The Florida Senate

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Committee on Health, Aging, and Long-Term Care James E. "Jim" King, Jr., President

MODEL LONG-TERM CARE SYSTEM/ANALYZING LONG-TERM CARE INITIATIVES IN FLORIDA

SUMMARY

Between now and the year 2025, Florida must prepare to provide, through public and private means, housing, health care, and supportive services for large numbers of Floridians who will reach their senior years as the "Baby Boom" generation ages. Florida policymakers have many reasons to improve state-funded long-term care service delivery programs, including offering consumers more service options, reducing the reliance on institutional care, improving care coordination between health and supportive services, improving access to services, controlling growth in state expenditures, and assuring quality of care. Over the past 20 years, the state has convened several long-term care advisory councils and undertaken multiple initiatives to reorganize delivery systems serving older people with functional limitations and chronic conditions. Although many of these programs have met with varying degrees of success, most have not evolved into successful, broadly implemented strategies for providing home and community-based long-term care services across the state.

This report is a condensed version of a more detailed report prepared by staff under the same interim project report number. The findings of these reports focus on legislative and other initiatives from 2001, 2002, and 2003 relating to the long-term care service delivery system and the progress that has been made in implementing these initiatives. The report identifies concerns related to the implementation of these initiatives.

The staff recommendations that flow from these concerns can be found on pages 8-11 and are in three specific areas: 1) the control of the number of Medicaid-funded nursing home days, 2) the Office of Long-Term Care Policy, and 3) the integration of long-term care services.

BACKGROUND

Population Aging

Florida is particularly affected by demographic aging trends because of its already large and growing number of senior residents. Nearly one in five Floridians is age 65 or older. Between 1991 and 2001, the population age 65 and older grew by over half a million individuals (18 percent). In Florida, 17.9 percent of the population is age 65 or older compared to 12.4 percent nationally. Between 2003 and 2025, the 65 and older population in Florida is expected to increase by 93 percent. Looking at just those individuals age 65 to 84, this population group is predicted to increase in Florida by 130 percent between 2003 and 2025.

Because life expectancies have increased and are expected to continue to do so, the proportion of the population 85 and older will also rise dramatically. This population—the population most likely to need long-term care services—grew 58.1 percent from 1990 to 2000, and is estimated to grow by another 77 percent between 2003 and 2025.

Elderly Medicaid Population

Florida has a proportionately larger elderly population than the nation as a whole, but provides Medicaid services to a smaller proportion of its elderly population, even though the elderly make up a larger percent of Florida's total Medicaid population as compared to the U.S. as a whole.

While 60 is generally the age where eligibility for age-based programs for the elderly begins in Florida, enrollees age 60 to 64 make up only 4.2 percent of the elderly Medicaid population. Proportionately, most Medicaid long-term care clients in FY 2001-2002 were age 85 or older (about 38 percent). Women receive Medicaid long-term care services at a much higher rate than men (72.3 percent and 27.7 percent respectively). The majority of elderly Medicaid beneficiaries are

Caucasian (71.2 percent) followed by African Americans (14.6 percent) and Hispanics (5 percent).

Administration of Long-Term Care Services

There is no single state agency in Florida with responsibility for oversight of the long-term care system. Operational responsibility for planning and management of the major long-term care programs is split between the Agency for Health Care Administration (AHCA), the Department of Elder Affairs (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.

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.

Florida has a number of long-term care waiver and diversion programs. The purpose of these programs is to provide services to individuals in their own homes and communities and prevent them from entering an institutional setting. Some of the programs are fee-for-service while others are capitated. (For a detailed description of the programs listed below, refer to the long report.)

Medicaid Home and Community-Based Service Programs for Elders

- 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

Non-Medicaid Home and Community-Based Services Programs for Elders

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

METHODOLOGY

Staff researched and documented legislation affecting the administration and funding of long-term care services in Florida from 2001, 2002, and 2003. Staff met and worked with staff of AHCA, DOEA, and DCF. Staff also met with staff of groups that represent consumers of long-term care services. Staff reviewed the operation of current capitated and fee-for-service long-term care waiver and diversion programs as well as evaluations and recommendations for the programs. Staff attended AHCA and DOEA meetings that dealt with the implementation of long-term care policies as well as the Long-Term Care Policy Advisory Council meetings. Staff also drew on discussions that have taken place with individuals from other states that have implemented integrated long-term care programs.

FINDINGS

Staff identified the following major initiatives relating to long-term care service delivery from 2001, 2002, and 2003. (For a more detailed description of the following initiatives, refer to the long report.)

2001 Initiatives

- Certificate of Need Moratorium on Nursing Home Beds
- Nursing Home Transition Program
- Medicaid "Up or Out" Program

2001 OPPAGA Recommendations

- Integrating Medicare and Medicaid Services
- Evaluation of the Nursing Home Diversion Pilot Project
- Co-Location of Comprehensive Assessment and Review of Long-Term Care Services (CARES) and DCF Eligibility Staff

2002 Initiatives

- Health and Human Services Access Act
- Consumer Directed Care Act
- Managed Integrated Long-Term Care Pilot Project
- Office of Long-Term Care Policy
- Plan to Reduce Medicaid-Funded Nursing Home Days
- CARES Program Review

2003 Initiatives

- Expansion of the Nursing Home Diversion Program
- Reduction of Medicaid Nursing Home Bed Days
- Medicaid Alzheimer's Disease Waiver
- Changes to the Office of Long-Term Care Policy
- Aging and Disability Resource Center

2003 Auditor General Recommendations

- DOEA Pilot Projects
- DOEA Medicaid Waivers

Controlling Medicaid Nursing Home Days

CON Moratorium

CS/CS/CS SB 1202 (2001) established a moratorium on AHCA approval of Certificate-of-Need (CON) applications until July 1, 2006, for all community nursing home beds. The 2000 Legislature had already created a workgroup to "study issues pertaining to the CON program, including the impact of trends in health care delivery and financing" and to "study issues relating to implementation of the CON Program." The nursing home subcommittee of the workgroup made some specific proposals in its final report, including: 1) allowing increased flexibilities for nursing homes to replace or transfer beds among facilities within districts without adding to the overall number of beds; 2) creating a CON advisory panel for nursing home issues; 3) increasing the occupancy standard in the current CON bed need methodology for nursing home beds; 4) deleting the requirement for Gold Seal designation for highly utilized nursing homes to seek additional beds without CON review; and 5) change requirements related to the submission of audited financial statements used in CON reviews.

To date, the Legislature has not acted on any of the CON Workgroup's proposals related to nursing homes. By 2006, the Legislature must decide whether to continue the moratorium and, if the moratorium is allowed to expire, whether to use CON for nursing homes to tightly restrict the nursing home bed supply and to influence the type of nursing home care that will be provided in the future.

Nursing Home Transition Program

During the 2001 legislative session, proviso language in the General Appropriations Act transferred $2,291,811 from AHCA's Medicaid nursing home budget to the Assisted Living for the Elderly waiver program line item. Transferred funds were specifically designated for nursing home residents assessed at an Intermediate II level of care who could be appropriately served in less restrictive, more cost-effective settings through the Medicaid Assisted Living for the Elderly waiver program. The appropriation was based on moving 445 individuals. As of September 2003, 652 individuals have been transitioned out of nursing homes into assisted living facilities via the Assisted Living for the Elderly waiver program

AHCA has contracted with the Pepper Institute on Aging at the Florida State University to evaluate the Nursing Home Transition program and provide a more in-depth analysis of the transitioning process. Results from the study will be available in December 2003.

Part of the CARES mission at DOEA is to refer elders who can be served in the community in non-institutional settings to these non-institutional services in the community. 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. Currently, CARES staff claim they do not have the capability to look at more than the 10 percent. Any expansion of the assessment of nursing home residents for possible transition to assisted living facilities may require increased funding for CARES and would require increased funding of the Assisted Living for the Elderly waiver program since there is already a waiting list for this program.

One approach to consider would be a "Transition Unit" that could travel around the state and perform these random sample assessments. For example, two RNs could handle the on-site review at the nursing home and once they found possible transition candidates, they could contact the local CARES offices which could then work with the individuals to see if transitioning was really an option.

Another approach would be to have CARES assess all nursing home entrants. CARES staff would intervene prior to Medicaid payment being authorized. In addition to assessing Medicare residents, CARES staff would be in a position to present a plan of services. This plan would be based on the resident's willingness to return to a community-based setting. The presentation of alternatives and choices to residents, family members, and nursing home staff either prior to or at the time of admission, would make all parties more inclined to consider discharge at a future date. Assessing all new nursing home entrants would be expensive and time consuming for CARES, however,

the additional expense and time could be limited if the CARES staff only assessed those entrants who remained in the nursing home longer than the 20 days fully reimbursed by Medicare. Once an individual reached the 21-day point, CARES could then present a plan of services as discussed above.

A funding option to consider is to support transition planning under the Medicaid state plan as targeted case management. An important issue concerns what kind of reimbursement methodology to use in supporting these services--either a "cost-based" approach that would pay providers for the amount of time devoted to transitional planning, or a "capitated" approach that would pay providers a fixed amount for each person transitioned, or for each person who was at least identified as a candidate for transition.

Medicaid "Up or Out"

The Up or Out Program was created in 2001 to address the quality of care in those long-term care facilities in the state that continually score in the bottom 25th percentile on the nursing home survey. The program was to provide assistance to nursing homes to improve their survey results within a given time period or risk de-licensure and loss of Medicaid funding. In 2002, the appropriation for the program was cut to $100,000 per year, limiting what AHCA could develop as a pilot. A contract was signed, in April 2003, with Evercare. This project is being evaluated as it develops, but it is too early to know the effect the program will have on quality of care in these poor performing facilities.

AHCA conducted site visits at two of the three nursing homes participating in the Up or Out program on October 22, 2003. The third facility was involved in its annual survey. Although it was too early to measure the overall progress in the facilities, the nursing homes visited by AHCA staff reported an excellent working relationship with the Evercare consultants. One nursing home discussed the following positive components of the Up or Out program thus far:

- The nursing home is assigned a nurse practitioner, who has extra expertise;
- The nurse practitioner makes phone calls to the families, which is very helpful;
- There is continuity of care;
- The nurse practitioner can answer questions for non-Evercare residents as well, although she concentrates on the Evercare residents;
- There is improvement in the care planning process; and
- There is training of the certified nursing assistants.

According to AHCA, there are a number of poor performing facilities with low occupancy that could be considered for termination of their Medicaid provider agreements. Because there may be no other institutional or community alternatives for people other than the nursing home in some areas, however, the state must be cautious in making decisions to close facilities or terminate Medicaid provider agreements.

One stipulation of AHCA terminating the Medicaid provider agreement could be the evaluation of the availability of home and community-based alternatives on a facility-by-facility basis. Medicaid funds could be redirected to waiver programs in cases when people are transferred from the nursing homes to a waiver program when a facility is closed. Another option could be to revoke the license of a facility that continues to perform below standard after having been enrolled in the Up or Out program.

Reduction of Medicaid Nursing Home Bed Days

CS/SB 1276 (2002) required AHCA, in consultation with DOEA, to submit to the Governor and Legislature a plan to reduce the number of Medicaid-paid nursing home bed days by substituting care provided in less costly alternative settings. The plan was to include specific goals for reducing Medicaid-funded bed days and recommend specific statutory and operational changes necessary to achieve the reduction. The plan also had to include an evaluation of the cost-effectiveness and relative strengths and weaknesses of alternative long-term care programs.

AHCA submitted a report with recommendations in December 2002. The report made several recommendations in five key areas:

- Restrict the supply of nursing home beds;
- Promote cost-effective independent living for at-risk older people;
- Increase nursing home diversion and transitioning;
- Make Medicaid a more selective purchaser of long-term care services; and
- Increase private spending for nursing home care.

Proviso language in Specific Appropriation 198 in SB 2-A (2003) mandated that AHCA, in consultation with DOEA, develop a statewide plan for reducing the proportion of total Medicaid long-term care funds committed to nursing home care in order to increase future resources available for home and community-based care. The plan must include options to reduce nursing home occupancy by 200 slots per quarter beginning October 1, 2003.

AHCA submitted its plan for reducing Medicaid-funded nursing home days on September 30, 2003. The plan, entitled the "Florida Nursing Home Transition Initiative," involves state and local transition teams that will work to transition people from nursing homes back to the community or a more appropriate setting such as an assisted living facility. AHCA will designate a state project director for the initiative who will coordinate with staff from DOEA and DCF to assist in the project. AHCA will conduct a statewide study of the characteristics of the Medicaid-eligible nursing home residents to identify those with the greatest potential for transition to a community setting. This plan does not address the issue of dealing with high nursing home occupancy in rural areas. The state still should consider developing community-based alternatives in rural settings.

The Legislature could consider targeting individuals before they become enrolled in the Medicaid Institutional Care Program. As discussed earlier, having staff monitor individuals who are in the nursing home for rehabilitation and then counsel them, once they hit the 20-day fully reimbursed Medicare limit will help to keep these individuals from ever entering the program and will engage the family up front. Once an individual is settled in a nursing home for an extended period of time, the individual and the family will be less likely to want to deal with a move.

Long-Term Care Service Integration

OPPAGA Recommendations

In 2001, OPPAGA recommended that DOEA petition the Centers for Medicare and Medicaid Services to pursue waivers that achieve the integration of Medicaid and Medicare services under one provider. OPPAGA also recommended that DOEA contract for a comprehensive evaluation of the Long-Term Care Nursing Home Diversion Pilot Project that addresses the areas required by law.

DOEA performed an internal evaluation in June 2000 to assess the first year of operation of the program. This evaluation focused on client outcomes, such as consumer satisfaction and disenrollment patterns. A preliminary evaluation of the providers who began enrolling individuals in the Nursing Home Diversion Pilot Project in 1998 and 1999 was completed in November 2001 by the Florida Policy Exchange Center on Aging at the University of South Florida. The evaluation found that enrollees in the project 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.

The evaluation did not cover most of the recommendations made by OPPAGA, including a focus on client-specific outcomes, adverse incident comparisons, and an actuarial analysis. This was partly due to the limited data available because the program was in its early stages. 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.

To improve the efficiency of CARES staff assessments and increase client diversions from nursing homes, OPPAGA recommended that CARES staff should continue to co-locate with service providers whenever possible in order to collaborate more closely with service providers and DCF financial eligibility staff.

There are a number of reasons why it could take a while to complete the financial part of an eligibility application, including difficulty getting the necessary income and asset information from the applicants. It is difficult to determine why the process takes so long because there are so many ways that an individual can enter the long-term care system and there is inconsistency in the process across areas of the state. One would almost have to follow individuals on a case by case basis as they go through the process, starting from the various entry points, to see where the slow-down in the process occurs.

A system could be put in place to ensure that individuals are tracked appropriately when they are moving through the application process. Case managers often do not get involved with individuals until they are deemed eligible because they get reimbursed for case management and have no incentive to get involved before reimbursement is guaranteed. Under the Nursing Home Diversion program, according to DOEA, CARES staff have an active role in getting individuals through the eligibility process and enrolled in the program. CARES staff identify problems enrollees face when waiting for their eligibility determination. Individuals waiting for eligibility determination under other programs do not

necessarily have an advocate. There is much potential for an individual waiting for services to end up in a nursing home, converting over time to Medicaid nursing home care. Also, under the managed care programs, case managers have more of an incentive to track potential enrollees because they know if someone gets into the program more quickly, that this is an extra month of capitation payment and that they also can start managing the person's care more quickly, in the hopes of delaying nursing home placements.

Managed Integrated Long-Term Care Pilot Project
CS/SB 1276 (2002) required DOEA, in consultation with AHCA, to develop a model system in which a single entity would administer a mandatory comprehensive health and long-term care service delivery system that would serve all persons aged 65 and older who are in need of federal and state-funded services and meet eligibility requirements.

The legislation called for one entity to be responsible for organizing the entire service delivery system in a specific area, developing provider networks, and developing contracts with providers currently under contract with the department, area agencies on aging, or Community Care for the Elderly lead agencies. The entity would also subcontract for assessment, service, care plan development, and quality assurance, and maintain a separation between the authorization for enrollment, payment, and the provider actually providing the services.

During the 2002-2003 fiscal year, DOEA worked with AHCA to develop the managed integrated long-term care pilot project as required under s. 430.205(6), F.S., however, progress has been slow. In early 2003, AHCA and DOEA conducted public meetings in five cities (Orlando, Jacksonville, Tampa, Ft. Lauderdale, and Tallahassee) to seek the advice of stakeholders in the integrated long-term care project design. Discussion was organized around five topics: access; assessment and care plan development; integrating long-term and acute care; issues of finance, administration, and risk; and program evaluation.

Participants in the meetings had many questions about the new program. Since the statute included certain design features but no details about how the program would actually be constructed, much of the discussion involved attempts to figure out how a program of that sort could be configured for Florida. Through this general activity, participants described problems with the current system that they felt the new system could remedy, but they also identified features of the current system they feared would be lost, and were doubtful that a single design would work equally well statewide. Instead, they suggested that any program would have to be molded to fit the particular area served, and they argued that the more rural parts of the state were not well suited to this type of program. On the whole, participants emphasized the need for DOEA to proceed cautiously and for the time schedule of the project to be extended.

Since the stakeholder meetings were completed in March, little progress has been made on implementing the legislation. This is due in part to a change in DOEA's and AHCA's focus to mandates from 2003 that required immediate action. These are discussed below.

Nursing Home Diversion Program Expansion
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 the 2003-2004 fiscal year. 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 staff report that there were 550 new enrollments in the program by the end of October 2003.

CARES staff are being trained to work with DCF's FLORIDA System database so that they can input the medical assessment information that goes to DCF for processing the applications for enrollment into the Nursing Home Diversion waiver program at a faster rate. Staff in new areas will have to receive training on enrolling participants in this program. This training has begun in Hillsborough county.

It will be important for DOEA to carefully assess the capabilities of those entities that want to apply to become nursing home diversion program providers. Such entities will need to understand and be able to manage a risk-based system. They will also need to have the necessary technology to develop quality data collection techniques, especially with the new HIPAA requirements. The Legislature may want to consider establishing minimum standards and rule authority for DOEA for providers under the waiver.

The mandate to expand the Nursing Home Diversion waiver program is compelling change on the state's long-term care system. The expansion has the potential

to be the catalyst for the changes seen as necessary to prepare Florida for the growth in the elderly population as well as manage rising Medicaid costs. The traditional fee-for-service waiver programs and state-funded programs did not receive the additional funding that the Nursing Home Diversion waiver program did. Opportunities for change are in the capitated reimbursement system. Reimbursement shapes how long-term care services are delivered.

Aging and Disability Resource Center

DOEA is working to develop an Aging and Disability Resource Center (ADRC) that would serve as single point of access for information, counseling, referrals, assessment, and eligibility functions for privately and publicly funded long-term care services. As DOEA moves forward in the development of an ADRC, it should clearly define the functions of a resource center and the qualifications an entity would need to have in order to act as an ADRC. For example, will the ADRC have the final say in program slot allocation? If an entity other than a AAA becomes a center, how will the funding be distributed and what will the role of the AAA be? Also, what information systems will be used in the ADRC and will they interface with other entities? These questions should be considered before the implementation of an ADRC.

DOEA could also develop performance standards for the centers before they move forward with the project. A quality assurance plan, as well as quality improvement mechanisms for the resource centers, could also be addressed. The Legislature may want to consider establishing minimum standards in statute for entities that want to act as resource centers.

There has been discussion of the need to hold stakeholder meetings in an effort to get local entities involved, as well as to develop local ADRC councils under the auspices of the Office of Long-Term Care Policy. The specific role of the Office of Long-Term Care Policy versus DOEA's role in the development of the ADRCs is unclear. The involvement of the Office of Long-Term Care Policy in "administering" a program raises questions about the role of the office vis-à-vis the role of the agencies responsible for the delivery of services. The purpose of the office as set forth in s. 430.041(2), F.S., does not appear to include administrative functions such as overseeing implementation of a grant or any other state program. The development of the ADRC would be more appropriate for DOEA, AHCA, and DCF to coordinate.

Office of Long-Term Care Policy

Included in CS/SB 1276 (2002) was the creation of 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 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.

The office never fully developed as it was laid out in the legislation. The office was supposed to have high-level policy people gather data on long-term care service delivery and financing from the state and analyze this information. This policy analysis would then serve as the means for the office to make broader policy decisions about the financing and provision of long-term care services in the state. One of the functions that was supposed to take place involved the office coordinating with AHCA, DOEA, DCF the Department of Health, and the Department of Veteran's Affairs, to bring each agency's long-term care policy staff together. This coordination never occurred.

Since the resignation of the director of the Office of Long-Term Care Policy, the advisory council has worked with the state agencies to gather the necessary information to develop the report that is due to the Governor in December 2003. DOEA staff are providing this information to the advisory council. This raises questions about the appropriate role of the advisory council, which has become, by default,

involved in the office decision-making process instead of acting in an advisory role as laid out in statute. Another issue involves DOEA staff working for the office. There is the sense that the office and DOEA are too closely tied together and that the office is not operating in an objective fashion to coordinate with all of the state agencies.

Other than the report that was submitted in February 2003, little progress has been made by the office. The director resigned in May 2003. An employee of DOEA has taken over as interim director of the office until a new director is hired. The advisory council took over most of the responsibilities of the office in coordination with DOEA and continues to meet monthly in order to prepare the December report. However, only a limited number of council members attend the monthly meetings, making it difficult for the office and the council to perform the functions assigned by statute. The advisory council members who regularly attend the meetings continue to work hard to fulfill their responsibilities to the office.

DOEA is responsible for hiring a new director for the Office of Long-Term Care Policy. As of early November, little progress in hiring a new director had been made. DOEA staff have been assisting the advisory council by staffing its meetings, gathering information, and writing the report that is due in December.

RECOMMENDATIONS

This report has reviewed the numerous legislative mandates from the 2001, 2002, and 2003 legislative sessions, and other initiatives during that time period, related to the provision of long-term care services in Florida and has identified concerns related to the implementation of these program changes. The staff recommendations that flow from these concerns are in three specific areas: 1) the control of the number of Medicaid-funded nursing home days, 2) the role of the Office of Long-Term Care Policy, and 3) the integration of long-term care services.

Controlling the Number of Medicaid-Funded Nursing Home Days

The Legislature could consider a number of options for controlling the number of Medicaid-funded nursing home days, including limiting the nursing home bed supply, diverting potential nursing home residents to home and community-based programs, and transitioning nursing home residents back into home and community-based programs.

CON Moratorium

The nursing home occupancy rate should be reevaluated on a yearly basis to determine if, and when, the CON moratorium should be lifted. At current occupancy rates, the moratorium could be continued. The projected growth in the 85 and older population will start between 2005 and 2010. The CON moratorium is set to expire on July 1, 2006, and the 2006 Legislature will need to determine whether to extend the moratorium.

If a decision is made to lift the moratorium prior to 2006, or let the moratorium expire in 2006, the Legislature could consider using CON for nursing homes to tightly restrict the nursing home bed supply and to influence the type of nursing home care that will be provided in the future.

Medicaid Up or Out

AHCA should report on the results of the Medicaid Up or Out pilot program, with a recommendation whether to continue the program, by December 31, 2004, and whether failing facilities should be removed from the Medicaid program or have their licenses revoked.

Diversion from Nursing Homes

The Legislature should continue current diversion efforts, maintaining an emphasis on the use of home and community-based services.

Assessment Intervention Prior to Medicaid Conversion

The CARES program could commit staff to assess Medicare nursing home residents as soon as a resident's nursing home stay exceeds 20 days fully reimbursed by Medicare.

Nursing Home Transitioning

While staff recognizes that, over time, transitioning individuals out of nursing homes may not yield big results, transitioning efforts should be continued. Whether working through a private contractor as suggested by AHCA or designating staff at DOEA to work specifically in nursing homes to locate individuals eligible for transitioning, staff recommend that a larger number of case files be reviewed for transitioning purposes.

Role of the Office of Long-Term Care Policy

The Legislature could consider repealing the statutory authority for the Office of Long-Term Care Policy and

its advisory council since they do not appear to be fulfilling their statutory responsibilities.
Communication and coordination between the state agencies involved in the provision of long-term care services and financing will still be important. These entities should work together to develop a comprehensive plan for long-term care service provision and financing in the future.

Long-Term Care Service Integration

The Legislature could lay out a plan for developing a model integrated long-term care system, following the initial mandate of CS/SB 1276, and in the context of the other long-term care initiatives that have passed since CS/SB 1276. The plan could require specific annual activities, with goals to be met at the end of each year. A proposed plan for legislative consideration is laid out below:

Nursing Home Diversion Program Expansion

DOEA and AHCA should determine the number of Nursing Home Diversion program providers appropriate for the eligible population in each area where the Nursing Home Diversion program is operating.

Provider Requirements

The Legislature could establish additional criteria necessary for entities to become Nursing Home Diversion program providers.

Capitation Rates

AHCA, in consultation with DOEA, should secure Medicare data to be used in the development of Nursing Home Diversion waiver program capitation rates.

DOEA and AHCA should consider the following questions as the rate methodology is reevaluated and solidified for the next contract period:

- How does Florida's methodology and the resulting rates compare with other states' methodologies and rates for similar programs?
- How can the state develop a system to begin to collect utilization data across plans that is consistent and accurate as well as HIPAA compliant?
- Are there any differences between the Nursing Home Diversion program and the Aged/Disabled Adult waiver program and Assisted Living for the Elderly waiver program service delivery systems that are not accounted for in the current rate methodology?
- Do Nursing Home Diversion waiver program enrollees achieve better outcomes than Aged/Disabled Adult waiver program and Assisted Living for the Elderly waiver program enrollees and can these outcomes be quantified?

Program Evaluation

AHCA, in consultation with DOEA, should contract for an independent comprehensive evaluation of the Nursing Home Diversion waiver program and its providers who were operating prior to 2003. The evaluation could include an organizational analysis of the providers as well as a cost effectiveness analysis. The evaluation could also look at consumer satisfaction and program outcomes by provider. The evaluation should be completed by June 30, 2005, and should be specifically funded.

Integration Activities - July 1, 2004 - June 30, 2005

Waiver Integration

The Channeling, Frail Elder, and Nursing Home Diversion capitated long-term care programs could be integrated during FY 2004-2005. The Legislature could give AHCA the authority to apply for a new federal waiver that would cover all three programs. AHCA is already looking at how to simplify the waiver application process for providers so that they only have to apply once for the different waiver programs. This includes making the necessary changes to services definitions across waiver programs so that they are the same. The new capitated program would continue to report monthly on enrollments, etc., as was initially mandated for the Nursing Home Diversion waiver program.

The Aged/Disabled Adult waiver and the Assisted Living for the Elderly waiver programs could be integrated during FY 2004-2005. This would give a fee-for-service option to an individual that is very similar to the capitated model allowing for assisted living facility care. The Legislature could give AHCA the authority to apply for a new federal waiver that would cover these two programs.

In the fee-for-service model, DOEA could be given rule authority to separate case management from service provision. Staff recommends that language be included to prevent large companies with many subdivisions from being able to provide both case management and services.

DOEA could capitate case management in the fee-for-service model. Rule authority could be given to the appropriate agency to develop uniform standards for

case management in both the fee-for-service and the capitated systems.

DOEA, in consultation with AHCA, should begin to look at how to integrate the CARES and CIRTS databases, develop a plan for database integration, and report to the Legislature by December 31, 2004, on the plan.

Aging and Disability Resource Center
DOEA should initiate a request for proposals to develop an Aging and Disability Resource Center. By December 31, 2004, DOEA, in consultation with AHCA and DCF, could develop an ADRC implementation plan including ADRC qualifications, protocols, etc. The Legislature may want to consider establishing minimum standards for entities that want to act as resource centers. By June 30, 2005, DOEA should select two sites as pilots for an ADRC.

Evaluation Plan
By December 31, 2004, DOEA, in consultation with AHCA, should develop an evaluation plan that will follow the two new programs (one fee-for-service and one capitated) over time, from the beginning of the implementation process forward. The evaluation would be ongoing and would determine whether the new system is achieving its goals and what effects the system changes have had on consumers. The evaluation plan would include baseline measures for evaluating the capitated and fee-for-service systems with a focus on cost effectiveness and consumer satisfaction.

AHCA, in consultation with DOEA, could work with the Medicaid fiscal agent to develop a service utilization reporting system for the capitated plans that goes through the Medicaid fiscal agent. Data collected from the plans through this system would be used to evaluate the programs and monitor their status over time, as well as provide comparisons to the fee-for-service system and help in the development of capitated payment rates. AHCA and/or DOEA could be given rule authority to require providers to report service utilization through the Medicaid fiscal agent.

Integration Activities - July 1, 2005 - June 30, 2006
During the second year, DOEA and AHCA should monitor the capitated and fee-for-service programs, reporting on their progress to the Governor and the Legislature by June 30, 2006.

DOEA should also monitor the ADRC pilot areas to see how these projects are functioning and report on their progress to the Governor and the Legislature by June 30, 2006.

DOEA could integrate the CARES and CIRTS databases into one system by the end of FY 2005-2006. DOEA, in consultation with AHCA and DCF, could develop a plan that will allow the newly integrated DOEA assessment database to interface with FMMIS and the FLORIDA System.

Integration Activities - July 1, 2006 - June 30, 2007
DOEA, in consultation with AHCA, could initiate a competitive procurement to develop a pilot project whereby an entity(s) will be placed at risk for the fee-for-service program (Medicaid waiver and the state-funded services including Community Care for the Elderly, Home Care for the Elderly, and the Alzheimer's Disease Initiative). OAA funds would remain separate. By June 30, 2007, the entity(s) chosen could be operating under a risk-based system. The state should assure that the entity(s) placed at risk for these services have the tools necessary to manage the risk. The state could share the risk with the entity(s). Risk and responsibility would be phased in over time (3-5 years) until the appropriate balance between the state and the entity is reached. An entity could not act as an ADRC and be at risk for state-funded and Medicaid waiver services. The entity at risk would turn any savings from the programs back to the community to serve more individuals.

DOEA and AHCA should work with rural areas to make sure that there are feasible alternatives for smaller areas to be competitive in the procurement process.

AHCA, in consultation with DOEA, should evaluate the Alzheimer's disease waiver and the Adult Day Health Care waiver to see 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.

AHCA, in consultation with DOEA, could begin discussions with CMS as to how to include Medicare in an integrated system. By December 31, 2006, AHCA would provide to the Governor and the Legislature a plan for including Medicare in a model long-term care system. The goal would be that both Medicare and Medicaid would become fully capitated after the entities at risk for Medicaid and state-funded programs had gained considerable experience.

Integration Activities - July 1, 2007 – June 30, 2008
AHCA, in consultation with DOEA and the chosen risk-bearing entity(s) that has been operating on a pilot basis, could consider whether the entity(s) should also be placed at risk for Medicaid nursing home care and prescription drug coverage. DOEA, in consultation with AHCA, could also consider whether those providers operating in the capitated system would then be placed at risk for the state-funded programs.