The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	SB 7056
INTRODUCER:	Health Policy Committee
SUBJECT:	Long-term Care Managed Care Prioritization
DATE:	February 9, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Lloyd	Stovall		**HP Submitted as Committee Bill**
1.	Brown	Pigott	AHS	**Pre-meeting**
2.			AP	

I. Summary:

SB 7056 addresses Medicaid's long-term care managed care (LTCMC) program and revises ss. 409.962 and 409.949, F.S., relating to eligibility, enrollment, and prioritization for the program.

The bill requires the Department of Elderly Affairs (DOEA) to maintain a statewide wait list for enrollment for the community-based services portion of LTCMC and to prioritize individuals for potential enrollment using a frailty-based screening tool that generates a priority score. The DOEA must develop the screening tool by rule. The DOEA is also required to make publicly available on its website the specific methodology used to calculate an individual's priority score. The bill requires individuals to be rescreened at least annually or upon notification of a significant change in the individual's circumstances.

When the DOEA Comprehensive Assessment and Review for Long-Term Care Services (CARES) program is notified of available enrollment capacity by the Agency for Health Care Administration (AHCA), a pre-release assessment is conducted of individuals based on the priority scoring process. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list will receive priority for pre-release assessment.

If found financially and clinically eligible, the individual may be enrolled in LTCMC.

An individual may also be terminated from the LTCMC wait list. Once terminated, an individual would be required to initiate a new request for placement on the wait list, and any previous priority consideration would be disregarded.

The bill identifies certain populations that are provided priority enrollment for home and community based services through LTCMC, and which do not have to complete the screening or

wait-list process as long as all other program eligibility requirements are met. These populations consist of:

- Individuals who are 18, 19, and 20 years of age who have chronic, debilitating diseases or conditions of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention; and
- Nursing facility residents requesting to transition into the community who have resided in Florida-licensed skilled nursing facility for at least 60 consecutive days.

The bill authorizes the DOEA and the AHCA to adopt rules to implement the bill.

Both the DOEA and the AHCA estimate no fiscal impact.

The effective date of the bill July 1, 2016.

II. Present Situation:

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[1]

Over 3.9 million Floridians are currently enrolled in Medicaid.[2] The Medicaid program's estimated expenditures for the 2015-2016 fiscal year are $24.7 billion.[3] The current traditional federal share is 60.51 percent with the state paying 39.49 percent for Medicaid enrollees.[4] Florida has the fourth largest Medicaid population in the country.[5]

Medicaid currently covers:

---

[1] *See* s. 409.963, F.S.
[2]Agency for Health Care Administration, *Report of Medicaid Eligibles* (Dec. 31, 2015), on file with the Senate Appropriations Subcommittee on Health and Human Services.
[3] Social Services Estimating Conference, *Medicaid Services Expenditures*, Jan. 7, 2016.
[4] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate* (February 2015), http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed Jan. 21, 2016). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.43% for SFY 2015-16.
[5]Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview* (January 22, 2015), slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited Jan. 21, 2016).

- 20 percent of Florida's population;
- 27 percent of Florida's children;
- 62.2 percent of Florida's births; and
- 69 percent of Florida's nursing homes days.[6]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures also varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[7] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[8]

Federal Poverty Guidelines for 2015[9] Annual Income (rounded)				
Family Size	**100%**	**133%**	**150%**	**200%**
1	$11,770	$15,654	$17,655	$23,540
2	$15,930	$21,187	$23,895	$31,860
3	$20,090	$26,720	$30,135	$40,180
4	$24,250	$32,252	$36,375	$48,500

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[10] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[11] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[12]

---

[6] Id at 10.
[7] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 3 (January 2015), http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited Jan. 21, 2016).
[8] Id.
[9] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited Jan. 21, 2016).
[10] Section 409.905, F.S.
[11] Section 409.906, F.S.
[12] *See* Section 1905 9(r) of the Social Security Act.

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized under federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate[13] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. As of December 2015, 3.19 million Medicaid recipients were enrolled in an SMMC plan while 793,515 were enrolled in Medicaid on a fee-for-service basis.[14]

Long-Term Care Managed Care

LTCMC provides services in two settings: nursing facilities and community settings such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees; however, home and community based services are delivered through waivers and are dependent on the availability of annual funding.

Enrollment in the home and community based services portion of LTCMC is managed based on a priority system and wait list. For the 2015-2016 state fiscal year, the state is approved for 50,390 unduplicated recipients in the home and community based services portion of the program.[15]

Eligibility and Enrollment

The AHCA is the single state agency for Medicaid; however through an interagency agreement with the DOEA, the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for LTCMC.[16] The CARES program has 18 field offices across the state which are staffed with physicians, nurses, and other health care professionals who evaluate the level of care an individual may or may not need for waiver services. The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

---

[13] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.

[14] The Agency for Health Care Administration, "Florida Statewide Medicaid Monthly Enrollment Report," December 2015, available at http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Dec. 23, 2015).

[15] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (June 11, 2015), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Waiver_Amend_Approval_Letter_2015-03-17.pdf (last visited Jan. 21, 2016).

[16] Florida Dep't of Elderly Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, http://elderaffairs.state.fl.us/doea/cares.php (last visited Jan. 21, 2016).

To receive nursing facility care, an individual must also be determined to meet the requirements of s. 409.985(3), F.S. This subsection requires:

> The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4), F.S. When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:
>
> (a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
>
> (b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
>
> (c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. Before being released, however, individuals must also meet the following eligibility requirements or participate in one of the following waivers, as applicable, to enroll in the program:

- Age 65 years or older and need nursing facility level of care;
- Age 18 years of age or older and are eligible for Medicaid by reason of a disability and need nursing facility level of care;
- Aged and Disabled Adult (A/DA) waiver;
- Consumer Directed Care Plus for individuals in the A/DA waiver;
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Frail Elder Option; or

- Channeling Services waiver.[17]

Individuals who are enrolled in the following programs may enroll in the LTCMC, but are not required to:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[18]

Individuals, both those who are enrolled in LTCMC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[19]

Aging Resource Centers

The Aging Resource Centers (ARCs) provide information to elders and adults who request long-term care services and may make referrals to lead agencies for vulnerable adults in need of other services. Under contract with the DOEA, the ARCs coordinate all initial screenings to determine prioritization for long-term care services, provide choice counseling for nursing facility placements, assist with informal resolution of member grievances with LTCMC plans, and provide enrollment and coverage information to LTCMC enrollees.

The ARCs are also responsible for services funded through these programs:

- Community care for the elderly;
- Home care for the elderly;
- Contracted services;
- Alzheimer's disease initiative; and
- The federal Older American's Act.[20]

The ARCs serve as a "one-stop shop" for all elder services, as elders can receive a single financial determination for all services, including Medicaid, food stamps, and Supplemental Security Income.[21] Minimum standards of operation and responsibilities for the ARCs are provided in s. 430.2053, F.S., and in administrative rules under ch. 58B-1, F.A.C.

---

[17] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Long-term Care Program*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last visited Jan. 21, 2016).
[18] *Id.*
[19] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Jan. 22, 2016).
[20] *See* s. 430.2053(9), F.S.
[21] *See* s. 430.2053(9), F.S.

Delivery System and Benefits

The AHCA conducted a competitive procurement to select LTCMC plans in each of the 11 regions. Contracts were awarded to health maintenance organizations (HMO) and provider service networks (PSN). Six non-specialty plans are currently contracted, including one PSN that is available in all 11 regions and one HMO that is in 10 regions.[22] Recipients receive choice counseling services to assist them in selecting the plan that will best meet their needs.

Each plan under LTCMC is required to provide a minimum level of services. These services include:

- Adult companion care;
- Adult day health care;
- Assisted living;
- Assistive care services;
- Attendant care;
- Behavioral management;
- Care coordination and case management;
- Caregiver training;
- Home accessibility training;
- Home-delivered meals;
- Homemaker;
- Hospice;
- Intermittent and skilled nursing;
- Medical equipment and supplies;
- Medication administration;
- Medicaid management;
- Nursing facility;
- Nutritional assessment/risk reduction;
- Personal care;
- Personal emergency response system;
- Respite care;
- Therapies; and
- Non-emergency transportation.[23]

A LTCMC plan may elect to offer expanded benefits to its enrollees. Some of the approved expanded benefits within LTCMC include:

- Cellular phone service;
- Dental services;
- Emergency financial assistance;
- Hearing evaluation;
- Mobile personal emergency response system;
- Non-medical transportation;
- Over-the-counter medication and supplies;

[22] *Supra*, note 19.
[23] *See* s. 409.98, F.S.

- Support to transition out of a nursing facility;
- Vision services; and
- Wellness grocery discount.[24]

LTCMC enrollees who are not eligible for Medicare receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may choose the same managed care plan for both components, but is not required to.

III. Effect of Proposed Changes:

Section 1 adds four definitions to s. 409.963, F.S., relating to long-term care managed care (LTCMC):

- "Authorized representative" means an individual who has the legal authority to make decisions on behalf of a Medicaid recipient or potential Medicaid recipient in matters related to the managed care plan or the screening or eligibility process;
- "Rescreening" means the use of a screening tool to conduct annual screenings or screenings due to a significant change which determine an individual's placement and continuation on the wait list;
- "Screening" means the use of an information collection tool to determine a priority score for placement on the wait list;
- "Significant change" means change in an individual's health status after an accident or illness; an actual or anticipated change in the individual's living situation; a change in the caregiver relationship; loss of or damage to the individual's home, or deterioration of his or her home environment; or loss of the individual's spouse or caregiver.

Section 2 amends s. 409.979, F.S., to clarify the existing eligibility process for the home and community based services through LTCMC. The bill establishes that Medicaid recipients must meet prerequisite criteria for eligibility and be determined eligible by the Long-Term Care Services (CARES) program preadmission screening program at the Department of Elderly Affairs (DOEA) to require nursing facility care as defined in s. 409.985(3), F.S.

The bill clarifies that offers for enrollment in LTCMC will be made subject to the availability of funds and based on wait-list prioritization. Before making any enrollment offers, the Agency for Health Care Administration (AHCA) and the DOEA are required to determine that sufficient funds are available.

The DOEA is directed to maintain a statewide wait list for enrollment into the program for home and community based services through LTCMC. Individuals will be prioritized for enrollment through a frailty-based screening tool that results in a priority score. The priority score is used to determine the release order for individuals from the wait list for potential enrollment. If capacity is limited for individuals with the same priority score, the individual with the oldest date of placement on the wait list receives priority for release.

[24] Agency for Health Care Administration, MMA - Model Contract - Attachment I - Scope of Services (Effective date 11/1/15) p. 5, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Attachment_I-Scope_of_Services_2015-11-01.pdf (last visited Jan. 21, 2016).

Aging Resource Center personnel certified by the DOEA are charged with performing the screening or rescreening for those requesting enrollment in the home and community based services through LTCMC.

To be placed on the wait list, an individual requesting long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening. A rescreening of the individual must occur annually or upon notification of a significant change in an individual's circumstances.

The DOEA must adopt the screening tool that generates the priority score by rule and make publicly available on its website the specific methodology used to calculate an individual's priority score. When an individual's screening has been completed, the DOEA must inform the individual or the individual's representative that the individual has been placed on the wait list.

If the DOEA is unable to contact the individual or the individual's representative to schedule an initial screening or rescreening, a letter must be sent to the last documented address to advise the individual to contact the DOEA within the next 30 calendar days to schedule a screening or rescreening. Failure to conduct a screening or rescreening will result in the individual's termination from the screening process and the wait list.

The bill requires the CARES program to conduct a pre-release assessment of individuals after notification by the AHCA of available capacity in the long-term care managed care program. The DOEA must release individuals from the wait list based on the priority score process and the prerelease assessment. An individual must be both financially and clinically eligible to enroll in LTCMC.

The bill directs the DOEA to terminate an individual on the wait list if the individual:
- Does not have a current priority score due to the individual's action or inaction;
- Requests to be removed from the wait list;
- Does not keep an appointment to complete the rescreening without scheduling another appointment;
- Receives an offer to begin the eligibility determination process for LTCMC; or
- Begins receiving services through LTCMC.

If an individual is removed from the wait list for one of these reasons, and subsequently requests to be placed on the wait list again, the individual is required to initiate a new request for placement on the wait list and any previous placement is disregarded.

The bill provides for priority enrollment for home and community based services through LTCMC for certain individuals. These individuals are not required to complete the screening or wait-list process described above if all other LTC eligibility requirements are met:
- Individuals who are 18, 19, or 20 years of age who have chronic, debilitating diseases or conditions of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention or

- Nursing facility residents requesting transition into the community who have resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days.

The bill provides both the DOEA and the AHCA authority to adopt rules to implement the provisions of this act.

The bill deletes obsolete statutory language.

Section 3 provides that the bill's effective date is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Elderly Affairs (DOEA) reports SB 7056 has no fiscal impact.[25]

The Agency for Health Care Administration (AHCA) reports the bill has no fiscal impact.[26]

VI. Technical Deficiencies:

None.

[25] Email from Jo Morris, Legislative Affairs Director, Department of Elderly Affairs (Jan., 22, 2016) (on file with the Senate Committee on Health Policy).
[26] Conversation with Joshua Spagnola, Legislative Affairs Director, Agency for Health Care Administration (Jan. 22, 2016).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.962 and 409.979.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 26, 2016:
The Committee Substitute names the Aging Resource Center personnel as the entity to conduct the screenings and rescreenings consistent with their current statutory duties in s. 430.2053, F.S. The CS also reinstates current law with respect to receiving long-term care services through the long-term care managed care (LTCMC) program.

B. Amendments:

None.