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 Committee on Appropriations

BILL:	CS/CS/SB 1242
INTRODUCER:	Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Health Policy Committee; and Senator Book
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	April 20, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.	McKnight	Sadberry	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1242 codifies the Program of All-Inclusive Care for the Elderly (PACE) in section 430.84, Florida Statutes. The bill:

- Establishes a statutory process for the review, approval, and oversight of future and current PACE organizations.
- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to federal regulations.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS and the AHCA.
- Requires the AHCA to provide oversight and monitoring of Florida's PACE program and organizations.
- Exempts all PACE organizations from the requirements of ch. 641, F.S., which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The bill has no fiscal impact on state revenues or expenditures. *See* Section V of this analysis.

The bill takes effect on July 1, 2021.

II. Present Situation:

Medicaid

Medicaid is the health care safety net for low-income Floridians. 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 (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 are reviewed. Additionally, a personal needs allowance is 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 $2,382 for an individual and $4,764 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 Agency for Health Care Administration (AHCA). The AHCA, however, delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the Department of Elder Affairs (DOEA). The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services.

The DOEA assesses Medicaid recipients to determine if they require nursing home level of care. Specifically, the DOEA determines whether an individual requires or is at imminent risk of nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires:

- Medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.[3]

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance.

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[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 and Families (DCF), *Glossary (Chapter 4600) "Personal Needs Allowance," p. 19, available at* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last visited Mar. 16, 2021).

[2] DCF, *SSI-Related Program-Financial Eligibility Standards: Apr. 1, 2021, available at* https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf (last visited Mar. 16, 2021).

[3] Section 409.985, F.S.

Long-Term Care Managed Care

In 2011, Statewide Medicaid Managed Care (SMMC) was established,[4] requiring both Medicaid Long-Term Care (LTC) services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

Long-Term Care Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home care;
- Services provided in assisted living facilities;
- Hospice;
- Adult day care;
- Medical equipment and supplies, including incontinence supplies;
- Personal care;
- Home accessibility adaptation;
- Behavior management;
- Home delivered meals;
- Case management;
- Therapies, including physical, respiratory, speech, and occupational;
- Intermittent and skilled nursing;
- Medication administration;
- Medication management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response system.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)[5] that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing mechanism. The model was developed to address the needs of long-term care clients, providers, and payers.

The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid LTC managed care plan option providing comprehensive long-term and acute care services which support Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[6]

[4] Chapter 2011-134, Laws of Fla.
[5] Specifically, services under the PACE are authorized under Section 1905(a)(26) of the Social Security Act.
[6] Department of Elder Affairs (DOEA) and Agency for Health Care Administration (AHCA), *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014),

The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process; however, the state is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve participants. An approved PACE organization must sign a contract with the federal CMS and the state Medicaid agency, the AHCA.

The PACE is administered by the DOEA in consultation with the AHCA. The DOEA oversees the contracted PACE organizations but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations.[7] The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature through the necessary appropriation of the state matching funds.

PACE Organizations

A PACE organization is a private not-for-profit 501(c)(3) organization, for-profit private or public entity that is primarily engaged in providing PACE services and must also:

- Have a governing board 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 conflicts of interest;
- Have demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.[8]

Eligibility and Benefits

To be eligible for PACE, an individual must:

- Be 55 years of age or older;
- Live within the defined service area of the PACE Center;
- Meet medical eligibility requirements as determined by a Comprehensive Assessment and Review of Long-Term Care Services (CARES);[9]

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available at https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 31, 2021).

[7] *Id.*

[8] HHS, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 31, 2021).

[9] Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. Federal law mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks

- Be able to live safely in the community; and
- Be dually eligible for Medicaid and Medicare, or Medicaid only. There is also a private pay option with PACE, however this is not regulated by the State.[10]

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.[11] Review of the PACE organization may continue after the trial period by the Secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.[12] The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.[13]

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven Quality Assurance and Performance Improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. At a minimum, the plan should address the following 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; and
- Outcomes in the organization's non-clinical areas.[14]

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to receive home and community-based services through Medicaid waivers like Familial Dysautonomia Waiver, and Statewide Medicaid Managed Care Long-Term Care Program. Any person or family member can initiate a CARES assessment by applying for the Medicaid Institutional Care Program (ICP). Assessments are completed at no cost to the clients and are performed by a registered nurse and/or assessor. DOEA, *Comprehensive Assessment and Review for Long-Term Care Services (CARES), available at* http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 31, 2021).

[10] DOEA, *Program of All-Inclusive Care for the Elderly (PACE), available at* http://elderaffairs.state.fl.us/doea/pace.php (last visited Mar. 31. 2021).

[11] *See* 42 U.S.C. s. 1395eee(e)(4)(A) (2020).

[12] HHS, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Mar. 31, 2021).

[13] DOEA and AHCA, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Mar. 31, 2021).

[14] *Id.*

Florida PACE

The original Florida PACE project was authorized in 1998,[15] under the administration of the DOEA operating in consultation with the AHCA.[16] Florida's first PACE organization, located in Miami-Dade County, 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 General Appropriations Act (GAA) or general law.

In 2011, administrative responsibility for the PACE was moved from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the SMMC program.[17] Participation by the PACE in the SMMC program is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[18]

The current approval process for a new PACE project authorized by the Legislature 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. PACE 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 PACE providers in the same geographic region are not 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 PACE center, staffing for key positions, and signed provider network contracts, the AHCA certifies to the federal CMS that the PACE site is ready. At that time, the federal 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.

Enrollment and Organizational Slots

Slots are authorized by the Legislature for a specific PACE area; however, slots may not always be fully funded in the same year the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations.

[15] Chapter 98-327, Laws of Fla.
[16] Chapter 2011-135, s. 24, Laws of Fla., repealed s. 430.707, F.S., effective October 1, 2013, as part of the expansion of Medicaid managed care.
[17] Chapter 2011-134, Laws of Fla.
[18] Section 409.981(4), F.S.

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the GAA or through one of the GAA's accompanying implementing or conforming bills.[19] These directives provide specific slot increases or decreases by county or authorization for implementation of a new program.

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 for the PACE.

The Fiscal Year 2020-2021 GAA provided just over $73 million in PACE program funding to PACE organizations around the state.[20] The following table includes allocation and enrollment information outlined in the Fiscal Year 2020-2021 GAA:

Current PACE Programs[21]				
PACE Organization		**Enrollment**		
Service Area	**Organization**	**Authorized Slots**	**Funded Slots**	**Enrollment (Feb. 2021)[22]**
Broward	Florida PACE	150	125	99
Charlotte	Hope Select PACE	150	150	89
Clay, Duval	Northeast PACE Partners	300	150	57
Collier	Hope Select PACE	120	120	63
Lake, Orange, Osceola, Seminole, Sumter	InnovAge PACE	300	150	0
Lee	Hope Select PACE	380	380	260
Martin	Florida PACE	150	125	0
Miami-Dade	Florida PACE	828	828	816
Palm Beach	Morse PACE	706	706	649
Pinellas	Empath PACE	325	325	314
Total		**3,409**	**3,059**	**2,347**

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE) within the Florida Statutes. Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget. In addition, the bill:

[19] Chapter 2013-40, Laws of Fla.
[20] Chapter 2020-111, Laws of Fla.
[21] Email from the DOEA, (March 9, 2021) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[22] AHCA, *Florida Statewide Medicaid Monthly Enrollment Report* (February 28, 2021), *available at* https://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Mar. 31, 2021).

- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to 42 U.S.C. s. 1395eee. Applications, as required by the federal 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 be published in the Florida Administrative Register.
- Requires a prospective PACE organization to submit an application to the AHCA before submitting a request for program funding. An applicant must meet the following requirements:
  - Provide evidence that the applicant can meet all of the federal regulations and requirements established by the federal 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; and
  - Develop and provide a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Requires each applicant to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic area.
- Authorizes a PACE organization that has received funding for slots in a given geographic area to use the funding and slots to provide services in an authorized contiguous geographic area, upon approval from the AHCA.
- Requires an existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the AHCA to show evidence of regulatory compliance and meet market study requirements.
- Requires any prospective PACE organization that is granted initial state approval by the AHCA, in consultation with the DOEA, to submit its complete federal PACE application to the AHCA and the federal CMS within 12 months after date of initial state approval. If the organization fails to timely meet this requirement, the state approval of the application is void.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS and the state administering agency (the AHCA). The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and the federal CMS.
- Exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law that regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

Section 2 provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional private sector providers that meet the criteria to be a Program of All-Inclusive Care for the Elderly (PACE) organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to the PACE model for medical care and long-term care.

C. Government Sector Impact:

CS/CS/SB 1242 poses a minor operational impact to the AHCA, however, the workload can be absorbed using existing agency resources. Although the bill does not direct the AHCA to initiate rulemaking in conjunction with the new statutory language, the AHCA would need to utilize existing statutory authority to promulgate an administrative rule to clearly outline the AHCA's standard business operation. This can also be completed using existing agency resources.[23]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[23] AHCA, *House Bill 905 Fiscal Analysis* (Feb. 12, 2021) (on file with Senate Committee on Health Policy).

VIII. Statutes Affected:

This bill creates section 430.84 of the Florida Statutes.

IX. Additional Information:

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

CS/CS by Appropriations on April 19, 2021:
The committee substitute authorizes a Program of All-Inclusive Care for the Elderly (PACE) organization that has received funding for slots in a given geographic area to use the funding and slots to provide services in an authorized contiguous geographic area, upon approval from the Agency for Health Care Administration (AHCA).

CS by Health Policy on March 24, 2021:
The CS requires all PACE organizations to meet specific quality performance standards established by the federal CMS and the state administering agency (the AHCA), rather than just the federal CMS.

B. Amendments:

None.