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.)

Prepared By: Health Care Committee

BILL:	SB 1000
INTRODUCER:	Senator Peaden
SUBJECT:	Medicaid/Fall-Prevention Program
DATE:	January 23, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Favorable**
2.			HA	
3.				
4.				
5.				
6.				

I. Summary:

This bill requires the Agency for Health Care Administration (AHCA) to establish a comprehensive geriatric fall-prevention program for Medicaid recipients in Broward and Miami-Dade Counties. The program shall serve 8,000 Medicaid recipients during the first year of operation and must be operational within 120 days of the effective date of this act.

The bill requires AHCA to evaluate the cost effectiveness and clinical effectiveness of the program and report the findings to the Legislature by January 1, 2009. If the evaluation demonstrates effectiveness, AHCA must develop a plan and timeline for statewide expansion of the program.

The bill also specifies legislative intent that the geriatric fall-prevention program will be included in the general Medicaid program and as a condition of credentialing for health plans participating in the integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older as established in s. 409.912(5), F.S.

This bill creates an undesignated section of law.

II. Present Situation:

Falls and Fractures Among Older Adults

Geriatric falls constitute a large, growing and costly health problem both nationally and in Florida. Falls are among the most common and serious problems facing elderly persons. Falling is associated with considerable mortality, morbidity, reduced functioning, and premature institutional placement.

According to the federal Centers for Disease Control and Prevention's National Center for Injury Prevention and Control, more than one-third of adults ages 65 years and older fall each year. Among older adults, falls are the most common cause of nonfatal injuries and hospital admissions for trauma. In 2003, more than 1.8 million seniors were treated in emergency departments for fall-related injuries and more than 421,000 were hospitalized.[1] Some additional national statistics related to falls among older adults include:

- In 2002, nearly 13,000 people ages 65 and older died from fall-related injuries.
- Of those who fall, 20 percent to 30 percent suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence, and increase the risk of premature death.
- Among people ages 75 years and older, those who fall are four to five times more likely to be admitted to a long-term care facility for a year or longer.
- Women sustain about 80 percent of all hip fractures.
- Among both sexes, hip fracture rates increase exponentially with age. People ages 85 years and older are 10 to 15 times more likely to sustain hip fractures than are people ages 60 to 65.
- By 2020, the national cost of fall injuries is expected to reach $43.8 billion (in current dollars).

In recent years, Florida has had the second highest incidence of deaths due to geriatric falls in the U.S., and falls are the leading cause of injury-related deaths in the state.[2] For Florida, there was a total of 24,219 hospital discharges with hip fractures as the principal or secondary diagnosis in 2003. The average age of these patients was 79 years of age; the average length of stay in the hospital was 6.9 days; and the average charge for an event was $39,672.[3]

Researchers have identified a number of risk factors for falls in older adults, most of which can be addressed through appropriate interventions and prevention efforts. Some of these risk factors include:

- Lower body weakness.
- Problems with walking and balance.
- Taking four or more medications or any psychoactive medications.
- Other factors such as Parkinson's disease, a history of stroke, arthritis, cognitive impairment, and visual impairments.

Strategies to prevent falls among older adults include exercises to improve strength, balance, and flexibility; reviews of medications that may affect balance; and home modifications that reduce fall hazards such as installing grab bars, improving lighting, and removing items that may cause tripping.

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[1] *Falls and Hip Fractures Among Older Adults: A Tool Kit to Prevent Senior Falls.* Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. http://www.cdc.gov/ncipc/factsheets/falls.htm

[2] Summary of Governor's FY 2004-05 Budget Recommendations. Agency for Health Care Administration.

[3] Hospital Discharge Data. Hip fracture diagnosis code: ICD-9-CM 820-820.9

Medicaid Geriatric Fall-Prevention Projects

Florida's Medicaid program had a geriatric fall-prevention demonstration program on two different occasions over the last few years. Each time, the program was authorized in proviso language in the General Appropriations Act (GAA), but would later cease operation as continuing funding was not appropriated. Specifically, in the FY 2002-03 GAA (2002-394, L.O.F.), funds were appropriated for demonstration projects "to reduce geriatric falls among community-based Medicaid recipients."

This first demonstration project was operational from March 19, 2003 through June 14, 2003, when the contract was terminated due to lack of continuation funding. The program was intended to have an average monthly caseload of up to 6,000 participants, although only 2,320 participants were actually screened. Of those that were screened, 1,984 participants were found at high risk of falling and 1,738 participants received intensive services during the project's three months of operation. The program, if it had been implemented for the full fiscal year, was expected to have had net savings of over $1 million.

In FY 2003-04, there was no appropriation for the project. In FY 2004-05, proviso language was included in the GAA that appropriated funds for the geriatric fall-prevention program (2004-268, L.O.F.), which was implemented in July 2004. The program was similar to the first project and was administered by the same company in Miami-Dade and Broward Counties. The programs provided the following services:

- **A Fall Risk Screening** which included occupational therapy tests for gait, balance and range of motion measures, ability to perform daily living activities, health history and pharmacy-related analysis, and other assessments to determine degree of fall risk.
- **A Comprehensive Assessment** presented to elders who were at significant risk for a fall, which included a recommended action plan to reduce the risk of falling and a detailed explanation of their risk factors.
- **Consultation** with the recipient's primary care physician, family and other professional or vocational caregiver, upon recipient's approval, to discuss risk-reduction strategies.
- **A Home Safety Assessment** for those deemed at high risk to determine home environments that increase risk and offer simple and low-cost risk reduction strategies.
- **A Care Plan** that included individualized services and strategies including environmental modifications, health-related interventions, assistive devices, and behavioral and educational programs.

The programs also provided education and support services including:

- **A Face-to-Face** visit each month to provide support and information. Telephone contacts were also to be made with program participants.
- **Educational Materials** for participants, family members and caregivers to provide continued education on risk behaviors, reduction strategies, and to offer support.
- **Information and Referrals** to other health professionals as needed, as well as referrals to other supportive and rehabilitative services.

- **A Call Center** staffed with trained professionals to provide information about falls, receive reports of falls and provide referrals.

The FY 2005-06 GAA (2005-70, L.O.F.) contained continuing base funding and funds for expansion of the geriatric fall-prevention program. However, these appropriations were subject to the Governor's line-item veto (which he exercised) and the program was discontinued for a second time due to a lack of continuation funding.

Program Savings

The only state estimate of cost savings in the program come from the Summary of Governor's FY 2004-05 Budget Recommendations. In this document, AHCA projected that implementation of the program would produce $1,048,900 in general Medicaid cost savings and an additional $5,872,900 in savings from nursing home cost avoidance. This represented a gross savings of $6,921,800, and net savings of $2,097,800.

In addition, the Medicaid geriatric fall-prevention program provider evaluated the programs after the Governor's projection to examine cost and clinical effectiveness.[4] In order to assess the cost savings to Florida Medicaid which were achieved between March 2003 and February 2005, ElderCare compared the healthcare utilization and costs observed in their screened and serviced Medicaid elder population (n=5,516) to the care and cost data for a control group of 5,516 other Medicaid elders. The control group was selected in a way such that their care and cost statistics were identical to the totals and averages in the entire population of Medicaid elders in Miami-Dade and Broward Counties. Based on this comparison, ElderCare determined the following:

- On long-term care, the Medicaid elders treated by ElderCare were 76 percent less likely to require nursing home care or other long-term care stays and had 51 percent lower cost per elder. These two factors resulted in an observed gross savings of $10,962,342 to Florida Medicaid.
- Medicaid elders served by ElderCare (n=5,516) had an 88 percent lower hospitalization rate than the control group--resulting in total savings to Florida Medicaid of another $2,585,854.
- Concerning outpatient services, the ElderCare group had a 24 percent lower utilization rate than did the control group--resulting in savings of $4,689,832.
- With reference to pharmaceutical use and costs, the Medicaid elders in the experimental group had a 21 percent lower utilization rate and a 30 percent lower cost-per-case than did the control group, yielding savings to Florida Medicaid of $8,750,094.
- Combining long-term care, hospitalization, outpatient, and pharmacy services, the ElderCare program achieved a total gross savings to the Florida Medicaid program of $26,988,122. Subtracting ElderCare's fees of $5,628,000 for this same time period yields a net savings if $21,360,122.

[4] *An Interim Report on the Outcomes of ElderCare's Geriatric Fall-Prevention Program for Florida's AHCA After 24 Months of Program Activity*. The ElderCare Companies, Inc. March 2005.

III. Effect of Proposed Changes:

Section 1. Requires AHCA to establish a comprehensive geriatric fall-prevention program. The program must be evidence-based and expand the programs previously implemented under state contracts M0337 and M0509 awarded in 2003 and 2004, respectively. The bill requires the program to serve 8,000 Medicaid recipients during the first year of operation and requires the program to be operational within 120 days of the act's effective date. The bill requires AHCA to evaluate the cost-effectiveness and clinical effectiveness of the program and report the findings to the Legislature by January 1, 2009.

The bill requires the fall prevention services provided during the first two years of operation of the program to be paid for using the same reimbursement system that was allowed under the previous program contracts, however, AHCA is required to change the reimbursement system to a capitated, risk-adjusted payment system by the first day of the third year of operation.

The bill specifies that the intent of the Legislature is that a geriatric fall-prevention program should be expanded statewide and included as a condition of credentialing for a health plan participating in the integrated long-term care, fixed payment delivery system established in s. 409.912(5), F.S.

Section 2. Provides an effective date of upon becoming a 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, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill authorizes the provision of fall-prevention services to 8,000 Medicaid recipients during the first year of operation at a rate of $804 per person or $6,432,000. The rate per person is based on the bill's requirement that services provided be paid as in the previous demonstration contracts (M0337 and M0509). Beyond the first year, the bill does not provide the number of persons to be served but does require that the same rate per person be continued the second year. The third year, the bill requires services to be reimbursed only on a capitated, risk-adjusted basis, although no specific information was provided regarding what that rate would be or how the risk-adjustment would be determined.

Other expenditures during the first year include the cost of one full-time program analyst (pay grade 24) position at AHCA to develop and manage the procurement process and provide contract management services, including monitoring contract requirements.

An evaluation by the AHCA of the cost-effectiveness and clinical effectiveness of the comprehensive geriatric fall-prevention program is required with a report to the President of the Senate and Speaker of the House of Representatives by January 1, 2009. The report is to include a plan and timetable for statewide implementation, if findings of the evaluation indicate that the program is cost-effective and clinically effective. The agency is further required to consider findings from previous evaluations and site-visits conducted under the earlier contracts, implying a multi-year evaluation. This evaluation would be completed by an independent entity and would require procurement and contract management activities.

The bill does not provide sufficient information to determine the scope of work required to conduct the evaluation, the number of years the evaluation should encompass, or the number of subjects to be evaluated and, as a consequence, it is difficult to estimate the cost of the evaluation. During the first year, however, an estimate is projected to cover the cost of developing the scope of work, identifying the variables to be measured, projecting the number of subjects to be evaluated, and defining the methods to be employed to determine cost-effectiveness and clinical effectiveness.

Beyond the first year of implementation, costs are difficult to project as the bill does not contain adequate information to determine the number of persons to be served nor is information available to estimate the cost of the required evaluation. One FTE at AHCA would be required throughout the implementation and contract period to undertake contract management and monitoring activities.

The greatest potential fiscal impact on AHCA is the bill's requirement to include comprehensive geriatric fall-prevention services as a statutorily-mandated Medicaid program making it available statewide to all Medicaid recipients. Potentially, hundreds of thousands of Floridians could be eligible for these services at a cost of $200 to $300 million per year (based on an estimate of the number of person who are community-dwelling, Medicaid eligible, 60 years and older: 340,000 individuals at a cost of $800 per person per year).

An undetermined amount of these costs should be offset by savings from reduced emergency department services, inpatient hospitalizations, pharmaceutical utilization, and nursing home and other long-term care services.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.