating discussions with the family on moving the enrollee to a less restrictive setting and providing information about the benefits of integrated settings. This includes communication with the parents or guardians to ensure that they have an informed choice of service setting for their child and that their choices are acted upon. This includes making certain that the parents or guardians are specifically aware that a federal court has ordered the State to provide reliable private duty nursing (PDN) to all NF Children who transition to the Community. For enrollees in LTC, the Care Coordinator is to ensure that they involve the enrollee's authorized representative in all face-to-face visits with the enrollee if the enrollee is unable to participate due to a cognitive impairment.
- Inviting and sending out Transition Planning Process meeting information and arranging for accommodations, if needed, including language interpreter services. The Transition Planning Process *must* begin before admission to a Nursing Facility.
- Completing and disseminating the Transition Plan to involved participants and sharing information related to transition planning as needed to coordinate care. The Transition Plan *must* be completed within 30 days after admission to a Nursing Facility and *must* be updated every three months, using the Transition Planning Process.
- Collaborating with the Nursing Facility Care Coordinator to implement the Transition Plan.
- Ensuring the completed Pre-Admission Screening and Resident Review (PASRR) is in the enrollee's Nursing Facility record, in accordance with 42 CFR Part 483 and 59G-1.040, Florida Administrative Code.
- Ensuring that Freedom of Choice Forms are completed within seven business days of instituting nursing facility services and prior to authorization, as well as at the multidisciplinary team meetings (semi-annual).
- Ensuring referrals to the Comprehensive Assessment and Review for Long Term Care Services (CARES) are completed and submitted for enrollment into the Long Term Care Program, six months prior to the enrollee's 18th birthday.
- Providing their contact information to the enrollee, the enrollee's parent/guardian, and the Nursing Facility Care Coordinator, for contact during business hours.
- Providing the after-hours telephone line information to the enrollee, the enrollee's parent/guardian, and the Nursing Facility Care Coordinator for emergency backup care coordination during after-hours.
- Tailoring the development of the care plan, based on the individual and consistent with evidence-based guidelines for treatment.

- Revising the plan of care with the enrollee and/or parent/guardian/authorized representative at least quarterly.
- Updating the plan of care with the enrollee and/or parent/guardian/authorized representative at least annually.
- Coordinating care among all treating providers/entities.
- Making referrals to and facilitating communication with service providers (for both covered and non-covered services) in anticipation of discharge from the Nursing Facility.
- Ensuring the quality of enrollee services.
- Facilitating visits or other experiences in integrated settings. This includes family-to-family home visits to other family homes where PDN Children are receiving PDN in the community.
- Offering opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families, and with community providers. This includes family-to-family peer support from a family that has received PDN for a child with Complex Medical Needs.
- Ensuring that DCF is notified when an enrollee is admitted or discharged from a Nursing Facility, within ten business days using the appropriate forms.
- Ensuring that the Nursing Facility Care Coordinator provides the instruction or arranges for the instruction of the parents, legal guardians, or other caretakers on how to provide the necessary interventions, how to interpret responses to therapies, and how to manage unexpected responses to facilitate a smooth transition from the Nursing Facility to the home, including instruction regarding care coordination.
- Ensuring that all necessary services, equipment, and supports are in place upon transition from the Nursing Facility to the home.
- Directing the enrollee or parent/guardian/authorized representative to the Nursing Facility Care Coordinator for any of the roles, functions, or responsibilities described in the *Nursing Facility Care Coordinator* section below.

Nursing Facility Care Coordinator

Roles

Nursing Facility Care Coordinator Roles:

- Day-to-day Care Management of the enrollee's needs while in the Nursing Facility
- Participant in the Transition Planning Process
- Participant in multidisciplinary team meetings

Functions

Nursing Facility Care Coordinators provide the following:

- An assessment upon admission and every twelve months thereafter and revised as needed, with reviews at least every 120 days or after a significant change.
- A Plan of Care developed by an interdisciplinary team and in accordance with 59A-4.1295(3)(c), Florida Administrative Code, that includes objectives and timeframes to meet the enrollee's medical, nursing, mental, and psychosocial needs identified in the assessment.
- A comprehensive assessment of the enrollee's functional capacity and a post-discharge plan of care, upon admission and quarterly, as part of the enrollee's Plan of Care. The post-discharge plan of care includes plans, actions, and goals to transition the enrollee to a home and community-based, non-institutional setting.
- Therapies, in accordance with the enrollee's needs and Plan of Care.
- Enrichment activities, in accordance with the enrollee's needs and Plan of Care.

Responsibilities

Nursing Facility Care Coordinators are responsible for:

- Complying with PASRR requirements, in accordance with 42 CFR Part 483 and 59G-1.040m Florida Administrative Code, prior to the enrollee's admission to a Nursing Facility. The completed PASRR must be in the enrollee's Nursing Facility record.
- Utilizing the applicable health plan's secure Provider Portal for information-sharing related to the enrollee's health.
- Communicating any changes in an enrollee's health status to the enrollee's Medicaid Managed Care Plan Care Coordinator.
- Participating in discussions with the family and the Medicaid Managed Care Plan Care Coordinator regarding moving the enrollee to a less restrictive setting.
- Attending Transition Planning Process meetings and multidisciplinary meetings convened by the Medicaid Managed Care Plan Care Coordinator.
- Partnering in the Transition Planning Process to assist enrollee transitions to lower levels of care.
- Collaborating with the Medicaid Managed Care Plan Care Coordinator to implement the Transition Plan.
- Collaborating with the public school system to ensure each enrollee's (under 21 years of age) intellectual needs are met and to enhance each enrollee's quality of life with age-appropriate educational programming.
- Including the enrollee and family, at their option, as well as other members of the enrollee's care team in the development, implementation, maintenance, and evaluation of the enrollee's Plan of Care.
- Instructing or arranging for the instruction of the parents, legal guardians, or other caretakers on how to provide the necessary interventions, how to interpret responses to therapies, and how to manage unexpected responses to facilitate a smooth transition from the Nursing Facility to the home. This instruction must cover care coordination and must gradually pass the role of care coordinator to the parent/guardian, as appropriate. This is to facilitate knowledge transfer and encourage empowerment and autonomy for their child's condition.
- Directing the enrollee or parent/guardian/authorized representative to the Medicaid Managed Care Plan Care Coordinator for any of the roles, functions, or responsibilities described in the *Medicaid Managed Care Plan Care Coordinator* section below.

<u>Information Sharing between Medicaid Managed Care Plan Care Coordinators and Nursing Facility Care Coordinators</u>

A secure Provider Portal shall be used by both the Medicaid Managed Care Plan Care Coordinators and the Nursing Facility Care Coordinators to share information related to the enrollee's health, including, at a minimum:

- Information on their diagnosis, treatment, and health status
- All assessments completed by the Medicaid Managed Care Plan Care Coordinators and the Nursing Facility Care Coordinators outlined in this document
- Medicaid Managed Care Plan Care Coordinator's Care Plan
- Nursing Facility Care Coordinator's Plan of Care
- Transition Plan
- Freedom of Choice Form

Documentation shall be maintained in accordance with all applicable confidentiality and protected health information laws. Documents must be kept up to date, with the most recent documents being uploaded within one business day of completion. The secure provider portal must allow for uploading and downloading of documents by either the Medicaid Managed Care Plan Care Coordinator or Nursing Facility Care Coordinator. Both the Medicaid Managed Care Plan Care Coordinator and the Nursing Facility Care Coordinator shall be responsible for reviewing the provider portal for new information.

Both the Medicaid Managed Care Plan Care Coordinator and Nursing Facility Care Coordinator shall ensure the availability of secure (or encrypted) email as an alternative, or backup, means of communicating information. Information shared by this method must be shared within one business day of completion. The Medicaid Managed Care Plan Care Coordinator and Nursing Facility Care Coordinator shall test the secure email capability in advance to ensure its availability if needed.