HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1123 Program of All-Inclusive Care for the Elderly
SPONSOR(S): Health Market Reform Subcommittee, Ponder
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N, As CS	Grabowski	Crosier
2) Health Care Appropriations Subcommittee	8 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Healthcare Administration (AHCA). AHCA and DOEA have operated the program using authority granted by the federal government.

HB 1123 codifies the PACE in Florida law and sets specific parameters on program services and participating organizations. The bill directs AHCA, in consultation with DOEA, to review and consider program applications submitted by entities seeking to become PACE organizations.

The bill also requires PACE organizations to meet specific quality and performance standards, as outlined by the federal Centers for Medicare and Medicaid Services (CMS). AHCA is charged with monitoring the reporting requirements assigned to PACE organizations.

The bill will have an indeterminate fiscal impact on the Florida Medicaid Program.

The bill provides an effective date of July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.8 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets will be reviewed. Additionally, a personal needs allowance will be applied as part of the eligibility determination process.[1] The current standard income limit in Florida for institutional care or services under the home and community based services waiver is $2,313 for an individual and $4,626 for a couple. There is also an asset limit for either category of $2,000 for an individual or $3,000 for a couple.[2]

In Florida, the Medicaid program is administered by the AHCA. AHCA delegates certain functions to other state agencies, including the Department of Children, Families and Elder Affairs (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. DCF is responsible for determining financial eligibility for Medicaid recipients.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997 (BBA)[3] that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing.[4] The PACE is an optional Medicaid benefit, but operates as a three-way agreement between the federal government, a relevant state agency, and a PACE organization.[5] In Florida, the PACE is a Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[6]

The PACE provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to

[1] The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. *See* Department of Children, Families and Elder Affairs, *Glossary (Chapter 4600) "Personal Needs Allowance," pg. 19,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last accessed March 9, 2019).
[2] Dep't of Children, Families and Elder Affairs, *SSI-Related Program-Financial Eligibility Standards: January 2019,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed March 9, 2019).
[3] Pub. L. 105-33.
[4] Services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[5] Department of Health and Human Services, Centers for Medicare and Medicaid Services, CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual (issued 6-9-2011), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last accessed March 8, 2019).
[6] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), available at http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last accessed March 8, 2019).

meet a person's health care needs while continuing to live safely in the community. The purpose of a PACE program is to provide comprehensive health care services that are designed to:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize dignity of and respect for older adults;
- Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.[7]

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Healthcare Administration (AHCA). DOEA is the operating entity and oversees the participating PACE organizations, while AHCA is formally responsible for maintaining the PACE agreement with the federal government. DOEA, AHCA, and the federal Centers for Medicare and Medicaid Services (CMS) must approve any application for new PACE agreements, as well as any expansion of current PACE organizations.[8]

PACE Organizations

A PACE organization is a not-for-profit, for-profit private or public entity that is primarily engaged in providing PACE services. For-profit entities operating PACE organizations do so under demonstration authority. The following characteristics also apply to a PACE organization. It must:

- Have a governing body or a designated person functioning as a governing body that includes participant representation.
- Be able to provide the complete service package regardless of frequency or duration of services.
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.
- Have a defined service area.
- Have safeguards against conflict of interest.
- Have demonstrated fiscal soundness.
- Have a formal participant bill of rights.
- Have a process to address grievances and appeals.[9]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[10]

Eligibility and Benefits

Under federal program rules, PACE participants must:

- Be age 55 or older.
- Reside in the PACE organization's service area.
- Be certified as eligible for nursing home care by their state and be able to live safely in a community setting at the time of enrollment.

Eligible beneficiaries who choose to enroll in PACE agree to forgo their usual sources of care and receive all their services through the PACE organization. PACE provides participants all the care and

[7] Supra note 6.
[8] Supra note 7.
[9] Id.
[10] Id.

services covered by Medicare and Medicaid, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. The benefit package for all PACE participants includes:

- Primary Care;
- Hospital Care;
- Medical Specialty Services;
- Prescription Drugs (including Medicare Part D drugs);
- Nursing Home Services;
- Nursing Services;
- Personal Care Services;
- Emergency Services;
- Home Care;
- Physical Therapy;
- Occupational Therapy;
- Adult Day Health Care;
- Recreational Therapy;
- Meals;
- Dental Care;
- Nutritional Counseling;
- Social Services;
- Laboratory/X-Ray;
- Social Work Counseling;
- End of Life Care and Transportation.

In most cases, the comprehensive service package permits participants to continue living at home rather than be institutionalized.[11]

Quality of Care

Each PACE organization is responsible for identifying areas in which to improve service delivery and patient care as well as developing and implementing plans of action to improve or maintain quality of care. Such activities are documented in the PACE organization's Quality Assessment and Performance Improvement (QAPI) plan. The QAPI plan must demonstrate improved performance in regard to five areas:

- Utilization of services in the PACE organization, especially in key services.
- Participant and caregiver satisfaction with services.
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period.
- Effectiveness and safety of direct and contracted services delivered to participants.
- Outcomes in the organization's non-clinical areas.[12]

[11] Supra note 6.
[12] Supra note 7.

Florida PACE Project

The Florida PACE project provides alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. Florida's first PACE organization was located in Miami-Dade County and began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, PACE organizations with funded slots exist in these Florida counties: Baker, Broward, Charlotte, Clay, Collier, Desoto, Duval, Lee, Miami-Dade, Palm Beach, Pinellas, Manatee, Martin, Nassau, Sarasota, and St. John's.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed Care program (SMMC).[13] Participation by PACE in SMMC is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC managed care plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[14]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to federal CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Funding

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through the state's General Appropriations Act (GAA).[15]

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference (SSEC) for the PACE. The SSEC principals from the Office of Economic and Demographic Research, the Governor's Office of Planning and Budget, the budget staff of the House of Representatives and the Florida Senate, seek a consensus on an appropriate risk-adjusted rate for the program which takes into account the current membership, any statutory or regulatory changes that may affect health care utilization, and any other changes that may impact costs positively or negatively.

[13] Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct. 1, 2013.
[14] Section 409.981(4), F.S.
[15] Chapter 2013-40, L.O.F.

Effect of Proposed Changes

HB 1123 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE). The program is not currently outlined in statute and has been operationalized through the annual appropriations process.

Program Parameters

HB 1123 authorizes the AHCA, in consultation with the DOEA, to approve organizations who have submitted the required application and data to CMS as PACE organizations pursuant to 42 U.S.C. s. 1395eee (2019). Applications, as required by CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must also be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must do the following:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by CMS by the proposed implementation date.
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve.
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Show evidence of regulatory compliance and meet market studies requirements, if applicant is an existing PACE organization which seeks to expand to an additional service area.
- Implement program within 12 months after date of initial state approval if granted authorization as a prospective PACE organization or such approval is void.

Quality of Care

HB 1123 requires that all PACE organizations meet specific quality and performance standards, as established by CMS. The bill designates AHCA as the state agency responsible for oversight of PACE organizations with regard to data reporting requirements.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Creates s. 430.84, F.S.; relating to Program of All-Inclusive Care for the Elderly.
Section 3: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. If the PACE program were to be expanded or additional funding provided, AHCA and DOEA could experience an increase in workload related to oversight of the program.

The bill will have an indeterminate fiscal impact on the Florida Medicaid Program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law appears to provide AHCA with sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2019, the Health Market Reform Subcommittee adopted an amendment to the bill that removed specific state funding requirements for the PACE program. The requirements originally included in the bill would have limited limit the ability of the Legislature to determine appropriate funding levels, which have traditionally been set in the General Appropriations Act.

The amendment also eliminated the ability for PACE organizations to provide services to program applicants prior to final determination of Medicaid eligibility.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.