SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1226

SPONSOR: Health, Aging, and Long-Term Care Committee

SUBJECT: Long-Term Care Service Delivery System

DATE: February 5, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Parham	Wilson	HC	Favorable/CS
2.			AHS	
3.			AP	
4.				
5.				
6.				

I. Summary:

This bill implements the recommendations contained in Senate Interim Project Report 2004-144, "Model Long-Term Care System/Analyzing Long-Term Care Initiatives in Florida."

This bill makes changes to the long-term care service delivery system administered through the Department of Elder Affairs (DOEA) and the Agency for Health Care Administration (AHCA). Specifically, the bill does the following:

- Requires each Area Agency on Aging (AAA) board, in consultation with the Secretary of Elder Affairs, to annually appoint a chief executive officer of the AAA, requires the performance of the executive director of each AAA to be annually evaluated by the Secretary, and requires the board to consider this evaluation and recommendation when it considers reappointments;
- Gives AHCA the authority, in consultation with DOEA, to contract for any function or activity of the Comprehensive Assessment and Review of Long-Term Care Services (CARES) program including any function or activity required by 483 of the Code of Federal Regulation relating to Preadmission Screening and Resident Review (PASARR);
- Requires CARES staff to assess all individuals whose nursing home stay is expected to exceed 20 days regardless of the initial funding source for nursing home placement, and provides that this requirement does not apply to continuing care facilities licensed under chapter 651, and retirement communities that provide a combination of nursing home, independent living, and other long-term care services;
- Requires DOEA to develop a database to track individuals over time, who are assessed under the CARES program and who are diverted from nursing home placement, and requires DOEA to submit to the Legislature and the Office of Long-Term Care Policy each year, a longitudinal study of the individuals who are diverted from nursing home placement;

- Revises the requirements by which DOEA can take action against a AAA to include: the AAA exceeds its authority related to its contract with the department or has exceeded its authority, or otherwise failed to adhere to the provisions specifically provided by statute or rule adopted by DOEA; and if the AAA has failed to properly determine client eligibility as defined by DOEA or efficiently manage program budgets;
- Makes changes to the Office of Long-Term Care Policy including:
  - Locating the Office of Long-Term Care policy in DOEA for administrative purposes only;
  - Providing that the office and its director shall not be subject to control, supervision, or direction by DOEA;
  - Replacing the advisory council with an inter-agency coordinating team and specifying the composition of the inter-agency coordinating team; and
  - Revising reporting requirements;
- Redefines the terms "community care service system" and "lead agency," and requires a single lead agency to provide the array of services to functionally impaired elderly persons. This agency can provide any combination of those services;
- Requires DOEA and AHCA to develop an integrated long-term care service delivery system including:
  - Requiring DOEA and AHCA to phase in implementation of the integrated long-term care system;
  - Specifying timeframes and activities for each implementation phase;
  - Authorizing AHCA to seek federal waivers to implement the changes;
  - Providing rulemaking authority to AHCA and DOEA; and
  - Requiring reports to the Governor and the Legislature.
- Requires CARES staff to review at least 20 percent of Medicaid nursing home resident case files annually to determine whether these residents can be transitioned to a less restrictive setting;
- Provides additional requirements for entities that want to enroll as Nursing Home Diversion waiver program providers;
- Provides additional requirements to be used in the development of capitation rates for the Nursing Home Diversion waiver program[1]; and
- Provides additional requirements for the evaluation of the Nursing Home Diversion waiver program.

This bill amends ss. 20.41, 409.912, 430.04, 430.041, 430.203, 430.205, 430.7031, 430.705, and 430.709, Florida Statutes.

II. Present Situation:

State Long-Term Care Planning and Administration

A major impediment for states in planning an efficient long-term care system has been the difficulty of managing the interrelationship of requirements of the Medicare and Medicaid financing systems, and the effect that care of acute illnesses has on the eventual need for long-term care. States often have little control over the admission of a patient into a nursing home

[1] This program is also known as Long-Term Care Community Diversion pilot project.

since the initial portion of a nursing home stay is usually financed by Medicare or other sources. Once these resources are exhausted (often after community support systems have unraveled) state Medicaid programs become responsible for financing continuing stays.

There is no single state agency in Florida with responsibility for oversight of the long-term care service delivery system. Operational responsibility for planning and management of the major long-term care programs is split between AHCA, DOEA, and the Department of Children and Families (DCF). The Department of Health and the Department of Veterans' Affairs have smaller roles in long-term care service delivery.

Florida Statutes delegate the responsibility for long-term care policy development to DOEA. DOEA is Florida's state unit on aging, operating a number of state and federally funded programs for the elderly, including the Federal Older Americans Act programs. DOEA also has rule-making authority for adult day care, Alzheimer's disease training for nursing homes, assisted living facilities, adult family care homes, and hospice programs; and operates the Medicaid Aged/Disabled waiver, the Medicaid Assisted Living for the Elderly waiver and the CARES nursing home preadmission screening program. DOEA operates the state-funded Home Care for the Elderly, Community Care for the Elderly, and Alzheimer's Disease Initiative programs. DOEA also administers on behalf of AHCA the Program of All Inclusive Care for the Elderly and the Nursing Home Diversion waiver program. DOEA runs the Long-Term Care Ombudsman Program for nursing homes, assisted living facilities, and adult family care homes. DOEA also has oversight of the Statewide Public Guardianship Office and runs volunteer and caregiver support programs.

AHCA operates the Medicaid program, which purchases 66 percent of the nursing home bed days in Florida and has responsibility for the policy control for Medicaid home and community-based waivers. AHCA determines the need for additional nursing home capacity and regulates the operation of nursing facilities. AHCA also licenses and regulates assisted living facilities, adult family care homes, home health agencies, hospices, nurse registries, homemaker and companion services, and adult day care centers.

DCF establishes Medicaid financial eligibility. In order to be determined eligible for Florida's Institutional Care Program, the Medicaid program that pays for nursing home care, an individual must apply through DCF's Office of Economic Self-Sufficiency. DCF also runs the Adult Protective Services program, serving disabled adults and the frail elderly who are considered vulnerable to abuse, neglect, or exploitation.

The Department of Health provides licensure and regulation of health care professionals including physicians, nurses, certified nursing assistants, and other allied health practitioners. The Department of Veterans' Affairs runs the state veterans' homes which serve honorably discharged Florida veterans in need of nursing home or assisted living facility care.

DOEA and AHCA provide about $265 million in home and community-based services to elderly individuals through a variety of programs. Though the stated purpose of these programs is to assist elderly individuals to remain in their homes as they become more frail, the programs differ in the characteristics of their target groups and their payment methodologies and rates. Some of these programs are targeted at elderly people who meet nursing home admission criteria and who

are in the process of entering a nursing home, while others serve people who have lesser levels of disability and who can be assisted in remaining in their homes with the provision of limited supportive services. There are other programs that provide supportive services to lessen isolation, keep elders healthy, or relieve the burdens and stresses placed on families caring for aged family members.

Long-Term Care Alternatives

Since the late 1960's there has been an on-going process of "downward substitution" of care from highly institutional settings to less expensive, less institutional and more home-like settings for people with many types of disabilities. Although Florida's nursing home alternative programs serve similar target populations (people at some level of risk for nursing home placement) the system is a "patchwork quilt" which exhibits substantial geographic variation in terms of coverage, provider networks, payment rates, payment methodology, and whether or not the programs are required to pay for nursing home placement if they are unsuccessful in providing an alternative.

Provision of supportive services to elderly persons can help them to remain in their own homes as an alternative to nursing home placement. Traditionally, the majority of the supportive services needed are assistance with the activities of daily living such as assistance with bathing, dressing, light housekeeping, adult day care, home delivered meals, and home repair (construction of wheelchair ramps, installation of grab bars). Generally, home and community-based programs require an assessment of an individual's functional deficits and a prescription for the supportive services required to substitute for the individual's ability to provide self-care. The assessment is preformed by a "case manager," who arranges for the services, oversees delivery of the services, and modifies the plan of care as the individual's needs change.

Financing Long-Term Care

The federal government, through the Medicare program, pays for the majority of health care required by older people, including short-term nursing home care and recuperative home health care. The federal government also funds long-term community care services through the Older American's Act. States, through their Medicaid programs, finance the majority of nursing home bed days (long-term nursing home care). Medicaid also finances the home and community-based care that serves as an alternative to nursing home placement through the use of Medicaid waivers.

Medicaid
Medicaid is jointly funded by the federal, state, and county governments to provide adequate medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

Some services, such as nursing home care and home health care, are mandatory services that must be covered in any state that participates in the Medicaid program. Other services, such as personal care, are optional. A state may choose to include optional services in its state Medicaid plan, but such services must be offered to all individuals statewide who meet Medicaid eligibility criteria.

Florida's Institutional Care Program is the Medicaid payer for nursing home care. Federal requirements define what states are permitted to look at with regard to income and assets when determining eligibility for the Institutional Care Program. While the states have the option of setting more rigid standards than those applied by the federal government for determination of eligibility for Supplemental Security Income, Florida uses the Supplemental Security Income standards as the basis for determining eligibility for public assistance programs for the aged and disabled. In order to be determined eligible for Florida's Institutional Care Program, an individual must apply through DCF's Office of Economic Self-Sufficiency. Medicaid is the primary payer for many long-term care services in Florida. About three-fourths of Medicaid spending on long-term care is for institutional services, with a large percentage going toward nursing home care.

The primary reason for Medicaid covering these services is the gap in services covered by the Federal Medicare program. While Medicare covers physician and hospital services as well as short-term skilled nursing care, it does not cover extended stays in long-term care facilities. Medicare will cover the cost of some skilled care in approved nursing homes (100 percent for the first 20 days) or in the home, but only for expenses resulting from acute care episodes rather than from chronic disabilities. Yet, the trend toward Medicare-covered sub-acute nursing home care accelerated dramatically after 1988, when the federal Centers for Medicare and Medicaid Services (CMS) issued an administrative directive that clarified and expanded the definition of what constituted "skilled" nursing care under Medicare as well as expanded services to persons whose health and functional status were not necessarily going to improve. After the guideline changes, more beneficiaries could claim Medicare skilled nursing facility reimbursement than previously, facilitating the transfer of Medicare patients from hospitals to nursing homes. Together, Medicare hospital prospective payment system implementation and eased regulations for Medicare skilled nursing facility benefits expanded payment options for post-hospitalization nursing home stays and increased the percentage of nursing home residents admitted directly from hospitals.

Many of these Medicare beneficiaries end up converting to Medicaid. Medicaid conversion in nursing homes occurs when a resident spends all of her assets to pay for an extended stay in a nursing home and is without private long-term care insurance. When an individual is eligible for Medicaid at the time of nursing home entry and Medicare coverage is available as well, Medicare is considered the primary payer although Medicaid might also fund part of the costs of the nursing home stay. Medicaid per diem payments begin only after the Medicare benefit is exhausted. Most Medicaid conversions in Florida happen within the first year of a nursing home stay. Medicaid per diem payments in Florida nursing homes were the most common payment source in 2001.

Annual costs to an individual for nursing home care average about $46,000. Unlike private health insurance, Medicaid is a means-tested program that provides assistance only when

financial resources are substantially exhausted. Many individuals enter nursing homes and pay for their own care. However, over a period of months or years, income and assets eventually are depleted or “spent down” and people then qualify for Medicaid.

Between FY 1990-1991 and FY 2002-2003, Medicaid nursing home expenditures increased from $759 million to almost $2.2 billion per year, a 65 percent increase. Nursing home expenditures represented 19 percent of total Medicaid expenditures in FY 2002-2003. This rise in costs is not primarily related to an increase in the Medicaid caseload, however. The Medicaid nursing home average monthly caseload has increased 18 percent in the same time period, from 38,952 to 47,796. The annual cost per person is the primary factor driving up the total Medicaid expenditures for nursing home care. Between FY 1990-1991 and FY 2002-2003, the annual cost per person enrolled in the Medicaid Institutional Care Program increased 57 percent from $19,485 to $45,353. The biggest increase occurred between FY 2001-2002 and FY 2002-2003, when the state saw a 14 percent increase in annual costs per person for Medicaid nursing home care. The increased cost is associated with the additional regulatory mandates regarding staffing increases since January 2002.

The oldest old population in Florida, those 85 and older, will account for 41 percent of Medicaid nursing home costs in FY 2003-2004. Those age 75 to 84 will account for 32 percent of nursing home costs. These two age groups together will make up 73 percent of Medicaid nursing home costs. Individuals age 21 to 64 and age 65 to 74 will account for 13 and 14 percent respectively of Medicaid nursing home expenditures.

Home and community-based service delivery programs have become a growing part of states’ Medicaid long-term care coverage, serving as an alternative to care in institutional settings such as nursing homes. To provide these services, states obtain waivers from certain federal statutory requirements for Medicaid. States often operate multiple waiver programs serving different population groups, such as the elderly, persons with mental retardation or developmental disabilities, persons with physical disabilities, and children with special care needs. There are three basic types of waivers.

1115 Waiver
Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive provisions in Title XIX, the Medicaid statute. These "waivers" permit a state to further the purposes of Title XIX "to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, (and) public health..." Generally a waiver is approved for a five-year period. A central element of many of the waivers is the expansion of Medicaid eligibility to low-income persons not covered under federal rules of Title XIX. The new populations covered, however, vary from waiver to waiver, as does the scope of coverage, and the nature of the provider organizations.

1915(b) Waiver
Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain provisions of the Medicaid statute that prevent a state from mandating that Medicaid beneficiaries obtain their care from a single provider or health plan. Waivers must be approved by the Centers for Medicare & Medicaid Services (CMS) and are good for two years with the option to renew for successive two-year periods. States are

permitted to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers are limited in that they apply to existing Medicaid eligible recipients. Authority under this waiver cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice waivers:

(b)(1) Mandates Medicaid enrollment into managed care
(b)(2) Utilizes a "central broker"
(b)(3) Uses cost savings to provide additional services
(b)(4) Limits the number of providers for services through competitive procurement

A 1915(b) waiver program cannot negatively impact beneficiary access, quality of care of services, and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver). 1915(b) waivers do not carry the evaluation requirements of 1115 waivers; however, an independent assessment is due each period. The evaluation requirement may be waived by CMS after the first two years of the waiver's implementation.

1915(c) Waiver
Section 2176 of PL 97-35 established section 1915(c) of the Social Security Act (the Act), the Medicaid Home and Community-Based Services (HCBS) Waiver program. Prior to the passage of this legislation, Medicaid long-term care benefits were limited to home health and personal care services and to institutional facilities: hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation ICF/MR). The HCBS legislation provided a vehicle for states, for the first time, to offer additional services not otherwise available through their Medicaid programs to serve people in their homes and communities. HCBS waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care. Home and community-based waivers (1915(c)) must be approved by CMS and are good for three years, after which they may be renewed every five years.

CARES Medicaid Preadmission Screening Program

The Comprehensive Assessment and Review of Long-Term Care Services (CARES) program is Florida's pre-admission screening program for nursing facilities and is federally mandated (see 42 CFR 456.372) for any person seeking financial assistance through Medicaid for nursing home care. AHCA has regulatory oversight for CARES and has delegated responsibility for determining individual level of care to DOEA. CARES staff within DOEA handle the medical component of eligibility determination for nursing home care through on-site assessment of the people who apply for Medicaid reimbursement for their nursing home care. Assessments must comply with the 1987 Federal Nursing Home Reform Act, which requires additional screening for applicants with certain mental illness or mental retardation diagnoses. CARES staff also are responsible under 42 CFR 441.391(3)(b)(1)(ii) for determining whether applicants meet eligibility criteria for most of Florida's home and community-based waiver programs. Section 409.912 (13)(a), F.S., requires AHCA to operate CARES in such a way as:

> to ensure that Medicaid payment for nursing home care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall ensure that individuals participating in Medicaid home and community-based waiver programs meet the criteria for those programs, consistent with approved federal waivers.

AHCA administers CARES through an interagency agreement with DOEA. The agreement was revised in 2002 to conform to amended language in s. 409.912, F.S., related to cost-effective purchasing of health care, to incorporate additional agency oversight of CARES. AHCA must monitor activities statewide through annual programmatic and administrative reviews and participate in quarterly meetings with CARES staff.

Part of the CARES mission at DOEA is to refer elders who can be served in the community to community service programs. Currently, CARES staff look at a 10 percent random sample of nursing home residents to see if there are individuals who could be transitioned into the Assisted Living for the Elderly waiver program. In 2002, AHCA, in consultation with DOEA, recommended that CARES staff look at a larger sample of the nursing home population. Currently, CARES staff claim they do not have the capability to look at more than the 10 percent sample.

Financial eligibility determination is the responsibility of DCF. Referrals to the program come from a variety of sources including hospitals, nursing homes, Elder Helplines, DCF themselves, and other state or local programs. Financial eligibility paperwork is often sent back and forth, resulting in delays in processing. CARES client tracking data is collected and maintained in the CARES Management System.

Florida Medicaid Home and Community-Based Services Programs for Elders

The state operates several programs through Medicaid waivers for home and community-based services. These programs offer services to frail elders (and others who are Medicaid eligible) that enable them to avoid Medicaid nursing home placements. These waivers reflect explicit policy choices intended to reduce the level of Medicaid nursing home utilization. Individuals must meet, at a minimum, a nursing home level of care to be eligible for the programs. Because Medicaid is a joint state/federal program, both entities share the costs for these waiver programs. For a detailed description of the programs, refer to Interim Project Report 2004-144, long report. These programs include:

- Adult Day Health Waiver
- Aged/Disabled Adult Services Waiver
- Assisted Living for the Elderly Waiver
- Assistive Care Services
- Channeling Waiver
- Consumer Directed Care
- Frail Elder Program
- Nursing Home Diversion Waiver

- Program for All Inclusive Care of the Elderly

State-Funded Home and Community-Based Services Programs for Elders

In addition to the Medicaid waiver and other diversion programs described above, the state also provides services and case management to frail elders funded exclusively through state revenues and federal Older Americans Act funding. The programs listed below are administered by DOEA to help elders at risk of nursing home placement remain at home or in a community setting. For a detailed description of the programs, refer to Interim Project Report 2004-144, long report. These programs include:

- Alzheimer's Disease Initiative
- Community Care for the Elderly
- Home Care for the Elderly
- Older Americans Act Programs

Enrollee data for the state-funded programs is collected and maintained in DOEA's Client Information and Registration Tracking System (CIRTS).

Nursing Home Diversion Waiver Program

The goal of the Nursing Home Diversion waiver program is to test the effectiveness of a long-term care program that uses managed care and outcome-based reimbursement principles. The Nursing Home Diversion waiver program uses a managed care delivery system to offer home and community-based services, both acute and long-term, as an alternative to nursing home care. The waiver is a managed care program, with all services needed by the individual capitated in a monthly rate. Waiver providers are responsible for providing all services that would have been provided under the Medicaid state plan, plus an array of home and community-based services. The capitation rate does not vary based on an individual's service utilization. Waiver providers subcontract with local providers for the majority of services. Beneficiaries in the waiver program choose providers from those under sub-contract with the waiver provider. By receiving integrated acute and long-term services, such as home-delivered meals, health services, and intensive case management, clients are better able to remain in the community.

The waiver was approved by CMS in 1997 and was started in Orange, Seminole, and Osceola Counties (Area 7) in 1998 and in Palm Beach County (Area 9) in September 1999. Many Medicare HMOs in the pilot areas decided not to provide services in Florida, which originally reduced the number of interested providers in the Nursing Home Diversion waiver program. There are four waiver providers, including one "other qualified provider" that is not an HMO. DOEA administers this program in consultation with AHCA through a cooperative agreement.

Enrollees in the Nursing Home Diversion waiver program must be age 65 or older, receiving Medicare Part A and Part B, and living in one of the program areas. These individuals must meet the CARES criteria of need for nursing home placement and must meet one or more of the following criteria:

- Require assistance with five or more activities of daily living;

- Require total assistance with two or more activities of daily living;
- Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with three or more activities of daily living; and
- Have a diagnosed degenerative or chronic medical condition requiring daily nursing services.

Participation in the program is voluntary and limited to the very frail to ensure that those served are truly at risk of nursing home placement. Program enrollees must be 65 and over, be dually eligible for Medicare and Medicaid, live in the project service area, and undergo a financial assessment by DCF to confirm their eligibility to receive services under Medicaid and a clinical assessment to determine if they meet the clinical criteria for being at risk of nursing home care.

Program Evaluation
DOEA performed an internal evaluation in June 2000 to assess the first year of operation of the long-term care community diversion pilot projects. This evaluation focused on client outcomes, such as consumer satisfaction and disenrollment patterns.

A preliminary evaluation of the providers who began enrolling individuals in 1998 and 1999 was completed in November 2001 by the Florida Policy Exchange Center on Aging at the University of South Florida. At the time of the Florida Policy Exchange Center on Aging evaluation, these projects had been in operation from 21 to 31 months. The evaluation found that enrollees in the waiver have complex health care needs and are, on average, more impaired than Medicaid beneficiaries enrolled in the Aged/Disabled Adult waiver. Ongoing communication is maintained through case managers in order to coordinate services. Case records document preventive care, family training and risk reduction. The study also found that case managers need ongoing training to understand the extensive number of services needed by and available to frail elders and that the eligibility process needed to be accelerated.

Currently, there has been no systematic, comprehensive evaluation of the Nursing Home Diversion program that includes consumer satisfaction and a look at quality of care and enrollee outcomes. At this point, no funds have been appropriated to evaluate this program.

Expansion of the Nursing Home Diversion Waiver Program
Specific Appropriation 198 and Specific Appropriation 203 in Senate Bill 2-A, the General Appropriations Act for FY 2003-2004, provided an increase in the Nursing Home Diversion waiver program budget of approximately $40 million. Proviso language accompanying the increase stated the goal of adding at least 1,800 new slots by the end of FY 2003-2004. Moreover, as a means of measuring progress toward the goal, the Legislature wanted to see at least 1,400 new enrollments by December 31, 2003.

DOEA has identified areas for expansion that would achieve the greatest impact on enrollment based on anticipated need, population density, and the effectiveness of current nursing home diversion efforts. DOEA has prepared a standard application packet and invited existing and new potential nursing home diversion program providers to a meeting to discuss the expansion of the program, the application process, and data collection issues. DOEA, in consultation with DCF also initiated statewide training of CARES staff and increased the capacity of staff in the current Nursing Home Diversion service areas to enroll individuals.

In order to expand the Nursing Home Diversion waiver program statewide, AHCA and DOEA had to seek approval from CMS. CMS wanted to see a fee-for-service option offered to potential diversion program enrollees as an alternative to the managed care option. After negotiations with AHCA and DOEA, CMS agreed to allow expansion of the program into specific areas of the state, but would not agree to allow the program to go statewide. Currently, the program will expand into Dade, Broward, Seminole, Osceola, Brevard, Hernando, Sarasota, Manatee, Hillsborough, Pinellas, Indian River, Okeechobee, and Martin Counties. According to DOEA, there were approximately 800 new enrollments in the program by early December 2003.

Changes to the Nursing Home Diversion Waiver Program Capitation Rate
In spring 2003, DOEA, in consultation with AHCA, contracted with Milliman USA (an actuarial firm) to study the capitation rate for the Nursing Home Diversion waiver program and to develop an actuarially certified rate. AHCA is now required under federal law [42 CFR 438.6(c)] to have actuarially certified rates for all payments under risk contracts. The contracts must specify the payment rates and any risk sharing mechanisms, and the actuarial basis for the computation of the rates and mechanisms. Rates must be based only on services covered under the Medicaid state plan. Thus, all managed care programs in the state must have actuarially certified rates that are recertified each year.

An actuarial analysis of the Nursing Home Diversion capitation rate was completed in September 2003. DOEA presented the new rates to Nursing Home Diversion providers and potential new providers on September 17, 2003 (See Senate interim project report 2004-144 for a detailed discussion of the methodology used to develop the new rates). After feedback and discussion with the plans, DOEA and AHCA decided on rates to be submitted to CMS. The submission was made in November 2003. Because the rates are substantially lower than what had been reimbursed, AHCA and DOEA proposed a three-year phase in of the rates so that the providers have time to adjust. AHCA is currently waiting on CMS approval of the new capitation rates.

Office of Long-Term Care Policy

CS/SB 1276 (2002) created the state Office of Long-Term Care Policy (s. 430.041, F.S.). The purpose of the office is to: 1) ensure close communication and coordination among state agencies involved in developing and administering a more efficient and coordinated long-term-care service delivery system in this state; 2) identify duplication and unnecessary service provision in the long-term-care system and make recommendations to decrease inappropriate service provision; 3) review current programs providing long-term-care services to determine whether the programs are cost effective, of high quality, and operating efficiently and make recommendations to increase consistency and effectiveness in the state's long-term-care programs; and 4) develop strategies for promoting and implementing cost-effective home and community-based services as an alternative to institutional care. The Director of the Office of Long-Term Care Policy is appointed by the Governor and is under the general supervision of the Secretary of DOEA. The 2002 Legislature funded three full-time equivalents (FTEs) and $350,000 in General Revenue for the office for FY 2002-2003. This was recurring for FY 2003-2004.

The office has a 13-member advisory council, whose chair was originally the director of the office. The role of the council is to provide assistance and direction to the office and ensure that the appropriate state agencies are properly implementing recommendations from the office. DOEA provides administrative support and services to the office.

The council is made up of the state agency heads involved in the provision of long-term care services as well as individuals appointed by the Governor from around the state who have experience in long-term care service delivery. During FY 2002-2003, the council held monthly meetings to discuss the current long-term care system and ways to improve it. The agency heads rarely attended meetings, sending representatives in their place. Since February 2003, the furthest back that attendance was available, there has not been full attendance at council meetings by council members.

The office submitted a report to the Governor in February 2003, based on recommendations from the council and other long-term care stakeholders. The report discussed the limitations of the current Florida long-term care system and recommended a study of the current waiver, diversion, and managed long-term care programs in the state. The report provided little analysis of the long-term care system and did not put together an action plan for how to evaluate or improve the long-term care delivery system.

CS/SB 642 (2003) removed the director of the Office of Long-Term Care Policy from the office's advisory council. The bill required the council to elect a chair from among its membership to serve for a 1-year term. The chair of the council may not serve more than two consecutive terms. A new chair was elected in mid 2003.

The director of the office resigned in May 2003. An employee of DOEA has taken over as interim director of the office until a new director is hired. DOEA is responsible for hiring a new director for the Office of Long-Term Care Policy. Little progress has been made in hiring a new director.

The office submitted its annual report in December 2003. While the report provides much information on the long-term care service delivery system and recommendations for changes to the system, including an aging resource center, it does not provide specific implementing strategies for the programmatic changes contained in this bill. In terms of the level of policy recommendations included, the report is similar to the master plan that DOEA must update for the Legislature every three years. The strategies discussed in the report are not specific enough to implement legislative changes to the current system and the report does not provide an overall plan on how to move Florida's long-term care system forward.

The office held a series of public hearings throughout the state during August 2003, as well as a two-day workshop for some members of Florida's elder services networks. The workshop was held in Tampa on August 6 and 7, 2003. According to DOEA, the meeting provided a format for service integration of long-term care services. Two key elements of the format were a single entry system with multiple access points, and a unified protocol to provide referrals and determine eligibility for publicly funded services. Other characteristics discussed included customer centered care and serving all seniors regardless of economic need with mechanisms such as capitation and prioritizing services based on standard criteria. The public meetings took

place in Panama City, Jacksonville, Tampa, and Ft. Lauderdale. Staff collected comments from the public and providers of long-term care services.

Older Americans Act, Area Agencies on Aging, Lead Agencies

The U.S. Congress enacted the Older Americans Act of 1965 to address concerns about the increasing numbers and needs of older Americans. The original act and subsequent amendments establish a network of federal, state, and local agencies that collaborate to plan and provide a variety of programs to meet the needs of older persons in the community. These networks are organized within planning and service areas (PSAs) determined by each state.

States have typically configured their PSAs around county, multi-county, or other existing service delivery systems such as health and human resources regions or education districts. Florida aligned its PSAs to coincide with the 11 Department of Health and Rehabilitative Services service districts then in existence. When DOEA became Florida's state unit on aging in 1992, it continued to use the same boundaries for program purposes. The Older Americans Act requires states to establish an Area Agency on Aging (AAA) in each PSA. Thus, there are 11 AAAs in Florida.

The AAAs serve as the advocate for elders within each PSA. Besides the federal Older Americans Act funds that the AAAs receive (including a 10 percent match of local and county funds), AAAs also receive state funds for the state general revenue funded programs, and Medicaid funds linked to specific home and community-based service waivers. The AAAs take on program oversight for DOEA at the local level. For example, DOEA has contractual agreements with the AAAs to oversee the Medicaid Aged/Disabled Adult waiver and the Medicaid Assisted Living for the Elderly waiver. The AAA board, in consultation with the secretary of DOEA, appoints a chief executive officer who has the responsibility for agency management and for implementation of board policy, and who is accountable for the AAA's performance.

DOEA is responsible for ensuring that each AAA operates in a manner to ensure that elderly Floridians receive the best services possible. DOEA can take action against a AAA if the department finds that:

- An intentional or negligent act of the AAA has materially affected the health, welfare, or safety of clients, or substantially and negatively affected the operation of an aging services program;
- The AAA lacks financial stability sufficient to meet contractual obligations or that contractual funds have been misappropriated;
- The AAA has committed multiple or repeated violations of legal and regulatory requirements or department standards;
- The AAA has failed to continue the provision or expansion of services after the declaration of a state of emergency;
- The AAA has failed to adhere to the terms of its contract with DOEA; and
- The AAA has failed to implement and maintain a DOEA-approved client grievance resolution procedure.

In Florida, the AAAs also administer the federally-funded Emergency Home Energy Assistance for the Elderly program, as well as the state-funded Community Care for the Elderly, Alzheimer's Disease Initiative, and Home Care for the Elderly programs.

Each AAA is responsible for developing a comprehensive and coordinated community-based system of care. They do this through needs assessment, contracting with lead agencies to provide direct client care, and advocating for increased federal, state, and local funding for services.

In Florida, lead agencies are community agencies that provide services directly to individuals. Lead agencies have provided case management services to the state's functionally impaired elders since 1980 when the Legislature expanded the Community Care for the Elderly program statewide. The Community Care for the Elderly Act required that each PSA in the state develop at least one community care service system to enable functionally impaired elders to live independently in the community and prevent unnecessary nursing home placement. A "community care service system" is defined in s. 430.203, F.S., as a "service network comprising a variety of home-delivered services, day care services, and other basic services, referred to as 'core services,' for functionally impaired elderly persons which are provided by several agencies under the direction of a single lead agency. Its purpose is to provide a continuum of care encompassing a full range of preventive, maintenance, and restorative services for functionally impaired elderly persons." A "lead agency" is defined in s. 430.203, F.S., as "an agency designated at least once every 3 years by an area agency on aging as the result of a request for proposal process to be in place no later than the state fiscal year 1996-1997."

The Community Care for the Elderly law requires AAAs to contract with lead agencies to coordinate case management and ensure that core services are available to meet the needs of the elders in their communities. Lead agencies may directly provide these services or subcontract with other providers. In essence, the lead agencies were developed specifically for the Community Care for the Elderly program, although they now function to provide case management and services under other programs (i.e., Home Care for the Elderly and Alzheimer's Disease Initiative) as well.

The AAAs are responsible for developing grants and contracts with the lead agencies that provide direct services as well as for monitoring and technical assistance to service providers. Although the majority of direct services are provided through contracts with the lead agencies, the AAAs can provide services directly to caregivers in crisis through the Family Caregiver Support Initiative. In addition, the AAAs manage the Elder Helpline. AAAs throughout the state vary significantly, partly due to the variation in size of the PSAs. The AAAs are local organizations that have adapted to meet the needs of individuals in their unique communities.

III. Effect of Proposed Changes:

Section 1. Amends s. 20.41, F.S., to require each Area Agency on Aging board, in consultation with the Secretary of Elder Affairs, to annually appoint a chief executive officer of the AAA, require the performance of the executive director of each AAA to be annually evaluated by the Secretary, and require the board to consider this evaluation and recommendations when it considers reappointments.

Section 2. Amends s. 409.912, F.S., to give AHCA the authority, in consultation with DOEA, to contract for any function or activity of the CARES program including any function or activity required by 42 CFR 483.20 relating to Preadmission Screening and Resident Review.

This section requires CARES program staff to assess all individuals whose length of stay in the nursing home is expected to exceed 20 days regardless of the initial funding source for nursing home placement. This requirement does not apply to continuing care facilities licensed under chapter 651, and retirement communities that provide a combination of nursing home, independent living, and other long-term care services.

This section also requires DOEA to develop a database to track individuals over time, who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall submit to the Legislature and the Office of Long-Term Care Policy, a longitudinal study of the individuals who are diverted from nursing home placement. The study must include:

- The demographic characteristics of the individuals assessed and diverted from nursing home placement including, but not limited to, age, race, sex, frailty, caregiver status, living arrangements, and geographic location;
- A summary of community services provided to individuals for 1 year after they have been assessed and diverted;
- A summary of inpatient hospital admissions for individuals who have been diverted; and
- A summary of the length of time between diversion and subsequent entry into a nursing home or death.

Section 3. Amends s. 430.04, F.S., revising the requirements by which DOEA can take action against a AAA to include:

- If the agency exceeds its authority related to its contract with the department or has exceeded its authority, or otherwise failed to adhere to the provisions specifically provided by statute or rule adopted by the department; and
- If the agency has failed to properly determine client eligibility as defined by the department or efficiently manage program budgets.

Section 4. Amends s. 430.041, F.S., locating the Office of Long-Term Care policy in DOEA for administrative purposes only; and providing that the office and its director shall not be subject to control, supervision, or direction by DOEA.

This section replaces the advisory council with an inter-agency coordinating team and specifies the composition of the inter-agency coordinating team to include at least one high-level employee appointed by the Secretaries of AHCA, DOEA, DCF, and the Department of Health, and the Executive Director of Veterans' Affairs with the authority to recommend and implement agency policy and with experience in the area of long-term care service delivery and financing. The inter-agency team shall meet monthly with the director of the office to implement the purposes of the office.

This section revises the reporting requirements of the office, requiring an annual report from the office which should contain additional information including the activities completed by the office during the calendar year, a plan of activities for the following year, and specific implementing strategies, with timelines, for accomplishing the recommendations and proposals set out in the report.

Section 5. Amends s. 430.203, F.S., redefining the terms "community care service system" and "lead agency." Requires a single lead agency to provide the array of services to functionally impaired elderly persons. This agency can provide any combination of those services. Requires the AAAs to exempt from the competitive bid process any contract with a provider who meets or exceeds minimum standards as determined by the department.

Section 6. Amends s. 430.205, F.S., to repeal the requirement that DOEA and AHCA develop a model integrated long-term care delivery system in one area of the state, and instead, to require DOEA and AHCA to develop a statewide integrated long-term care service delivery system.

During FY 2004-2005, this section specifically requires:

- AHCA, in consultation with DOEA, to integrate the Frail Elder Option and the Nursing Home Diversion waiver capitated long-term care programs and their funds into one capitated program serving the aged;
- AHCA and DOEA to develop uniform standards for case management in the newly integrated capitated system;
- AHCA, in consultation with DOEA, to integrate the Aged and Disabled Adult Medicaid waiver and the Assisted Living for the Elderly Medicaid waiver programs and their funds into one fee-for-service Medicaid waiver program serving the aged and disabled. Once the programs are integrated, funding to provide care in assisted living facilities under the new waiver shall be no less than the amount appropriated in fiscal year 2003-2004 for the Assisted Living for the Elderly Medicaid waiver;
- AHCA and DOEA to capitate case management services and develop uniform standards for case management in this fee-for-service Medicaid waiver program. The coordination of acute care services for individuals is to be included in the case management capitated rate;
- DOEA to reimburse providers for case management services on a capitated basis and provide uniform standards for case management in the Community Care for the Elderly program;
- DOEA, in consultation with AHCA, to study the integration of the CARES and CIRTS database systems and develop a plan for database integration. DOEA is required to submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2004;
- DOEA, in consultation with AHCA and DCF, to develop two resource centers on aging pilot projects. By December 31, 2004, DOEA, in consultation with AHCA and DCF, is to develop a resource center on aging implementation plan and submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The plan shall include center qualifications and functions to be performed by the centers. The department is to determine the entities to be designated as resource centers on aging by means of competitive procurement. This section provides necessary qualifications for resource center

on aging providers. This section requires DOEA to select two pilot sites for the resource centers on aging by June 30, 2005;

- DOEA, in consultation with AHCA, to develop a plan to evaluate the newly integrated capitated and fee-for-service programs over time, from the beginning of the implementation process forward. The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2004. The department shall contract with a research entity through competitive procurement to help develop the evaluation plan and conduct the evaluation; and
- AHCA, in consultation with DOEA, to work with the Medicaid fiscal agent to develop a service utilization reporting system that operates through the Medicaid fiscal agent for the capitated plans.

During FY 2005-2006, this section specifically requires:

- AHCA, in consultation with DOEA, to monitor the newly integrated capitated and fee-for-service programs and report on their progress to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2006. The report must include an initial evaluation of the integrated programs, in their early stages, following the evaluation plan developed by the department, in consultation with AHCA and the selected contractor;
- DOEA to monitor the resource center on aging pilot projects and report on their progress to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2006;
- DOEA, in consultation with AHCA, to integrate the CARES and CIRTS database systems into a single operating assessment information system by June 30, 2006; and
- DOEA, in consultation with AHCA and DCF, to develop a plan to improve the interface between the newly integrated DOEA assessment database, the Florida Medicaid Management Information System and the FLORIDA system in order to facilitate enrollment of individuals in the capitated and fee-for-service programs, as well as monitoring of eligibility requirements.

During FY 2006-2007, this section specifically requires:

- AHCA, in consultation with DOEA, to initiate a competitive procurement to develop a pilot project in which an entity or entities will be placed at risk for the fee-for-service Medicaid waiver program serving the aged and disabled and the state-funded programs serving the aged, including Community Care for the Elderly, Home Care for the Elderly and the Alzheimer's Disease Initiative. Qualified Community Care for the Elderly lead agencies will be given priority in the selection of pilot projects if they meet the minimum requirements specified in the competitive procurement.;
- AHCA, in consultation with DOEA, to develop capitation rates based on the historical cost experience of the state in providing Medicaid waiver services and state funded long-term-care services to the population over 60 years of age in the pilot area served;
- AHCA, in consultation with DOEA, to assure that the entity or entities placed at risk for these services have the tools necessary to manage the risk associated with providing services under a capitated program;

- AHCA, in consultation with DOEA, to work with rural areas of the state to make sure that there are feasible alternatives for these areas to be competitive in the procurement process;
- That an entity chosen as a risk-bearing entity may not act as a resource center on aging;
- AHCA, in consultation with DOEA, to evaluate the Alzheimer's Disease waiver and the Adult Day Health Care waiver programs to assess whether or not providing limited intensive services through these waivers produces better outcomes for individuals than if they received these services through the fee-for-service or capitated programs that provide a larger array of services; and
- AHCA, in consultation with DOEA, to begin discussions with CMS regarding the inclusion of Medicare in an integrated long-term care system. By December 31, 2006, AHCA is to provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives a plan for including Medicare in an integrated long-term care system.

During FY 2007-2008, this section specifically requires:

- AHCA, in consultation with DOEA and the chosen risk-bearing entities that have been operating on a pilot basis, to consider whether the entities should be placed at risk for Medicaid nursing home care and Medicaid prescription drug coverage. AHCA and DOEA are authorized to develop innovative risk-sharing agreements that limit the level of custodial nursing home risk that the administering entity assumes, consistent with the intent of the Legislature to reduce the use and cost of nursing home care; and
- DOEA, in consultation with AHCA, to consider whether providers operating in the capitated program should be placed at risk for the state-funded Community Care for the Elderly, Home Care for the Elderly, and Alzheimer's Disease Initiative Programs.

Section 7. Amends s. 430.7031, F.S., to require CARES program staff to review at least 20 percent of Medicaid nursing home resident case files annually to determine which nursing home residents are able to move to a community placement.

Section 8. Amends s. 430.705, F.S., relating to long-term care community diversion pilot projects to require DOEA to select providers that have a plan administrator dedicated to the Nursing Home diversion waiver program and project staff who can perform the necessary project administrative functions including data collection, reporting, and analysis. This section requires DOEA to select providers that demonstrate the following:

- Surplus requirements comparable to those for HMOs contained in s. 641.225, F.S.;
- Financial solvency standards comparable to those for HMOs contained in s. 641.285, F.S.;
- Prompt payment of claims comparable to those for HMOs contained in s. 641.3155, F.S.;
- Strong data collection technology capabilities that meet federal HIPAA security requirements as defined in 42 CFR 160 and 164; and
- Capacity to contract with multiple providers of the same service type.

This section also requires AHCA, in consultation with DOEA, to reevaluate and recertify the diversion pilot project capitation rates annually.

Section 9. Amends s. 430.709, F.S., specifying additional requirements for the evaluation of the Nursing Home Diversion waiver program. Specifically, this section requires AHCA to select a contractor with experience and expertise in evaluating capitation rates for managed care organizations serving a disabled or frail elderly population to conduct the evaluation of the Nursing Home Diversion waiver program as defined in s. 430.705, F.S. The evaluation contractor is to analyze and report on the individual services and the array of services most associated with effective diversion of frail elderly enrollees from nursing home placement, consumer and family satisfaction with the program, the quality of care for participants, the length of time diverted from a nursing home, the number of hospital admissions, and the cost effectiveness of the program and demonstrated savings to the state compared to fee-for-service Medicaid. The evaluation is to include an organizational analysis of each provider site.

This section requires AHCA to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the findings from the evaluation by June 30, 2005.

Section 10. Provides that the bill will take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providers offering case management and direct services to individuals across capitated programs will now be serving individuals under one program.

C. Government Sector Impact:

The costs to implement the bill will be spread out over the five years it takes to implement all of the provisions. The fiscal impact of the changes to integrate the long-term care system is presented by state agency below.

Department of Elder Affairs

The additional assessment, review, and case management requirements of CARES staff could require additional funding and FTEs for the CARES program. If more individuals are targeted for transition out of the nursing home into assisted living via the Assisted Living for the Elderly waiver program, the Assisted Living program will require additional funding. However, there should be a savings to the state based on the reduced cost of being served in an assisted living facility versus a nursing home.

Eliminating the advisory council will provide some savings to the state as well as ease up DOEA staff time that was being used to support the office.

FY 2004- 2005
Reimbursing case management services on a capitated basis could provide savings to the state, as it will limit a case management organization's potential to provide more case management than is necessary due to fee-for-service reimbursement.
The development of the resource center on aging pilot projects will require additional funding for administration as well as FTEs to oversee project development and start-up.

FY 2005-2006
Computer hardware and software may need extensive upgrading to accomplish the integration of the CARES and CIRTS databases. This upgrading will require additional funding. Development of a better interface between the integrated assessment databases and the FMMIS and FLORIDA systems could also require additional funding.

Agency for Health Care Administration

The AHCA administrative costs below are estimates. The costs are in the process of being further developed and refined. AHCA will incur administrative costs for:

- Planning and implementation of the integrated waivers;
- The development and implementation of a service utilization reporting system that operates through the fiscal agent for the capitated waiver plans;
- The interface of the new DOEA integrated assessment database with the Florida Medicaid Management Information System;
- Implementation of a competitively bid risk sharing program for the fee-for-service Medicaid waiver program and the state-funded programs serving the aged;
- An evaluation of the Alzheimer's Disease waiver program and the Adult Day Health Care Waiver program; and
- A contract for an independent, comprehensive evaluation of the community diversion pilot projects operating prior to FY 2003-04.

In addition, there may be an increase in Medicaid service costs, depending on the manner in which waivers are merged. Since the waiver programs being merged have varying levels of service provision and reimbursement levels, if the high-service, high-cost waivers are chosen as the standard model, the overall cost of the integrated waiver could be higher.

Total Revenues and Expenditures:	Amount Year 1 (FY 04-05)	Amount Year 2 (FY 05-06)
Sub-Total Non-Recurring Revenues	950,000	450,000
Sub-Total Recurring Revenues	800,000	1,550,000
Total Revenues	**$1,750,000**	**$2,000,000**

	Amount Year 1 (FY 04-05)	Amount Year 2 (FY 05-06)
Sub-Total Non-Recurring Expenditures	1,100,000	500,000
Sub-Total Recurring Expenditures	$1,100,000	$2,100,000
Total Expenditures	**$2,200,000**	**$2,600,000**

DIFFERENCE: **(Total Revenues minus Total Expenditures)**	Amount Year 1 (FY 04-05) **($450,000)**	Amount Year 2 (FY 05-06) **($600,000)**

This amount is the estimated General Revenue or other state funding required for the state match for the total estimated expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.