State Profile

Summary of Care Coordination Contract Provisions for the Florida Long-Term Care (LTC) Managed Care Program

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[1] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Florida Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All members receive care coordination. The program enrolls people who meet nursing facility level of care and are served in community or institutional settings.
2) Can eligible members opt out of care coordination?	Not addressed in contract	
3) Can members choose or change care coordinators?	Not addressed in contract	
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	No	Care coordinator must have one of the following: • Bachelor's degree in social work, sociology, psychology, gerontology, or other field with 2 years' relevant experience; • RN licensed to practice in the state and 2 years of relevant experience; • LPN licensed to practice in the state and 4 years of relevant experience; or • No degree with 6 years of relevant experience.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	Case managers are required to have 2–6 years of relevant work experience, depending on education.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
6) Are care coordinators required to receive training?	Yes	Contractor must provide adequate orientation and ongoing training in relevant topics. The contract specifies 12 topics that must be covered with newly hired care coordinators, including person-centered approach, rights and responsibilities, participant-directed option, local resources, provider network, etc. In addition, the contractor must designate a housing, education, and employment expert within each region of operation, who must be available to care coordinators as a resource on those issues.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	Contractor must include cultural competency among training topics for care coordinators.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Upon request, the contractor must provide, free of charge, interpreters for potential members and members whose primary language is not English. Contractor must make all written material available in English, Spanish, and all other languages spoken by 5 percent or more of the total population in the contract region.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	In general, care coordinators must be able to meet the needs of their assigned members. Specifically, care coordinators assigned to subpopulations (e.g., individuals with AIDS, dementia, behavioral health issues, traumatic brain injury) must have experience or training in case management techniques relevant to the subpopulations.
10) Is in-person contact required and at what frequency?	Yes	Care coordinators must review the plan of care in a face-to-face meeting at least every 3 months.
11) Is telephonic or other remote contact required?	Yes	Care coordinators must maintain a minimum of monthly telephone contact.
12) Must initial contact with a new member be made within a specified time period?	Yes	A face-to-face visit to develop an individualized plan of care must be completed within 5 business days of enrollment effective date for members in the community, and within 7 business days of enrollment effective date for members in nursing facilities.
13) Is an assessment required at initial enrollment?	Yes	An assessment is conducted as part of the initial visit to complete the plan of care.
14) Is reassessment required and at what frequency?	Yes	Care coordinators must conduct annual level of care redeterminations based on a tool and documentation required by the State.
15) Does the care coordinator authorize long-term services and supports?	Not addressed in contract	

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Other	Contractor is responsible for care coordination but a new care coordinator may be assigned, depending on qualifications. Contractor must assign a care coordinator trained extensively in the participant-directed option within 2 business days of the member electing the option.
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	Contractor is responsible for managing transitions and providing reports to the State on transitions.
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Yes	A single care coordinator is assigned to each member and serves as the point of contact.
Care Coordination Role with Family Caregivers		
19) Are family caregivers asked directly about (a) their own health and well-being; (b) level of stress and feelings of being overwhelmed; (c) need for training in assisting the member; and (d) any additional services or supports needed to better carry out their roles?	Other	Contractor must assess the need for training family and other unpaid caregivers and include any needed training in the plan of care. Training includes instruction about treatment regimens and other services included in the plan of care and use of equipment specified in the plan of care.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Other	Contractor must assess the need for training family and other unpaid caregivers and include any needed training in the plan of care.
21) Are family caregivers given care coordinator contact information?	Yes	Care coordinator contact information and the number for after-hours calls and emergencies are provided to family members.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must have data collection and analysis capabilities that enable the tracking of member service utilization, cost, and demographic information and maintain documentation of the need for all services provided to members.
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	The caseload for care coordinators must not exceed 60 members in the community or 100 members in nursing facilities. Mixed caseload (community and nursing facility) must not exceed 60.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must implement a systematic method of monitoring its care coordination program that includes quarterly case file audits submitted to the State.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor must submit reports demonstrating care coordination monitoring and evaluation including several care coordination performance measures, such as timeliness and accuracy of assessments, percentage of staff meeting training requirements, plan of care audit results, plan of care distribution to primary care providers, etc.
27) Care coordination entity	Partners permitted	The contract neither requires nor prohibits the contractor from using subcontractors to perform care coordination. All subcontracts must receive prior written approval of the State.

Contract Reviewed: Florida Managed Medical Assistance Model Contract *(July 1, 2014).*

1 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports.* AARP Public Policy Institute.

July 2015

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