

Model Florida Long- Term Care System/Analyzing Long-Term Care Initiatives in Florida

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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 long-term care policy and service delivery, 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 identifies trends affecting long-term care services in Florida, including demographic trends, the characteristics of Florida’s elderly Medicaid population, and trends in the nursing home and assisted living facility bed supply. Second, the report discusses how long-term care government funding and service programs are administered in Florida. Operational responsibility for planning and management of the major long-term care programs is split between the Agency for Health Care Administration, the Department of Elder Affairs and the Department of Children and Families. The Department of Health and the Department of Veterans’ Affairs have smaller roles in long-term care service delivery. Third, this report reviews the Medicaid and state-funded programs already serving elder Floridians with a focus on the individuals served by these programs, the services provided under each program, and the strengths and weaknesses of some of these programs.

The findings of the report 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 page 75 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. Each area is discussed, with specific recommendations laid out in each section.

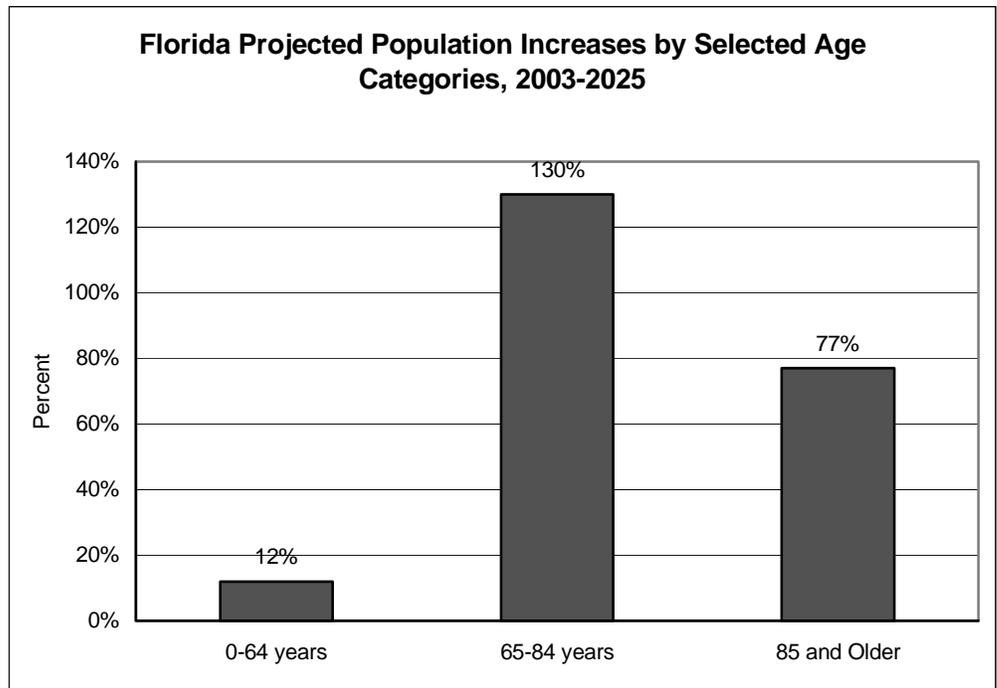
Background

Florida Demographic Trends

Between now and the year 2025, Florida must prepare to provide, through public and private means, housing, health care, and supportive services for many Floridians who will reach their senior years as the “Baby Boom” generation ages.

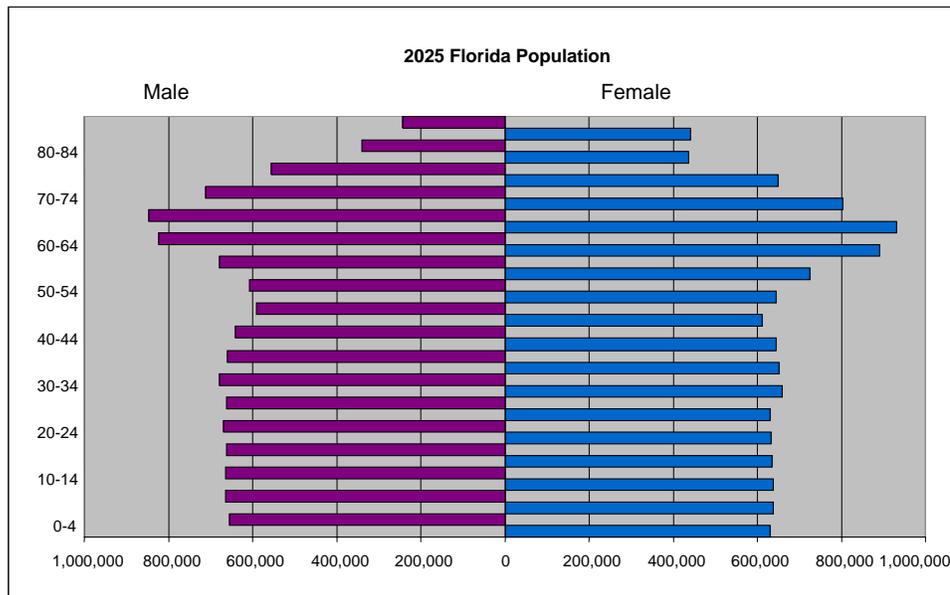
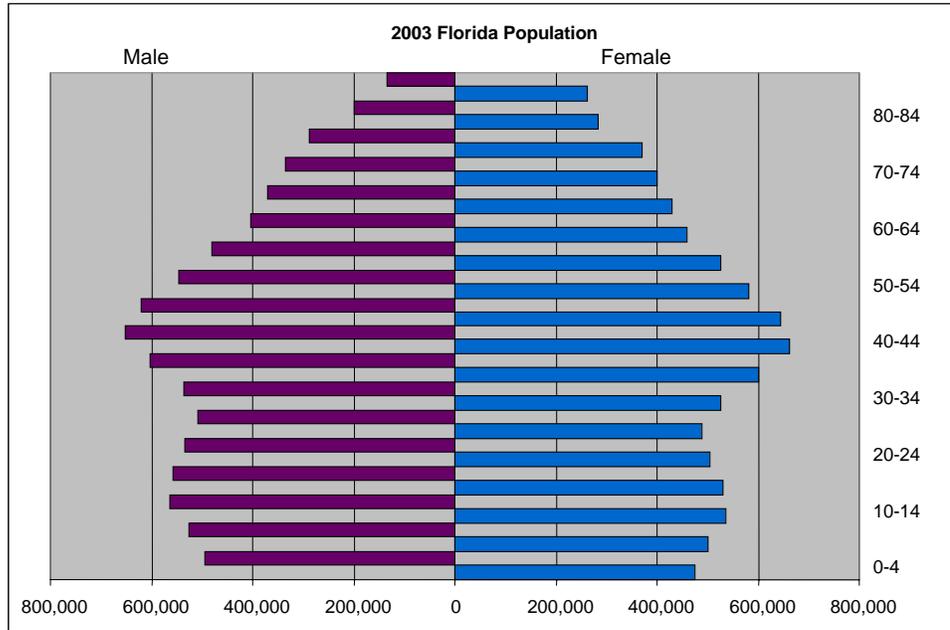
Florida is particularly affected by demographic aging trends because of its already large and growing number of senior residents. Nearly one in five Floridians is age 65 or older. Between 1991 and 2001, the population age 65 and older grew by over half a million individuals (18 percent). In Florida, 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.



Source: Office of Demographic & Economic Research, Florida Legislature, 2003.

Population pyramids give a clear picture of the structure of any population group at a specified point in time. The population pyramids below show the projected male and female population proportions in Florida, as well as the proportion of specific age categories of the population, for the years 2003 and 2025.



Source: Office of Economic & Demographic Research, Florida Legislature, 2003.

The large increases in the 65 to 74 and 85 and older age groups by 2025 discussed earlier can be clearly seen in the population pyramids above. By 2025, the

population pyramid will even out, except for those 60 and older, where the increase from the aging of the “Baby Boom” generation can be seen. In 2025, it is projected that there will be 568,476 more women 65 and older than men; 3,263,544 women compared to 2,695,068 men. Many of the challenges of an aging population will be felt more acutely by older women, who have outlived husbands, have fewer children to depend on, and face old age with limited incomes and few family resources on which to draw.

A commonly used measure of the relationship between the working age population and the economically dependent population is the dependency ratio. The dependency ratio is an indicator of the economic burden placed on the working population to care for the nonworking population. The total dependency ratio is the number of youths and elderly individuals per 100 individuals of working age (15 to 64) in a given population. The elderly dependency ratio is the number of individuals age 65 and older per 100 individuals of working age in a given population. The elderly dependency ratio, which has been fairly stable since 1960, will remain stable until about 2010. However, between 2010 and 2025 the elderly dependency ratio will rise from 27 to 42 elderly individuals per 100 individuals of working age in Florida. This is compared to a nationwide average of 35 elderly individuals per 100 individuals of working age in 2025.

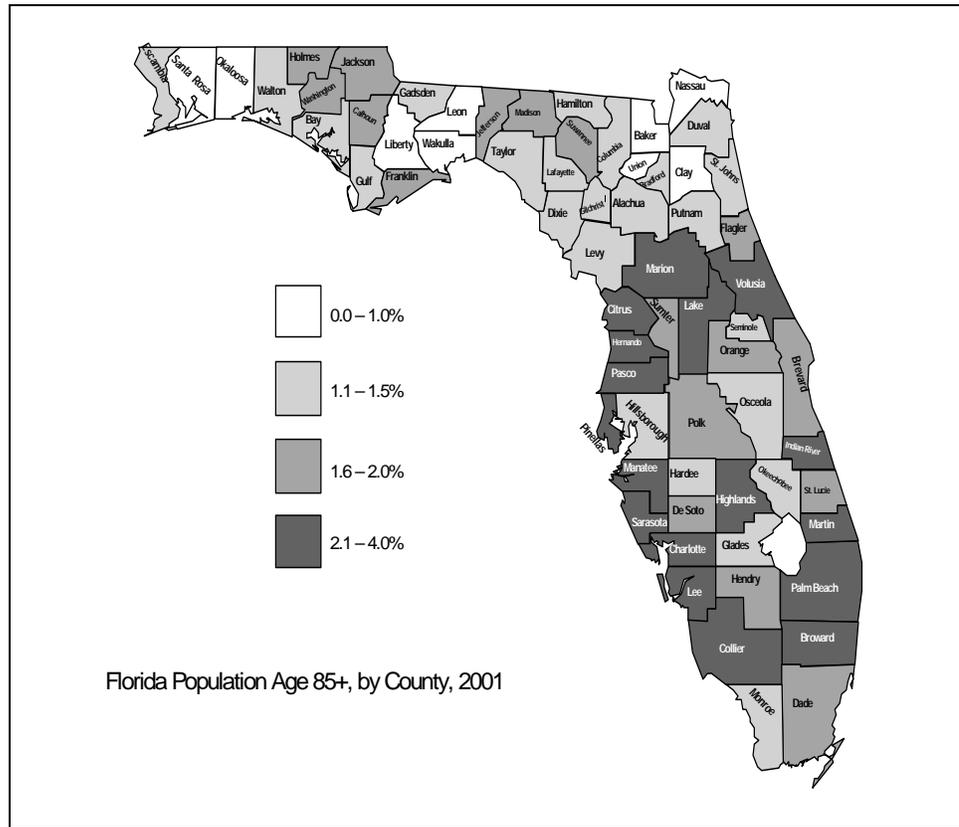
While marriage rates between now and 2025 are projected to remain relatively stable, the numbers of both women and men living alone will increase. This will result from an increase in those choosing to remain single, higher rates of separation and divorce, and smaller families. Also, elderly people are especially likely to live alone. In Florida, approximately 710,000 elderly individuals live alone.¹ This represents 24 percent of Floridians 65 and older, compared to 18.5 percent nationally. Elderly individuals who live alone are at higher risk for placement in a nursing home. Individuals who live alone and are admitted to a hospital during an acute care episode are more likely to be placed in a nursing home because there is no one to help with rehabilitation at home.²

The elderly who are 85 and older are more likely to need health care and long-term care support. These individuals experience twice as many chronic health problems as the rest of the population, often resulting in disabilities that interfere with daily activities. Even if disability rates among the elderly continue to decrease in the future, the sheer number of individuals in this age group will increase the prevalence of chronic conditions by almost 200 percent by 2025. This translates into a greater need for long-term care, including custodial care, support services, and housing options.

¹ U.S. Bureau of the Census. 2002. Florida Statistics.
<http://www.census.gov/PressRelease/www/2002/sumfile3.html>.

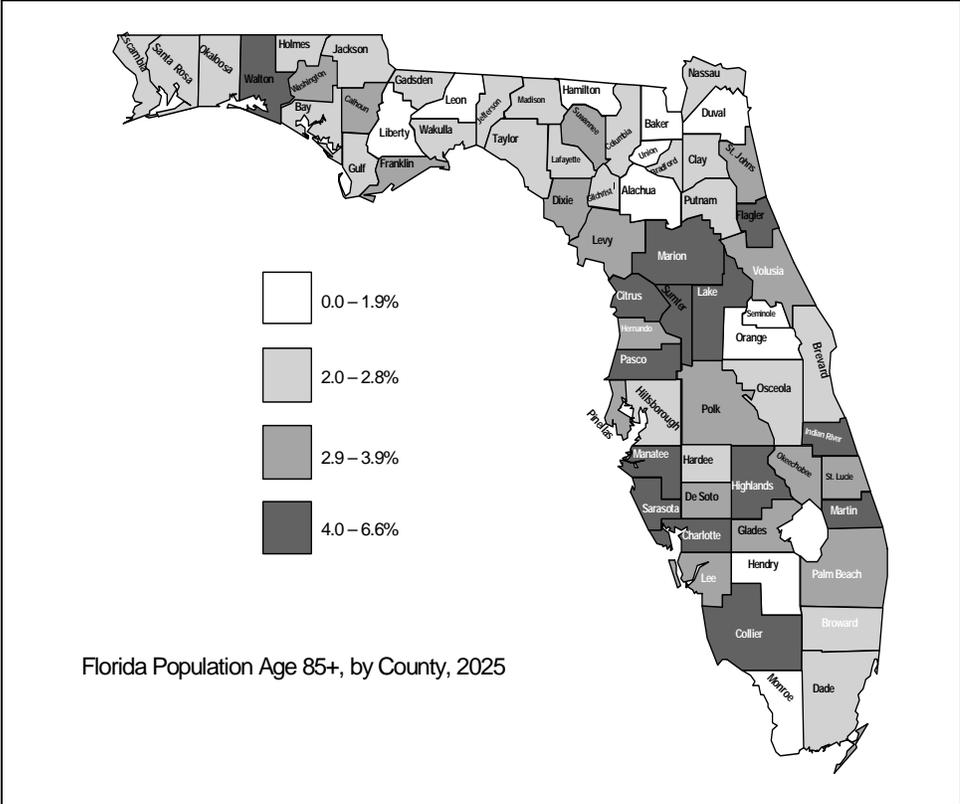
² Kane, R. L., Finch, M., Blewett, L., Chen, Q., Burns, R., and Moskowitz, M. 1996. “Use of Post-Hospital Care by Medicare Patients.” *Journal of the American Geriatrics Society*. 44:242-250.

County comparisons of the aging population also provide insight into where long-term care services will be needed most. The maps below show the change in the 85 and older population between 2001 and 2025. In 2001, 17 Florida counties reported that greater than two percent of the county population was age 85 or older. All of these counties were south and central counties.



Source: Office of Economic & Demographic Research, Florida Legislature, 2003.

Estimates show that by 2025, 56 Florida counties will have more than two percent of the population age 85 and older. Fourteen counties are projected to have more than four percent of their population 85 and older by 2025.



Florida Population Age 85+, by County, 2025

Source: Office of Economic & Demographic Research, Florida Legislature, 2003.

Areas of the state where many of the Medicaid home and community-based waivers are in place are projected to have smaller percentages of the oldest old by 2025. Among the most dramatic areas of growth in the percent of the population age 85 and older will be the rural areas where there are few providers of home and community-based services. As the year 2025 approaches, there will be increasing pressure to expand available long-term care services for elderly individuals into areas that currently have little capacity.

Elderly Medicaid Population

The table below compares demographic characteristics of Florida and its Medicaid program for people 65 years of age or older to national characteristics. 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.

Potential Demand for Medicaid Long-Term Care Services in Florida, 2002

	Total Elderly Population 65+	Elderly 65+ as % of Total Population	Elderly 65+ Medicaid Beneficiaries	Percent of elderly 65+ who are Medicaid Beneficiaries	Elderly 65+ Beneficiaries as % of All Medicaid Beneficiaries
US	35,000,000	12.4%	3,900,000	11%	8.5%
FL	2,913,435	18.0%	271,830	9.3%	13%

Source: Agency for Health Care Administration 2002.

Older Floridians receive Medicaid-funded long-term care services as part of the Medicaid State Plan through Florida nursing homes, hospices, and home health providers. They can also receive services through one of the Medicaid home and community-based services waivers.

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). Given that women have longer life expectancies than men, it is not surprising that women are overrepresented in Florida's Medicaid long-term care population. The majority of elderly Medicaid beneficiaries are Caucasian (71.2 percent), followed by African Americans (14.6 percent) and Hispanics (5 percent).

Data from the Medicaid program show that the 85 and older population was the most likely to receive long-term care services in FY 2001-2002, although there was a slight decline (almost two percent) in the number of people in this age group receiving services between FY 2000-2001 and FY 2001-2002. Between FY 2000-2001 and FY 2001-2002, there were slight increases in the number of people 60 to 80 years of age receiving long-term care services.

Nursing Home Care

The total number of licensed nursing home beds in the state increased from 65,174 in 1991 to 82,329 in 2003. Bed capacity in nursing homes that did not accept Medicaid recipients represented only four percent of all licensed nursing home beds in 1991; by 2001, only three percent of licensed beds in Florida were in facilities that did not accept Medicaid recipients.

Although there has been an increase in the number of nursing home beds, the number of beds available in relation to the size of the elderly population (nursing home bed supply) decreased over that same period. The table below shows changes between 1991 and 2001 in the number of nursing home beds per 1,000 in

Florida's elderly population. Note that the direction of change varies among age sub-groups. Between 1991 and 2001, nursing home beds per 1,000 for Florida's total elderly population increased only slightly, from 26 beds per 1,000 age 65 and older in 1991 to 27.9 beds per 1,000 in 2001.

Florida Nursing Home Bed Supply, 1991-2001

Year	Per 1000 age 65+	Per 1000 age 85+
1991	26.0	290.1
1992	26.1	285.2
1993	26.2	279.1
1994	27.0	281.7
1995	26.6	271.1
1996	26.7	263.1
1997	27.9	264.4
1998	28.7	263.6
1999	28.7	263.9
2000	28.5	240.8
2001	27.9	232.3

Source: Agency for Health Care Administration, Health Quality Assurance, Certificate of Need Unit, 2002.

For the oldest age group (85 and older), beds per 1,000 in the population declined from 290.1 in 1991 to 232.3 in 2001, a decrease of approximately 20 percent. During the 1990s, the nursing home bed supply available per 1,000 in the elderly population remained relatively constant; however, due to the disproportionate growth in the number of the oldest-old, those most at risk for experiencing nursing home admission, there was a decline in beds per 1,000 individuals age 85 and older.

Given the high proportion of elderly people in the state, Florida had a much lower nursing home bed ratio per 1,000 people age 65 and older in 1999 than the national average (28.7 beds compared to 52.3 beds nationally). There was also a smaller percentage of the 65 and older population residing in Florida nursing homes than the national average (2.5 percent compared to 4.3 percent nationally). Florida is ranked 46th nationwide in the number of beds per 1,000 people age 65-84 (34 beds) and is ranked 47th in the number of beds per 1,000 people 85 and older (232 beds).³

³ Agency for Health Care Administration. 2002. *Proposals to Reduce Medicaid Funded Nursing Home Bed Days: A Report to the Florida Legislature.*

Although this low level of bed supply may reflect successful efforts to keep individuals in the community, the bed supply may become insufficient in the future with the projected growth of the elder population in the state.

Total Licensed Residential Bed Supply

The trend for nursing home bed supply shows that the growth in the number of licensed nursing home beds has not kept pace with the rates of growth in Florida’s elderly population. However, when the supply of licensed residential beds is considered as a whole, it is clear that the nursing home and assisted living facility bed supply together grew at a faster rate than the elderly population. The table below shows changes between 1991 and 2001 in the number of licensed residential beds (nursing home and assisted living facility beds combined) per 1,000 in Florida’s elderly population.

Florida Licensed Residential Bed Supply, 1991-2001

Year	Per 1000 age 65+	Per 1000 age 85+
1991	34.7	387.6
1992	43.2	472.1
1993	44.8	477.3
1994	48.0	500.0
1995	49.3	502.8
1996	52.6	517.5
1997	53.4	507.4
1998	54.3	498.1
1999	57.5	506.3
2000	58.0	499.4
2001	55.0	464.6

Source: Agency for Health Care Administration, Health Quality Assurance, Certificate of Need Unit & Assisted Living Facility Unit, 2002.

Considering the entire elderly Florida population (which grew approximately 20 percent during the 1990s), available licensed long-term residential beds increased approximately 67 percent, from 34.7 to 55.0 licensed residential long-term care beds per 1,000 individuals over age 65. For the oldest-old, licensed residential long-term care beds grew from 387.6 to 464.6 per 1,000 individuals over age 85 between 1991 and 2001, nearly a 30 percent increase. There was one licensed nursing home or assisted living facility bed for every two Floridians age 85 or older in 2001. By the end of the 1990s assisted living facility growth peaked and has declined slightly in the last two years.⁴

⁴ Agency for Health Care Administration. 2002. *Proposals to Reduce Medicaid Funded Nursing Home Bed Days: A Report to the Florida Legislature.*

Assisted living is often seen as a preferable option by individuals and the state compared to nursing home care. However this preference may not be available if assisted living facilities do not have more capacity to care for the growing older, frail population. Also, assisted living facilities are limited in the level of care they can provide to residents. Low-income elderly have a more difficult time paying for assisted living facility care and often end up in nursing homes.

Medicaid Nursing Home Costs

Medicaid is the primary payer for many long-term care services in Florida. About three-fourths of Medicaid spending on long-term care is for institutional services, with a large percentage going toward nursing home care. The primary reason for Medicaid covering these services is the gap in services covered by the Federal Medicare program. While Medicare covers physician and hospital services as well as short-term skilled nursing care, it does not cover extended stays in long-term care facilities. Medicare will cover the cost of some skilled care in approved nursing homes (100% for the first 20 days) or in the home, but only for expenses resulting from acute care episodes rather than from chronic disabilities.

Annual costs to an individual for nursing home care average about \$46,000. Unlike private health insurance, Medicaid is a means-tested program that provides assistance only when financial resources are substantially exhausted. Many individuals enter nursing homes and pay for their own care. However, over a period of months or years, income and assets eventually are depleted or “spent down” and people then qualify for Medicaid.

Between 1989 and 2000, there was a slowing rate of growth in the number of Medicaid-funded nursing home resident days statewide. In 2001, there was an absolute decline in the number of Medicaid-funded nursing home resident days. The percent of nursing homes with decreases in Medicaid days has been variable over the last 10 years. The largest decreases happened in 2000 and 2001 when half of all nursing homes had a decrease in Medicaid resident days. In 2002, the number of Medicaid-funded nursing home resident days *increased* 2.2 percent.⁵ At this point the trend for Medicaid nursing home resident days is uncertain, and will need to be monitored over the next few years.

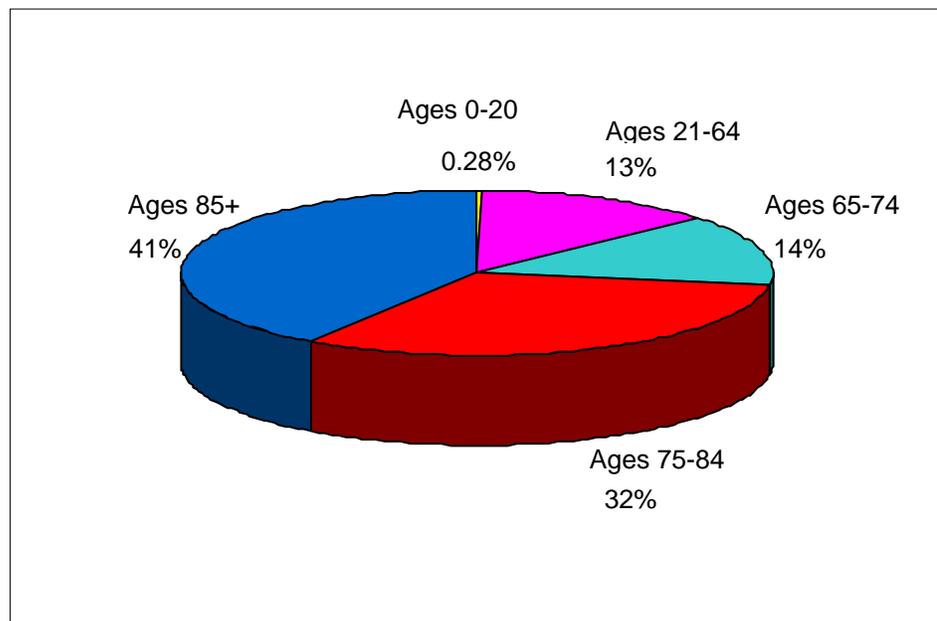
Between FY 1990-1991 and FY 2002-2003, Medicaid nursing home expenditures increased from \$759 million to almost \$2.2 billion per year, a 65 percent increase. Nursing home expenditures represented 19 percent of total Medicaid expenditures in FY 2002-2003. This rise in costs is not primarily related to an increase in the Medicaid caseload, however. The Medicaid nursing home caseload has increased 18 percent in the same time period, from 38,952 to 47,796. The annual cost per person is the primary factor in driving up the total Medicaid expenditures for

⁵ This number is based on Certificate of Need data collected by the Bureau of Health Facility Regulation in the Division of Health Quality Assurance at the Agency for Health Care Administration.

nursing home care. Between FY 1990-1991 and FY 2002-2003, the annual cost per person enrolled in the Medicaid Institutional Care Program increased 57 percent from \$19,485 to \$45,353. The biggest increase occurred between FY 2001-2002 and FY 2002-2003, when the state saw a 14 percent increase in annual costs per person for Medicaid nursing home care. The increased cost is associated with the additional regulatory mandates regarding staffing increases since January 2002.

The graph below shows the breakdown, by age group, of the projected Medicaid nursing home expenditures for FY 2003-2004. The oldest old population in Florida, those 85 and older, will account for 41 percent of Medicaid nursing home costs in FY 2003-2004. Those age 75 to 84 will account for 32 percent of nursing home costs. These two age groups together will make up 73 percent of Medicaid nursing home costs. Individuals age 21 to 64 and age 65 to 74 will account for 13 and 14 percent respectively of Medicaid nursing home expenditures.

Age Distribution of Medicaid Nursing Home Expenditures, FY 2003-2004



Source: Agency for Health Care Administration, 2003.

As the cost of nursing home care continues to rise, many states are shifting more of their long-term care funds to home and community-based services. Over the past decade, the percentage of Florida Medicaid spending on institutional care has decreased and more funds have been allocated to home and community-based services. In FY 1995-1996, 89 percent of Medicaid long-term care expenditures was allocated to institutional care and only 11 percent was allocated to home and community-based services waiver programs. In FY 2002-2003, the percentage of Medicaid long-term care institutional expenditures is estimated to decrease to 77

percent and home and community-based services waiver programs are estimated to increase to 22 percent.

Administration of Long-Term Care Funding and Services

The administration and funding of long-term care services is through both the public and private sectors. Federal, state, and local governments play a role as do private organizations and families. In the public sector, there is considerable overlap in sources of funding for long-term care services. For example, states administer the Medicaid program; however, there are many federal requirements as to how the program is run. There is also overlap between the public and private spheres, as families often depend on the state to help provide care to their loved ones.

State Agency Involvement

No single state entity manages all aspects of Florida's long-term care system. Operational responsibility for planning and management of the major long-term care programs in Florida is split between the Agency for Health Care Administration (AHCA), the Department of Elder Affairs (DOEA), and the Department of Children and Families (DCF), with the Department of Health and the Department of Veterans' Affairs having more limited roles. There is much overlap between agencies where long-term care programs are concerned.

Department of Elder Affairs

DOEA is Florida's state unit on aging, operating a number of state and federally funded programs for the elderly, including the Federal Older Americans Act programs. DOEA also has rule-making authority for adult day care, Alzheimer's disease training for nursing homes, assisted living facilities, adult family care homes, and hospice programs; and operates the Medicaid Aged/Disabled waiver, the Medicaid Assisted Living for the Elderly waiver and the Comprehensive Assessment and Review for Long-Term Care Services (CARES) nursing home preadmission screening program, under an inter-agency agreement with AHCA. DOEA operates the state-funded Home Care for the Elderly, Community Care for the Elderly, and Alzheimer's Disease Initiative programs. DOEA also administers on behalf of AHCA the Program of All Inclusive Care for the Elderly and the Nursing Home Diversion Program waiver. DOEA runs the Long-Term Care Ombudsman Program for nursing homes, assisted living facilities, and adult family care homes. DOEA also has oversight of the Statewide Public Guardianship Office and runs volunteer and caregiver support programs.

Agency for Health Care Administration

AHCA operates the Medicaid program, which purchases 66 percent of the nursing home bed days in Florida and has responsibility for the policy control for Medicaid home and community-based waivers. AHCA determines the need for additional nursing home capacity and regulates the operation of nursing facilities. AHCA also licenses and regulates assisted living facilities, adult family care

homes, home health agencies, hospices, nurse registries, homemaker and companion services, and adult day care centers.

Department of Children and Families

DCF establishes Medicaid financial eligibility. In order to be determined eligible for Florida's Institutional Care Program, the Medicaid program that pays for nursing home care, an individual must apply through DCF's Office of Economic Self-Sufficiency. DCF also runs the Adult Protective Services program, serving disabled adults and the frail elderly who are considered vulnerable to abuse, neglect, or exploitation.

Department of Health

The Department of Health provides licensure and regulation of health care professionals including physicians, nurses, certified nursing assistants, and other allied health practitioners.

Department of Veterans' Affairs

The Department of Veterans' Affairs runs the state veterans' homes which serve honorably discharged Florida veterans in need of nursing home or assisted living facility care.

Medicaid

Medicaid is jointly funded by the federal, state, and county governments to provide adequate medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

Some services, such as nursing home care and home health care, are mandatory services that must be covered in any state that participates in the Medicaid program. Other services, such as personal care, are optional. A state may choose to include optional services in its state Medicaid plan, but such services must be offered to all individuals statewide who meet Medicaid eligibility criteria.

Medicaid Institutional Care Program

Florida's Institutional Care Program is the Medicaid payer for nursing home care. Federal requirements define what states are permitted to look at with regard to income and assets when determining eligibility for the Institutional Care Program. While the states have the option of setting more rigid standards than those applied by the federal government for determination of eligibility for Supplemental Security Income, Florida uses the Supplemental Security Income standards as the

basis for determining eligibility for public assistance programs for the aged and disabled. In order to be determined eligible for Florida's Institutional Care Program, an individual must apply through DCF's Office of Economic Self-Sufficiency.

Medicaid Waivers

Home and community-based service delivery programs have become a growing part of states' Medicaid long-term care coverage, serving as an alternative to care in institutional settings such as nursing homes. To provide these services, states obtain waivers from certain federal statutory requirements for Medicaid. States often operate multiple waiver programs serving different population groups, such as the elderly, persons with mental retardation or developmental disabilities, persons with physical disabilities, and children with special care needs.

States may apply to the Federal Centers for Medicare and Medicaid Services (CMS) for a section 1915(b) Freedom of Choice waiver, which allows a state to provide services in only specific areas of the state, allows states to provide a subset of services that may not be in the state plan, and allows states to waive freedom of choice requirements. By waiving freedom of choice, this means that individuals are constrained to receive waiver services from select providers rather than choosing their own provider. The 1915(b) waivers are limited in that they apply to existing Medicaid-eligible beneficiaries; authority under this waiver can not be used for eligibility expansions to individuals not covered under the traditional Medicaid program.

States may apply to CMS for a section 1915(c) waiver to provide home and community-based services as an alternative to institutional care in a hospital, nursing home, or intermediate care facility for the mentally retarded. If approved, the waivers allow states to limit the availability of services geographically, to target services to specific populations or medical/disease conditions, or to limit the number of persons served; actions not allowed under Medicaid state plan services. Under a 1915(c) waiver, states determine the types of long-term care services they wish to offer and any provider who is interested and meets application requirements can provide services. Waivers may offer a variety of skilled services to only a few individuals with a particular condition, such as persons with traumatic brain injury, or they may offer only a few unskilled services to a large number of people, such as the aged or disabled.

States have shown a growing interest in providing long-term care services in a managed care environment or using a limited pool of service providers. Many states are proposing to include non-traditional home and community-based "1915(c)-like" services in their managed care programs. There is no authority under 1915(b) to cover individuals in a special eligibility category (the 42 CFR 435.217 group who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community) who are only Medicaid eligible through a link to a

1915(c) waiver. For these reasons, several states have chosen to simultaneously use 1915(b) and 1915(c) waivers to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) authority to limit freedom of choice, and use the 1915(c) authority to provide the home and community-based services and expand Medicaid eligibility to those in the 42 CFR 435.217 eligibility category.

States may also apply for section 1115 research and demonstration waivers. These waivers allow the Secretary of Health and Human Services to waive provisions of Medicaid law for demonstration projects that test a program improvement or develop a new idea of interest to CMS. For example, under an 1115 waiver, a state may be exempt from compliance with usual requirements or may receive federal matching funds for expenditures not ordinarily eligible under Medicaid. All 1115 waiver demonstration projects must be budget neutral; that is, they cannot result in greater federal expenditures than would have otherwise occurred in the absence of the waiver. Research and demonstration waivers are often transitioned into home and community-based services waivers [1915(c)] once the state and CMS determine that the program is innovative or provides services in an improved manner. The table below summarizes Medicaid waiver options used to provide long-term care services to elderly Floridians.

Comparison of Medicaid Waivers

Waiver Type	Requirements that are Waived	Eligibility for Waiver	Budget Requirements
Section 1915 (b) Freedom of Choice	Freedom of Choice Statewideness Comparability of Services	New eligibility groups cannot be added.	Must be cost-effective. Expenditures cannot exceed what they would have been in fee-for-service Medicaid.
Section 1915 (c) Home & Community-Based Services	Statewideness Comparability of Services Income rules	Must meet institutional level of care requirements. (NH Level of Care)	Annual per capita costs cannot exceed 100% of avg. per capita cost for institutional level of care contained in the request. Total HCBS & state plan costs cannot exceed 100% of the amount that would have been spent for all individuals in the waiver if residing in an institutional setting.
Section 1115 Research and Demonstration	Most Section 1902 (Title XIX of Social Security Act) requirements can be waived.	New eligibility groups can be added.	Budget neutrality over the course of the waiver.

Source: Center for Medicare and Medicaid Services, 2003.

Dual Eligibles

The Medicare program extends nearly universal acute care health insurance coverage to elderly Americans. In 2001, Medicare covered 96.1 percent of the nation's elderly population. Medicare has two parts: Part A, hospital insurance, which covers hospital services and some home health care and skilled nursing facility services, and Part B, supplemental medical insurance, which covers physician care outpatient hospital services, and independent laboratory services. To qualify for Medicare a person must have worked at least 10 years in Medicare-covered employment. A person who does not meet this requirement may pay a premium to cover part A. Medicare nursing home coverage is limited mostly to post acute care episodes, reimbursing fully the first 20 days of a nursing home stay.

Many elderly individuals are eligible for both Medicaid and Medicare. Certain Medicaid programs pay some or all Medicare premiums and may also pay Medicare deductibles and coinsurance for certain low-income people who are entitled to Medicare. The term "dual eligible" most commonly refers to low-income Medicare beneficiaries who also qualify for full Medicaid benefits, but there are varied groups of dual eligibles. For low-income beneficiaries who are not eligible for all Medicaid services, Medicaid fills in some of the gaps that fee-for-service Medicare does not cover; such as prescription drugs and long-term care either in a nursing facility or in the community. Nationwide, Medicaid covers approximately 14 percent of all elderly Medicare beneficiaries.

The amount of Medicaid coverage for Medicare enrollees varies by income. The poorest Medicare beneficiaries, as well as those who have exhausted their personal resources paying for health and long-term care, receive assistance with Medicare financial requirements and a full range of Medicaid benefits. Others may only receive Medicaid payment of Medicare Part B premiums. The table below lists the dual-eligible programs in place for low-income Medicare beneficiaries in Florida.

Medicaid Add-ons for the Dually-Eligible in Florida, June 2003

Program*	Eligibility	What is Covered?	Entitlement	Current Enrollment
Qualified Medicare Beneficiary (QMB)	<100% of poverty	Medicare Part B Premium & cost sharing	Yes	25,589
Specified Low Income Beneficiary (SLMB)	100-120% of poverty	Medicare Part B premium	Yes	33,164

Program*	Eligibility	What is Covered?	Entitlement	Current Enrollment
Qualifying Individuals 1 (QI1) (Block grant available on first come/first serve basis)	120-135% of poverty	Medicare Part B premium	No	15,802

*A \$20 general exclusion applies. Individuals can have up to \$20 more in unearned income and pass the income test.

Source: Department of Children and Families, 2003.

In Florida, as of June 2003, there were 278,619 individuals who were dually-eligible for Medicare and Medicaid. Of these individuals, 8,521 had Medicare Part B only and 270,098 had Medicare Parts A and B.

Older Americans Act, Area Agencies on Aging, Lead Agencies

The U.S. Congress enacted the Older Americans Act of 1965 to address concerns about the increasing numbers and needs of older Americans. The original act and subsequent amendments establish a network of federal, state, and local agencies that collaborate to plan and provide a variety of programs to meet the needs of older persons in the community. These networks are organized within planning and service areas (PSAs) determined by each state.

States have typically configured their PSAs around county, multi-county, or other existing service delivery systems such as health and human resources regions or education districts. Florida aligned its PSAs to coincide with the 11 Department of Health and Rehabilitative Services service districts then in existence. When DOEA became Florida's state unit on aging in 1992, it continued to use the same boundaries for program purposes. The Older Americans Act requires states to establish an Area Agency on Aging (AAA) in each PSA. Thus, there are 11 AAAs in Florida.

The AAAs serve as the advocate for elders within each PSA. Besides the federal Older Americans Act funds that the AAAs receive (including a 10 percent match of local and county funds), AAAs also receive state funds for the state general revenue funded programs, and Medicaid funds linked to specific home and community-based service waivers. The AAAs take on program oversight for DOEA at the local level. For example, DOEA has contractual agreements with the AAAs to oversee the Medicaid Aged/Disabled Adult waiver and the Medicaid Assisted Living for the Elderly waiver.

In Florida, the AAAs also administer the federally-funded Emergency Home Energy Assistance for the Elderly program, as well as the state-funded Community Care for the Elderly, Alzheimer's Disease Initiative, and Home Care for the Elderly programs.

Each AAA is responsible for developing a comprehensive and coordinated community-based system of care. They do this through needs assessment, contracting with lead agencies to provide direct client care, and advocating for increased federal, state, and local funding for services.

In Florida, lead agencies are community agencies that provide services directly to individuals. Lead agencies have provided case management services to the state's functionally impaired elders since 1980 when the Legislature expanded the Community Care for the Elderly program statewide. The Community Care for the Elderly Act required that each PSA in the state develop at least one community care system to enable functionally impaired elders to live independently in the community and prevent unnecessary nursing home placement. The Community Care for the Elderly law requires AAAs to contract with lead agencies to coordinate case management and ensure that core services are available to meet the needs of the elders in their communities. Lead agencies may directly provide these services or subcontract with other providers. In essence, the lead agencies were developed specifically for the Community Care for the Elderly program, although they now function to provide case management and services under other programs (i.e., Home Care for the Elderly and Alzheimer's Disease Initiative) as well.

The AAAs are responsible for developing grants and contracts with the lead agencies that provide direct services as well as for monitoring and technical assistance to service providers. Although the majority of direct services are provided through contracts with the lead agencies, the AAAs can provide services directly to caregivers in crisis through the Family Caregiver Support Initiative. In addition, the AAAs manage the Elder Helpline. AAAs throughout the state vary significantly, partly due to the variation in size of the PSAs. The AAAs are local organizations that have adapted to meet the needs of individuals in their unique communities.

Other Local Entities

Local entities such as senior centers also provide information and programs for seniors. Senior centers are sites for community-based health promotion activities as well as places to make new friends, strengthen social networks, and prevent premature institutionalization. Senior centers facilitate, promote, and provide wellness and aging programs, services and resources through educational, social, recreational, and health activities. They are often funded through city general revenue funds and local block grants.

Informal Caregivers

Family caregivers are the largest private resource for long-term care in Florida. Without them, many elderly Floridians would enter institutions for care. Many policymakers realize the cost savings that family caregivers provide and, as a result, many states have created public programs to assist them. States have

increased respite care programs, both as state-funded free-standing programs and as part of a series of benefits provided under Medicaid home and community-based waiver programs. Respite care, such as adult day care, short stay programs in nursing homes and attendant care in private homes, provides a temporary break from caregiving responsibilities that enable informal caregivers to “stay on the job” longer.

Informal caregivers can be primary or secondary caregivers, full time or part time, and can live with the person being cared for or live separately. An estimated 1.5 million family caregivers live in Florida. These family caregivers provide about 1.4 billion hours of caregiving per year at an estimated value to the state in 1997 of \$11.2 billion.⁶

Florida provides some caregiver support services for the elderly and for adults with physical disabilities, administered largely through DOEA. The original impetus for Florida’s family caregiver support program were the Older Americans Act Amendments in 2000, which created the National Family Caregiver Support Program and provided federal funding to the state units on aging to provide caregiver support services. While the National Family Caregiver Support Program is the only program administered by DOEA that specifically targets services to caregivers, other programs also provide some caregiver support. These include the Home Care for the Elderly program, which provides caregivers with a subsidy of up to \$106 per month. DOEA surveys indicate that the funds are most often used for food (32%), medical supplies (23%) and household bills (15%). Only three percent of caregivers served use the subsidy for respite.⁷

Long-Term Care Insurance

Long-term care insurance is an increasingly popular method of providing financial protection against the high costs of community-based or institutional long-term care among higher income segments of the working age population. Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a range of services not covered by regular health insurance, Medicare, or Medicare supplement insurance. Long-term care policies may be sold by an agent or through the mail. Some companies sell these policies through senior citizen organizations, fraternal societies, and continuing care retirement communities. Some employers now offer these policies as part of the benefit package to their employees.

In Florida, the Office of Insurance Regulation licenses the insurer, approves the policy forms, and regulates the rates for long-term care insurance. The Department of Financial Services also has some related duties, such as regulating the

⁶ Feinberg, L., Newman, S., and C. Van Steenberg. 2002. “Family Caregiver Support: Policies, Perceptions, and Practices in 10 States since Passage of the National Family Caregiver Support Program.” *Family Caregiver Alliance*.

⁷ *Ibid.*

insurance agents, handling consumer complaints, and liquidation and rehabilitation of insolvent insurers.

The long-term care insurance market has grown rapidly over the past decade, but pays for a very small share of nursing home care and still covers a tiny proportion of the population. The Congressional Budget Office reported that private long-term care insurance accounted for just 2.5 percent of national long-term care expenditures for the elderly in 2000.⁸

The main reason for the low number of purchasers is the cost of long-term care insurance policies. Weiner et al. (2000) estimated that only 10 to 20 percent of elderly people can possibly afford long-term care insurance. These policies will have a limited impact on Medicaid long-term care costs because only those individuals affluent enough to be unlikely to spend down to Medicaid can afford the insurance to begin with.

As of August 2000, 23 states provided either tax credits or tax deductions to stimulate the purchase of long-term care insurance policies. However, premiums are high for people over age 65; particularly for policies that offer more than just nursing home care and that include inflation protection and nonforfeiture of benefits. Without nonforfeiture of benefits, subscribers who buy, but later give up a long-term care insurance policy, have no rights to any coverage regardless of the amount of time they held the policy or the amount of money they spent for it. For many individuals, long-term care insurance does not seem to be a “good buy.”

Current Florida Medicaid Home and Community-Based Service Programs for Elders

The state operates several programs through Medicaid waivers for home and community-based services. These programs offer services to frail elders (and others who are Medicaid eligible) that enable them to avoid Medicaid nursing home placements. These waivers reflect explicit policy choices intended to reduce the level of Medicaid nursing home utilization. Individuals must meet, at a minimum, a nursing home level of care to be eligible for the programs. Because Medicaid is a joint state/federal program, both entities share the costs for these waiver programs. The table below provides a brief synopsis of key information about current Florida Medicaid home and community-based service programs and is followed by a more in-depth description of each program.

⁸ Weiner, J. Tilly, J. and S.M. Goldenson. 2000. “Federal and State Initiatives to Jumpstart the Market for Private Long-Term Care Insurance.” *Elder Law Journal* 8:59-99.

Florida Medicaid Home and Community-Based Service Programs for Elders, FY 2002- 2003

Program	Funding Source	Clients Served ¹	Average Length of Stay in Program (months) ²	Total Average Per Member Per Month Cost
		Cap		
Adult Day Health Waiver Implemented: 2003 in Lee and Palm Beach Counties	State/ Federal Medicaid Match	No one enrolled	Too early to calculate	FFS ³ No one enrolled
		130		
Aged/Disabled Waiver Implemented: 1982 Statewide	State/ Federal Medicaid Match	14,322	21.7 months	FFS \$668.61
		16,255		
Assisted Living for the Elderly Waiver Implemented: 1995 Statewide	State/ Federal Medicaid Match	4,473	15.2 months	Capitated ⁴ \$788.58
		5,630		
Assistive Care Services Implemented: 2002	State portion from existing OSS program/ Federal Medicaid Match	8,494	To early to calculate	\$307.63
		No cap- state plan option		
Channeling Waiver Implemented: 1985 Dade/Broward Counties	State/ Federal Medicaid Match	1,473	8.7 months	Capitated \$839.40
		1,855		
Consumer Directed Care Implemented: 2002 Statewide in 2003	Existing Medicaid Waiver Budgets	909	17 months ⁵	\$1018.91 ⁶
		3,350		

Program	Funding Source	Clients Served ¹	Average Length of Stay in Program (months) ²	Total Average Per Member Per Month Cost
		Cap		
Frail Elderly Program Option Implemented: 1982 Dade and Broward	State/ Federal Medicaid Match	3,151	Not able to calculate	Capitated Approx. \$1250.00
		3,967		
Nursing Home Diversion Waiver Implemented: 1998 Orange and Palm Beach Counties Expanded in 2003	General Revenue/ Federal Medicaid Match	499	22 months	Capitated \$2,342.41
		1,400		
PACE Implemented: 2002	General Revenue/ Federal Medicaid Match	14	To early to calculate	Capitated Medicare A&B: \$1943.62 Medicare B only: \$2677.24 No Medicare: \$3,169.33
		50		

¹ The number of clients served in the program each year is much greater than the number enrolled at a given point in time during the year.

² This number is based on individuals who left the program in FY 2002-2003.

³ Fee for Service is the method of charging whereby a physician or other practitioner bills for each encounter or service rendered.

⁴ Capitated payments are uniform payments based on the number of people in the population being served. The health care provider, accepts responsibility to deliver the health services needed by all members of a specific group, and an agreed-upon payment is made at regular intervals (here monthly) to them. The payment is made even if no services have been given, but the payment is no greater than the agreed-upon amount even if many services have been provided.

⁵ Average length of stay depends on which waiver the person was receiving services under before entering Consumer Directed Care. Those from the Aged/Disabled Adult waiver average 17 months.

⁶ Costs depend on which waiver the person was receiving services under. Those from the Aged/Disabled Adult waiver average \$1018.91 per member per month.

Source: Agency for Health Care Administration, 2003, and Department of Elder Affairs, 2003.

Adult Day Health Waiver

The Adult Day Health waiver is legislatively mandated, being developed solely to provide adult day health services to individuals who qualify for nursing home care. AHCA is in the process of setting up a demonstration project in Lee and Palm Beach Counties. The program is specifically intended to divert individuals from nursing homes. Enrollees will have to be age 75 or older, living with a

caregiver, and nursing home eligible. The services provided under the Adult Day Health waiver will include case management and adult day health care.

In order to implement the program, AHCA applied for a 1915(b)(c) combination of waivers. The waivers were approved in March 2003 by CMS. A request for proposals to choose a provider for Lee County and Palm Beach County was posted on the AHCA Internet site on September 3, 2003. AHCA hopes to have this program running by December 1, 2003.

Aged/Disabled Adult Waiver

The Aged/Disabled Adult waiver began in April 1982, and is a Medicaid 1915(c) waiver program. The program is operated by DOEA under the supervision of AHCA and is assisted by the Adult Services Office of DCF in managing the disabled adult component. The Aged/Disabled Adult waiver operates throughout the state. DOEA allocates Aged/Disabled Adult waiver spending authority to the AAAs. At least one Medicaid waiver specialist is employed by each AAA to enroll and monitor provider operations and the quality of service provision.

As the name of the program implies, not all recipients are elderly Floridians. The purpose of the waiver is to give individuals a home and community-based alternative to nursing home placement. Enrollees must meet the same eligibility requirements as Medicaid residents in nursing homes. They must be elderly adults age 65 or older or adults with disabilities ages 18 to 64. They must meet Supplemental Security Income or Medicaid waiver income and asset requirements. Waiver enrollees receive services on a fee-for-service basis. The services provided under the Aged/Disabled Adult waiver include:

- Adult day health care
- Adult companion
- Attendant care
- Case aide
- Case management
- Chore (housekeeping, yard work, etc.)
- Consumable medical supplies
- Counseling
- Environmental accessibility adaptations
- Escort
- Family training
- Financial assessment/risk reduction
- Health support
- Home delivered meals
- Homemaker
- Nutritional assessment/risk reduction
- Personal care
- Personal emergency response system
- Pest control
- Respite care
- Skilled nursing
- Specialized medical equipment and supplies
- Physical, occupational, and speech therapies

During FY 2002-2003, the services used most by Aged/Disabled Adult waiver enrollees were respite, in-facility respite, adult day health care, and companionship. Most of the expenditures in the program went to personal care (\$20.8 million), respite (\$13.5 million) and homemaker services (\$16.8 million). One complication with the Aged/Disabled Adult waiver program is that it is difficult to find waiver service providers in rural areas. It is also difficult to provide adequate services to disabled adults because of limited financing for the program. The Aged/Disabled Adult waiver has a large waiting list statewide.

Waiver Care Plan Protocols

There was a deficit in the Aged/Disabled Adult waiver in FY 2002-2003. DOEA has performed various analyses on spending levels, care plan costs, and caseloads for the Aged/Disabled Adult waiver program. The results of these analyses have led DOEA to conclude that there is a need for more structured guidelines for developing care plans based on client needs. For example, the average monthly service costs for the Aged/Disabled Adult waiver program range from a low of \$184.67 in Jefferson County to \$1,127.38 in Manatee County. Although some of this difference in cost may be due to differences in cost of living and cost of services, there are even large differences in comparable service delivery areas.

DOEA sent a notice to the AAAs on August 28, 2003, with the instruction to standardize the review of care plans, to improve communication with providers, and to control costs by monitoring the average care plan cost data and applying benchmarks by level of frailty for providers to use when developing a care plan. DOEA has established a workgroup that will develop a “prescription” for cost effective care plan development, review and oversight. DOEA’s goal is to establish guidelines for standardizing statewide the method by which the costs for quality services can be controlled, while at the same time responding to client need and client risk.

Assisted Living for the Elderly Waiver

In 1995, AHCA initiated development of a 1915(c) waiver program to help elderly people residing in assisted living facilities avoid nursing home placement. The program provides additional personal care and supervision services to aged individuals who would otherwise require nursing home placement. The assisted living facility must be licensed to provide extended congregate care or limited nursing services in order to be an Assisted Living for the Elderly waiver provider.

To qualify for the Assisted Living for the Elderly waiver, an individual must be age 60 or older and meet the same technical and financial criteria applied to individuals seeking Medicaid reimbursement for nursing home care. Additionally, they have to meet at least one of the following criteria:

- Require assistance with four or more activities of daily living or three activities of daily living plus supervision for administration of medication;

- Require total help with one or more activities of daily living;
- Have a diagnosis of Alzheimer’s Disease or other dementia and require assistance with two or more activities of daily living;
- Have a diagnosis of a degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard assisted living facility, but which are available in an assisted living facility licensed for Extended Congregate Care or Limited Nursing Services; or
- Must be a Medicaid-eligible recipient awaiting discharge from a nursing home who cannot return home because of a need for supervision, personal care, or periodic nursing services.

DOEA administers this program through an interagency agreement with AHCA. DOEA contracts with the AAAs for the employment of Medicaid waiver specialists to enroll and train providers and monitor service provision. DOEA allocates Assisted Living for the Elderly waiver spending authority to the AAAs. Allocations are provided to the AAA on a quarterly basis based on a formula that takes into account: 1) the number of assisted living facility beds in an area, 2) the number of Medicaid eligibles age 60 and older in an area, and 3) the number of case months captured in a given time frame.

Services provided under the Assisted Living for the Elderly waiver include case management, assisted living services (consists of 14 service components), and incontinence supplies, if needed. Assisted living facilities receive a fixed amount for each enrollee for case management (approximately \$100 per month) and assisted living services (approximately \$800 per month). Facilities are reimbursed for incontinence supplies on an “as needed” basis.

Initially, the waiver experienced problems due to assisted living facility providers’ lack of interest in the program. Currently, the program is very popular but the funding is limited. In December 1997, an evaluation of the Assisted Living for the Elderly waiver was conducted by the Institute for Health and Human Services Research at Florida State University. The Institute found that waiver enrollees were highly impaired and comparable to Medicaid nursing home residents.

Assistive Care Services

Assistive Care is a Medicaid optional state plan service for low-income people who live in qualified assisted living facilities, adult family-care homes, and residential treatment facilities. Services are based on assessed need and provided in accordance with an individual service plan for each resident.

The purpose of the Medicaid Assistive Care Services (ACS) option is to increase state payments for services provided by residential care facilities. To accomplish this goal, state funds are transferred from DCF to Medicaid to draw down federal Title XIX matching funds. This was accomplished through a redesign of the Optional State Supplementation program.

Assistive Care Services are similar to services typically provided in residential care facilities to residents who require an integrated set of services on a 24-hour basis. The services are specified in a resident care plan developed from an annual assessment. There are four components of ACS:

- Assistance with activities of daily living;
- Assistance with instrumental activities of daily living;
- Medication assistance; and
- Health support.

Three types of residences may qualify as Medicaid ACS providers: assisted living facilities, mental health residential treatment facilities, and adult family care homes. ACS was implemented in assisted living facilities beginning September 1, 2001, in qualified residential treatment facilities beginning November 1, 2001, and in adult family care homes beginning January 1, 2002. More than 50 percent of all assisted living facilities and approximately 75 percent of adult family care homes are enrolled as ACS providers.

To be eligible, recipients must have no assets, low incomes (\$671 per month or less) and need 24-hour care. As of June 2003, there were a total of 9,781 individuals enrolled in ACS, 8,554 with ACS only, and 1,227 receiving ACS and Assisted Living for the Elderly waiver services. Many low-income individuals who fall above the eligibility limit still cannot afford to pay for care in an assisted living facility.

Some individuals are eligible for both ACS and Assisted Living for the Elderly waiver services, while others are only eligible for one service or the other. ACS has more stringent financial eligibility criteria whereas the Assisted Living for the Elderly waiver has more stringent functional eligibility criteria. The Assisted Living for the Elderly waiver provides more to a provider per day (\$28) compared to ACS (\$9.28). However, provider qualifications under the waiver are much more stringent. Thus, there are three times as many ACS providers as there are Assisted Living for the Elderly waiver providers. Also, there are many individuals who are getting ACS and would be functionally eligible for the Assisted Living for the Elderly waiver, but there are no slots available. The Assisted Living for the Elderly waiver program has a large waiting list.

According to AHCA, the principal problems with ACS relate to billing. Some providers bill incorrectly when the ACS recipient is out of the residential facility for part of the month. AHCA has provided training and sent a mass mailing and banner message on this issue, which has helped to some degree. AHCA will most likely have to refer some of the chronic offenders to Medicaid Program Integrity. Also, when an ACS recipient is also on the Assisted Living for the Elderly waiver, billing has been confusing to some providers. The *Medicaid Handbook* is under revision and will include clarification on these issues.

AHCA reported that once the initial challenges of implementation are taken care of, most ACS providers have been very enthusiastic about this program. Not only do they receive more money than under the Optional State Supplementation Program, but they also have more control over their business operations when they bill the state for services, rather than having to try to collect from the resident. The increase in the personal needs allowance (from \$43 to \$54 per month) that was funded by the change to ACS was also a tangible benefit for the residents.

AHCA still reports some concerns with ACS. The number of recipients is somewhat less than projected in 2000 when AHCA began implementing the program. This may be due to some small assisted living facilities that have closed due to financial difficulties. Therefore, it is difficult to project future utilization.

AHCA's limited monitoring of ACS to date has shown a relatively high level of impairment of residents receiving ACS services, but generally good care. The assisted living facility training program operated by DOEA (but discontinued in July of this year) was a factor in maintaining the capacity of these paraprofessional caregivers. There are concerns as to what will happen as turnover reduces the number of trained staff. For example, will providers (especially smaller entities like adult family care homes) have the resources and willingness to pay privately for such training?

AHCA discussed whether the Florida rate of \$9.28 per day was adequate for providing 24-hour supervision, activities of daily living assistance, medication assistance, etc. Other states with comparable services pay at least 15 percent more for such services. By comparison, Florida Medicaid pays almost double that amount for one home health aide visit under the traditional Medicaid home health benefit.

Channeling Waiver

The Channeling waiver program was funded by CMS in 1982 as a national demonstration program to provide home and community-based services to enable frail elders at risk of nursing home admission to remain at home in the community. The Channeling waiver uses a comprehensive management model of service delivery. In 1985, AHCA was given federal approval to continue Channeling as a Medicaid 1915(c) waiver. Since July 1985, AHCA has contracted with the Miami Jewish Home and Hospital for the Aged to operate this program. AHCA's Bureau of Medicaid Services administers the program. The Channeling program operates only in Dade and Broward Counties.

Enrollees in the Channeling waiver must be 65 or older and meet the nursing home level of care as determined by CARES. They must also meet Supplemental Security Income or Institutional Care Program income and asset requirements. The waiver is a managed care program, with all services needed by the individual capitated in a daily rate. Waiver providers are responsible for providing all home

and community-based services. Services provided under the Channeling program include:

- Adult day health care
- Companion
- Case management
- Chore (housekeeping, yard work, etc.)
- Consumable medical supplies
- In-home counseling
- Environmental accessibility adaptations
- Home health aide
- Family training
- Financial education and protection services
- Personal care
- Personal emergency response system
- Respite care
- Skilled nursing
- Special medical equipment
- Special medical supplies
- Physical, occupational, and speech therapies
- Special home delivered meals
- Special drug and nutritional assessment

Consumer Directed Care

The Florida Consumer Directed Care project is one of three national demonstration projects (others in Arkansas and New Jersey) initiated to research issues and questions about Medicaid recipients managing their own care. The premise is that individuals are in the best position to make choices and decisions about their own health care.

The “Cash and Counseling” Demonstration is a large-scale public policy experiment designed to test the feasibility and assess the advantages and disadvantages of a consumer-directed approach to the financing and delivery of personal assistance services. The intent is to give Medicaid-eligible persons with disabilities more choice about and control over the personal assistance services they receive. The experimental intervention is a cash benefit which allows recipients to make more of their own decisions about and arrangements for personal attendant and related personal assistance services. A classical experimental design methodology (i.e., random assignment of volunteer participants to treatment and control groups) was used to identify and evaluate the effects of the experimental intervention in a scientifically rigorous manner.

Because the experimental intervention is a cash benefit and Medicaid law does not permit direct cash payments to clients, the state Medicaid programs participating in the Cash and Counseling Demonstration had to obtain an 1115 research and demonstration waiver from CMS.

In Florida, beginning in FY 2000-2001, participants were recruited from among Medicaid clients who were enrolled in the Aged/Disabled Adult waiver, the

Developmental Services waiver, and the Traumatic Brain Injury and Spinal Cord Injury waiver. In all three states, both older (age 65 and above) and younger adults (age 18 to 64) with disabilities were recruited to participate. In Florida only, there is a third target group of demonstration participants comprised of children with disabilities and their parents.

In each of the three states, a fixed number of Medicaid-eligible individuals with long-term functional disabilities were recruited to participate in the Cash and Counseling Demonstration. Although some participants were expected to be newly enrolled clients, the large majority were persons who were already receiving Medicaid-financed personal assistance services via the existing service delivery system. Because the evaluation incorporates a classical experimental design to test the effects of the new approach to service delivery, Cash and Counseling volunteers had to be willing to accept random assignment to the treatment or control group. That is, they had to agree to participate knowing that they would receive a cash payment in lieu of traditional services if assigned to the treatment group, but that only half of all participants would be assigned to the treatment group. The control group members continued to be restricted to receiving the traditional service package under the waiver.

DOEA administers the Consumer Directed Care demonstration with the guidance of a workgroup comprising representatives from DOEA, DCF's Developmental Disability Program and Adult Services Program, the Department of Health's Brain and Spinal Cord Injury Program and AHCA's Medicaid program.

Consumer Directed Care is not intended for individuals who need case management assistance or cannot accept responsibility for their own care. Florida is permitted to enroll 3,500 participants in the program. Enrollees are allowed, with minimal assistance, to direct their own care and manage the funds allocated for their needs. The original program was restricted to 19 counties; however, the program now serves elders statewide as well as children with developmental disabilities. Individuals enrolled in Consumer Directed Care have different monthly budgets depending on how they qualify for the program.

Frail Elder Program

The Frail Elder program is overseen by AHCA, and offers medical, nursing home, and home and community-based services to individuals enrolled in a United Health Care Plan in Dade, Broward, and Palm Beach counties. Enrollment is not limited to the elderly; individuals must be 21 or older to enroll, however most enrollees are 65 or older.

After operating as an 1115 research and demonstration waiver for 27 months, the Frail Elder program was determined by CMS to be a cost-effective alternative to nursing home placement. With the added services, which were not available through the Medicaid state plan, individuals were diverted from more restrictive and costly nursing home placements.

The decision was made to “mainstream” the project after the three-year demonstration period by incorporating it into a capitated risk-based contract with Mt. Sinai Hospital. The frail elder program became known as the Elder Care program. The contract not only includes home and community-based services, but also covers the risk of nursing home care as well as a comprehensive array of acute care services. If an Elder Care enrollee requires nursing home care, Elder Care must pay for the cost of care until the end of the contract period with the state (July of each year). At the end of the contract year, Elder Care can disenroll the individual at which time Medicaid begins paying for the nursing home stay.

The program has carried on through a series of contract assignments and acquisitions into the contract that AHCA currently has with United Health Care Plans of Florida, Inc. The frail elderly component of the Medicaid HMO contract is monitored by AHCA’s Bureau of Managed Health Care. Currently, the only information available on the Frail Elder program is enrollment. The agency is in the process of collecting detailed service utilization information. The Frail Elder program provides, at a minimum:

1. Medical care:

Medicaid state plan coverage (for example, prescriptions and crossover payments for the dually eligible and hospitalization, etc., for the “Supplemental Security Income-Medicaid only” members).

2. Long-term care:

- Up to one year of nursing home care (never more and usually less than one year);
- A plan of care;
- Coordination of care/case management;
- Adaptive equipment;
- Adult day health care;
- Homemaker/personal care; and
- Supplies.

The contract does say that “The plan shall provide other supportive services as deemed necessary,” per the contract section titled, “Expanded Supportive Service Requirements.” Several services are suggested, but the idea is to offer what is needed, with flexibility. The plan follows the basic home and community-based services waiver design, however, this program is not a Medicaid waiver program.

In response to the need for program evaluations, AHCA contracted with the Center on Aging at Florida International University in 2002 to evaluate the Frail Elder program. The evaluation looked at program organization, consumer satisfaction, and cost effectiveness. The final report will be released by AHCA in December 2003.

As part of the evaluation, Florida International University sub-contracted with an actuary, Milliman USA, to help develop capitation rates for the Frail Elder

program. The actuary examined data from two consecutive state fiscal years (1999 and 2000) and analyzed a subset of this data defined by the experience of enrollees in the Aged/Disabled Adult waiver. The assumption was that these individuals would have similar characteristics to those who were enrolled in the capitated programs. A statistical model was developed that described the relationship between enrollees' characteristics at the start of a fiscal year of data and their ensuing acute and long-term care costs. These statistical relationships were then applied to data from a more recent period (Fiscal Year 2002) to develop capitation rates for each region.

The average costs projected by the model developed by the actuary for the Frail Elder program are significantly less than the current rates for the Nursing Home Diversion waiver program. Other capitated programs do not include a service package that is similar to the Frail Elder program. This difference may have to do with the scope of services available under the Aged/Disabled Adult waiver. The nursing home admission rate of Aged/Disabled Adult waiver enrollees should be tracked for an additional one to two years to determine how the costs of the population change. The actuary did note the need for better assessment data on Frail Elder program enrollees and the importance of doing annual reassessments.

Nursing Home Diversion Waiver

The Nursing Home Diversion 1915(c) waiver provides home and community-based services to elderly individuals who are severely functionally impaired and have complex health needs. These individuals would require nursing home care if not enrolled in the waiver. The waiver was approved by CMS in 1997 and was started in Orange, Seminole, and Osceola Counties (Area 7) in 1998 and in Palm Beach County (Area 9) in September 1999. Many Medicare HMOs in the pilot areas decided not to provide services in Florida, which originally reduced the number of interested providers in the Nursing Home Diversion program. There are four waiver providers; including one "other qualified provider" that is not an HMO. DOEA administers this program in consultation with AHCA through a cooperative agreement.

Enrollees in the Nursing Home Diversion waiver must be age 65 or older, receiving Medicare Part A and Part B, and living in one of the program areas. These individuals must meet the CARES criteria of need for nursing home placement and must meet one or more of the following criteria:

- Require assistance with five or more activities of daily living;
- Require total assistance with two or more activities of daily living;
- Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with three or more activities of daily living; and
- Have a diagnosed degenerative or chronic medical condition requiring daily nursing services.

The waiver is a managed care program, with all services needed by the individual capitated in a monthly rate. Waiver providers are responsible for providing all services that would have been provided under the Medicaid state plan, plus an array of home and community-based services. The capitation rate does not vary based on an individual's service utilization. Waiver providers subcontract with local providers for the majority of services. Beneficiaries in the waiver program choose providers from those under sub-contract with the waiver provider. Services provided under the waiver include:

- All Medicaid state plan services including nursing home
- Adult day health care
- Companion
- Assisted living services
- Case management
- Chore (housekeeping, yard work, etc.)
- Consumable medical supplies
- Escort
- Environmental accessibility options
- Family training
- Respite
- Financial assessment/ risk reduction
- Nutritional assessment/ risk reduction
- Home delivered meals
- Personal emergency response system
- Personal care
- Physical, occupational, and speech therapies

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) was initially a Medicare demonstration model and is now an optional state plan service under Medicaid. Under PACE, a provider is paid both Medicaid and Medicare dollars for acute and long-term care services in a single capitated payment. In 1998, the Legislature authorized DOEA to develop a PACE demonstration model in Florida. One provider, Florida PACE Centers, Inc., met the qualifications laid out in state legislation and applied for provider status, which was approved.

PACE is an optional Medicaid benefit for older people who are eligible for nursing home care but wish to remain in their homes. PACE brings together all of the medical and social services needed by those persons and allows them to remain as healthy as possible at home and maintain their independence, dignity and quality of life.

The program is a capitated benefit that blends funding from the Medicare and Medicaid programs while operating a comprehensive managed care plan for frail elderly persons. Providers must cover all items and services provided by both Medicare and Medicaid without any limitation on the amount, duration, or scope of those services. Participants must be 55 years of age or older, be certified as eligible for nursing home care, and live in the program's service area.

Individuals interested in PACE may apply for the program by contacting the PACE center or their local CARES office. They will then be assessed to ensure that they meet the eligibility criteria. DOEA administers the PACE program in consultation with AHCA.

Once accepted into the program, each enrollee receives a needs assessment from an interdisciplinary team consisting of professional and paraprofessional staff. A care plan is developed and these professionals deliver all services (including acute care, when necessary, and nursing facility services), which are integrated for a comprehensive care delivery package. PACE also provides social and medical services, primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance or other type of Medicare or Medicaid cost sharing applies.

Currently, there are only 14 people enrolled in the PACE program in Miami. Of those enrolled, 13 are dually eligible for Medicare and Medicaid and one person is not Medicaid-eligible. According to AHCA, PACE is having difficulty building their census. They have had only limited successes once the potential enrollee and their caregivers have visited the site. However, there are significant limits imposed on how they may contact potential enrollees until those individuals have been through choice counseling with CARES.

The PACE staff has conducted community, CARES, and DCF in-service training to educate these individuals on the program and its benefits. To date they have received two or three referrals from CARES. They are also experiencing some resistance from potential clients with regard to leaving their current physician for the PACE provider. Finally, Medicaid eligibility determination takes up to 45 days from the time of the initial CARES assessment. In some instances the potential enrollee's health has declined such that they are institutionalized by the time the determination has been decided. PACE has identified two areas within Dade County in which they would potentially like to expand in the future. State staff are considering proposals by the PACE provider to remedy the enrollment situation.

Florida State-Funded Home and Community-Based Service Programs for Elders

In addition to the Medicaid waiver and other diversion programs described above, the state also provides services and case management to frail elders funded exclusively through state revenues. These programs listed below are administered

by DOEA to help elders at risk of nursing home placement remain at home or in a community setting.

State-Funded Home and Community-Based Services Programs for Elders, FY 2002-2003

Program	Clients Served	Funding Source	Average Length of Stay in Program (months)²	Total Per Member Per Month Cost
Alzheimer’s Disease Initiative Implemented: 1985 Statewide	2,647	General Revenue	12.3 months	\$498.11
Community Care for the Elderly Implemented: 1973, Law Amended 1976 Statewide	34,473 ¹	General Revenue	20 months ³	\$202.68
Home Care for the Elderly Implemented: 1985 Statewide	5,599	General Revenue	32 months	\$151.78

¹The number of clients served in the program each year is much greater than the number enrolled at a given point in time during the year. For example, the number of people enrolled in Community Care for the Elderly as of July 2003 was approximately 11,000. Many people are in the program for a shorter period of time and then move to another program.

²These numbers are based on individuals who left the program in FY 2002-2003.

³The average length of stay in Community Care for the Elderly is skewed towards longer lengths of stay because there are a few individuals who stay in the program for extended periods of time, up to five years. Most individuals, however, average 5.5 months in the program.

Source: Department of Elder Affairs, 2003.

Alzheimer’s Disease Initiative

The Alzheimer’s Disease Initiative, created by the Legislature in 1985, offers a continuum of services to meet the changing needs of individuals with Alzheimer’s disease and other memory-related disorders and their caregivers. DOEA administers this program, which is funded through state general revenue, and funds research on topics such as diagnostic techniques, therapeutic interventions, and supportive services. An Alzheimer’s disease advisory council composed of ten members selected by the Governor, advises DOEA regarding legislative, programmatic, and administrative matters related to Alzheimer’s disease.

Respite care services are provided in all Florida counties. The Alzheimer’s Disease Initiative enrollees are assessed a co-payment based on their ability to pay. There are 13 state-funded memory disorder clinics in Florida providing

medical diagnosis and treatment for residents as well as training and education for caregivers. Dade, Alachua, and Hillsborough Counties have Model Day Care programs in partnership with three of the university medical school memory disorder clinics. Model day care programs provide a safe environment where Alzheimer's residents congregate for the day and socialize with each other, as well as receive therapeutic interventions designed to maintain or improve their cognitive functioning.

During FY 2002-2003, the services used the most by Alzheimer's Disease Initiative enrollees were respite, in-facility respite, and model day care. Most of the expenditures in the program went to respite (\$5.4 million) and in-facility respite (\$4.5 million).

Community Care for the Elderly

Services offered under the Community Care for the Elderly program vary, and can include homemaker services, personal care and respite care. When funding is available, elders may also receive adult day care, home health aide, counseling, home repair, medical therapeutic care, and emergency alert response services.

In order to be eligible, an enrollee must be at least 60 years of age or older and assessed as functionally impaired. This means that she or he must have mental or physical limitations that restrict their ability to perform normal activities of daily living and that impede their capability to live alone. In 1998, the statute governing the Community Care for the Elderly program was revised. Primary consideration for services is given to elderly individuals who are referred and determined by adult protective services to be victims of abuse, neglect, or exploitation and who are in need of immediate services to prevent further harm.

DOEA administers the program through contracts with the AAAs, who then subcontract with Community Care for the Elderly lead agencies. There is a large waiting list for the program. Funding for the program comes from General Revenue and Tobacco Settlement funds. Service providers must contribute a 10 percent match. Enrollees are charged for services using a sliding scale system based on their ability to pay. This system makes services more available to those who can pay and provides funds to those who are less able to pay.

During FY 2002-2003, the services used the most by individuals enrolled in the Community Care for the Elderly program were adult day care, respite, home delivered meals, and emergency alert response. Expenditures for adult day care were the highest in the Community Care for the Elderly program (\$14.6 million) followed by personal care (\$10.5 million) in FY 2002-2003.

Home Care for the Elderly

The Home Care for the Elderly program provides financial subsidies to people who are willing to care for the frail elderly in their homes. Subsidies go to a

family member or caregiver to supplement Medicaid, Medicare, or other insurance. A special subsidy is available for supplies and respite care.

DOEA assists in administering the program and contracts with the AAAs for regional administration. Enrollees must be 60 years of age or older, they must meet Medicaid nursing home financial requirements, have a CARES assessment, and have an approved adult caregiver living with them who is willing and able to provide or assist in arranging care.

Enrollees in the Home Care for the Elderly program tend to be at high risk of nursing home placement and have low incomes. A basic subsidy averaging \$106 per month is provided for all enrollees. DOEA estimated in 2000 that keeping individuals in their home through this program costs \$1,821 per person compared to nursing home care, which would have cost approximately \$45,000 annually per person. During FY 2002-2003, services used the most by Home Care for the Elderly enrollees were respite and home delivered meals.

Older Americans Act Programs

The federal Older Americans Act was enacted in 1965 and reauthorized in November 2000. The Act provides funding for several nutrition programs, as well as in-home and supportive services for elders. Individuals 60 years of age and older are eligible for services under the Older Americans Act, although priority attention is given to those who are in greatest need of services. These home and community-based supportive services (not health care) are presumed to help keep elderly people out of nursing homes.

In FY 2002-2003, an estimated 96,784 elderly Floridians received OAA services including congregate meals, home delivered meals and supportive services. These services include: health/wellness, nutrition education, congregate/home delivered meals, chore/homemaker services, the Ombudsman program, elder abuse services, medical services, transportation, case management, and health screenings. The number served may be even higher, since several OAA programs do not require reporting in the CIRTS (Client Information Registration and Tracking System) database.

Program Waiting Lists

With an aging population, and the desire of the vast majority of people to stay in their homes as long as possible, there is increased need and demand for home and community-based services. These include adult day services, senior centers, home health, in-home services, and meals programs. Continued federal efforts—the New Freedom Initiative and Medicaid home and community-based services waivers—and state efforts to implement the Olmstead decision that mandates services to be delivered in the most integrated setting, also contribute to the demand.

Although the amount of funding for home and community-based services and the number of programs operating has increased, many of the programs have waiting lists. One reason for these lists is a lack of state funding to match federal funds. Also, any person age 60 or older in the state can put their name on the waiting list for services. According to DOEA, more than 55 percent of those on the waiting lists are not frail enough to be considered for long-term care services. Waiting lists are maintained for state-funded and Medicaid waiver programs. At the local level, lead agencies track the waiting list for their area from the DOEA system. Individuals are given priority on the waiting list if they have been residing in a nursing home and want to transition to a community setting via the Aged/Disabled Adult waiver or the Assisted Living for the Elderly waiver. Individuals are also given priority, once assessed, if they are at imminent risk of being placed in a nursing home or if their health or safety is in danger and could affect their ability to stay in the community. DOEA reported that as of September 2003, 19,453 individuals were waiting to enroll in either a state-funded or Medicaid waiver program.

DOEA has a statewide policy for the assessment process; however, the implementation of policy often differs by area. Individuals are initially assessed for the state-funded and Medicaid waiver programs through the use of one of two forms (701A and 701B), depending on where and how they first inquire about services. If a person calls their local lead agency, they are assessed using the 701A form, through a telephone interview that includes 12 questions about their income, assets, and ability to perform activities of daily living. The information collected from individuals (income, asset, and activities of daily living information) during the phone interview is self-reported by each individual. If individuals are deemed preliminarily eligible based on the phone interview, they are placed on the waiting list for services. There is no way to know for sure that when a slot becomes available that these individuals will be eligible for the program, since, to establish eligibility for the programs, each individual must go through the full 701B screening. These processes may also differ by area.

According to DOEA, if someone walks into a lead agency or DCF office, the individual is typically assessed using a 701B form through a face-to-face interview. If an individual gets the face-to-face assessment, this is a longer process, which can take up to two hours for the full assessment.

There is a special difficulty with the Medicaid waiver waiting lists. If a person is assessed for one of the Medicaid waivers and is deemed eligible for the program, DOEA can no longer put this person on a waiting list. Federal requirements stipulate that the individual must be served if deemed eligible for a Medicaid waiver program. If an individual applies for services under a Medicaid waiver program and there is no funding available, DOEA and DCF will not fully assess the individual. This means that the numbers reported on the Medicaid waiver waiting list kept by DOEA includes all individuals who have inquired and gone through the self-reporting assessment for services. There is the potential that some

of these people may never be eligible for Medicaid waiver services. Thus, it is difficult to tell whether the waiting list gives an accurate picture of current need for the Medicaid waiver programs.

Methodology

Staff researched and documented legislative and other initiatives 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

Florida, like many other states, has a fragmented long-term care service delivery system. The Florida system is confusing and difficult to navigate. Seniors find it difficult to get information about what options are available when support is needed. People often spend more than they should for care, and need public subsidies sooner than necessary because they are unaware of less expensive alternatives. Public funding is weighted heavily towards institutional and medical providers of care. There are long waiting lists for those programs that do provide flexible, personalized supports. As currently structured, the long-term care system will not be able to handle the projected growth in the number of people who are going to need long-term care services in the state in the future.

Florida policymakers have many reasons to improve state long-term care policy and service delivery, 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 expenditure growth, 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 or community-based long-term care services across the state.

This section looks specifically at Florida legislation that passed in 2001, 2002, and 2003, and other initiatives affecting long-term care policies and programs in Florida, as well as recent policy recommendations from the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Auditor General's Office.

2001 Initiatives

Certificate of Need Moratorium on Nursing Home Beds

CS/CS/CS SB 1202 established a moratorium on AHCA approval of Certificate-of-Need (CON) applications until July 1, 2006, for all community nursing home beds. Non-Medicaid beds in continuing care retirement facilities were exempted.

There are a certain number of nursing home projects and beds that received approval from the CON program prior to the imposition of the moratorium that have not yet been licensed. These are often referred to as “pipeline” projects and beds. Enactment of the moratorium on CON approval of new beds means that the size of the pipeline will diminish over time, as projects are completed or approval expires.

In July 2001, the start of the moratorium, there were 2,537 beds in the nursing home pipeline. By September 2002, there were 1,687 (these totals do not include sheltered beds or hospital-based skilled nursing unit beds). Out of the 1,687 new nursing home beds in the pipeline on September 1, 2002, there were 1,289, or 76.4 percent, approved for 13 new community nursing homes; and 398, or 23.6 percent, approved for additions to 15 existing facilities. An additional 263 beds at six facilities were licensed beds already in existence approved for transfer to another nursing home.

Many of these “pipeline” beds have not been developed and a significant percentage of the remaining beds are expected to remain undeveloped. Nursing home providers have reported difficulty in obtaining financing as the primary reason for their inability to develop and license the CON-approved beds.

Currently there are 1114 beds in the pipeline, according to AHCA. Based on occupancy and the pipeline figures, AHCA recommends that the moratorium continue. It will be important to reevaluate the moratorium, as well as occupancy rates, at the end of 2004.

The 2000 Legislature 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.” Florida’s 2001-2003 Certificate of Need workgroup was established in Chapter 2000-318, Laws of Florida. The workgroup interim report made several recommendations regarding CON and nursing homes. These included:

- CON regulation should continue for the construction of new nursing home bed allocations throughout the state, under a revised bed need methodology that includes an average occupancy threshold of 94 percent, rather than the 91 percent used prior to the moratorium. The bed need formula should be revised based on an occupancy threshold,

population trends and utilization of long term alternative care services;

- The provision for the submission of “special circumstance” applications outside the bed need pool should be retained;
- A Joint Working, Planning and Policy Group should be immediately created under direction of AHCA’s Division of Managed Care and Health Quality;
- The CON process for replacement facility, or for the consolidation or transfer of beds, during and after the moratorium, should allow a shifting of existing beds within a nursing home district or subdistrict as long as the net bed inventory in a nursing home district or subdistrict does not change; and
- Allow facilities free from Class 1 and 2 deficiencies for a 30-month period to increase beds exempt from CON when occupancy reaches 95 percent. Such increase would be for 10 beds or 10 percent of total licensed beds whichever is greater.

Some of these recommendations were reiterated in the final report by the nursing home subcommittee of the CON workgroup. The subcommittee made the following specific proposals:

- Allow increased flexibilities for nursing homes to replace or transfer beds among facilities within districts without adding to the overall number of beds;
- Create a CON advisory panel for nursing home issues;
- Increase the occupancy standard in the current CON bed need methodology for nursing home beds;
- Delete the requirement for Gold Seal designation for highly utilized nursing homes to seek additional beds without CON review; and
- 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 more tightly restrict the nursing home 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. Participants in the transition program had to meet nursing home level of care as well as at least one of the following additional criteria specified in the approved waiver criteria:

- Require assistance with four or more activities of daily living;
- Require assistance with three or more activities of daily living plus supervision or administration of medication;
- Have a diagnosis of Alzheimer's Disease or another type of dementia and require assistance with two or more activities of daily living;
- Require total help with one or more activities of daily living;
- Have a diagnosed degenerative medical condition requiring nursing services that cannot be provided in a standard assisted living facility but which are available in an assisted living facility licensed to provide limited nursing services or extended congregate care; or
- Are eligible for Medicaid, meet assisted living facility criteria, are awaiting discharge from a nursing facility placement and cannot return to a private residence because of the need for supervision, personal care, periodic nursing services, or a combination of the three.

The Nursing Home Transition initiative was implemented statewide on September 1, 2001. According to CARES staff, as of June 30, 2002, the following outcomes were achieved:

- 610 nursing home residents were identified as able and interested in returning to the community with the support of the Assisted Living for the Elderly waiver;
- From the original 610, 391 residents actually transitioned as of June 2002;
- Approximately 300 of these individuals had been in nursing facilities for six months or less; 68 percent were female with an average age of 79 years. The majority (86%) met the Intermediate I level of care criteria, which stipulate that extensive health-related care and services are needed. Participants with dementia comprised 43 percent of those initially identified in this group;
- 127 elders originally identified who did not move were either too ill to transfer, decided not to leave the nursing facility, or could not locate an appropriate Assisted Living for the Elderly waiver placement;
- Prior to transition into the Assisted Living for the Elderly waiver program, the average nursing home stay of those relocated was 239 days; and
- Only 62 percent of the appropriated \$2.3 million was spent. CARES staff state that the start-up took longer than expected and that if more Assisted Living for the Elderly waiver vacancies had been available, additional diversions would have been possible; and

- DOEA reports that the documented savings to the Medicaid program from transitioning these individuals out of the nursing home exceeds \$4 million.

As of September 2003, DOEA staff report that 652 individuals have been transitioned out of nursing homes into assisted living facilities via the Assisted Living for the Elderly waiver as part of the 2001 legislative initiative. The greatest number of transitions occurred in Volusia (29), Lee (21), Seminole (17), and Orange (16) Counties.

The appropriated funds from the 2001 legislative session and the proviso that accompanied them were not recurring in the next year's budget. An annualization of the Nursing Home Transition Program budget was put in place so that those individuals who were transitioned could continue to be served under the Assisted Living for the Elderly waiver.

The CARES staff has discontinued nursing home transitioning as it was originally designed because there are no slots in the Assisted Living for the Elderly waiver available to use for transitioning. According to DOEA, CARES continues to try to move individuals out of nursing homes within the framework of available community services. Of those nursing home residents identified during the Nursing Home Transition initiative in FY 2001-2002 that transitioned into the community, 198 are currently enrolled in the Assisted Living for the Elderly waiver, 61 died, 103 returned to the nursing home, and 45 left the Assisted Living for the Elderly waiver (moved, improved, left on own, transferred to another program, or no longer eligible). The Nursing Home Transition initiative funding from those who are no longer in the Assisted Living for the Elderly waiver program became part of the Assisted Living for the Elderly waiver program total budget for FY 2003-2004.

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 to community service programs. 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 of the nursing home population. 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, which was an AHCA recommendation in 2002, would be to have CARES assess all nursing home entrants. CARES diverts people from admission in the first place, and could be instrumental in diverting the large subset of nursing home residents who currently convert from a Medicare nursing home bed at admission to a Medicaid nursing home resident after 20 days. 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.

In order to identify individuals who may have a serious mental illness, the Nursing Home Reform Act of 1987 required that all nursing home applicants, regardless of payment source, be given a preadmission screening and annual resident review (PASARR). Effective in October 1996, the Federal requirement for annual resident review or reassessment was eliminated and the screen is now referred to as the preadmission screening and resident review (PASRR). The PASRR requirement also applies to individuals with mental retardation or developmental disabilities.

Responsibility for enforcing PASRR requirements is shared by each state Medicaid agency and CMS. AHCA’s field offices could use their monitoring of nursing homes for OBRA/PASRR compliance as the means to identify pre-Medicaid individuals for potential diversion from long-term nursing home placement. PASSR compliance staff could communicate with local CARES staff to let them know there are individuals in their area that might be appropriate for transitioning.

A funding option to consider, recommended by AHCA in 2002, 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” Program

In 2001, the Florida Legislature approved \$3 million in funding for a program 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 named “Up or Out” sought to provide assistance to nursing facilities to improve their survey results within a given time period or risk de-licensure and loss of Medicaid funding. The bill instructed AHCA to develop a pilot project to demonstrate the effect of assigning skilled and trained medical personnel to ensure the quality of care, safety, and continuity of care for long-stay Medicaid recipients in the highest-scoring nursing homes (i.e., lower quality scores) in the Florida Nursing Home Guide.

In 2002, the appropriation for the program was cut to \$100,000 per year, limiting what AHCA could develop as a pilot. The funding for the program is recurring in the state budget each fiscal year, whether or not the funds are used. A contract was signed, however, in April 2003, with Evercare. Evercare, an affiliate of United Health Group, has Medicare, Medicaid, and private-pay long-term care products and programs that serve individuals nationwide, from those who continue to live independently to individuals who reside in assisted living facilities and nursing homes. Evercare Choice is a Medicare product that offers enhanced medical coverage to frail, elderly, and chronically ill populations in both nursing homes and community settings through the partnering of nurse practitioners, physicians, and other health care professionals.

Evercare is providing services to individuals enrolled in Evercare Choice in three Evercare contracted nursing facilities that have volunteered to participate in the project. Through the Up or Out demonstration, Evercare is continuing with the enrollment process approved for Evercare Choice by CMS in the demonstration facilities. Potential enrollees are permanently institutionalized residents, who have Medicare Part A and Part B, and who do not have end stage renal disease. Evercare assigned one practitioner per facility who will continue to provide the following primary care services as defined under the Evercare model to the individuals enrolled in the demonstration:

- Management of the participating residents' medical needs and development of a plan of care in collaboration with their primary care physicians. The practitioner will provide on-site routine, follow-up and emergent visits with appropriate supporting documentation in the medical record;
- Assistance in developing individualized care plans that address risks for adverse outcomes and set realistic goals to manage the risks;

- Review of interdisciplinary documentation in the resident's medical record to determine adherence to consistency of clinical information; and
- Opportunity for the resident, family and/or responsible party to participate in conferences to review clinical status changes and the advanced care plan wishes of the resident. Conferences may be as frequent as the resident's condition warrants or on request.

In addition to the services provided to individuals enrolled in Evercare Choice, Evercare is providing the following services in order to improve quality of care for all residents in the three participating nursing facilities:

- Staff education and training on the development and implementation of best practice guidelines addressing any/all of the areas addressed in the quality improvement plan, including significant change in condition; pressure ulcers; restraint reduction; pain management; non-pain symptom management (care planning at the end of life); advance care planning; restorative best practice for activities of daily living improvement; and communication guidelines; and
- Scheduled and hands-on practical training and education in the areas of palliative care, pain management, advanced care planning/ethics of end of life decision making communication skills with physicians, other health care professionals, patients, and families. Emphasis is placed on issues related to pain management and palliative care, as this is an area of interest to CMS, and is important to the nursing facilities for staff training.

Evercare is providing the services of a part-time clinical services manager, also called a demonstration liaison, who is experienced with the Evercare Choice program. This person will provide oversight and coordination of the day-to-day implementation and evaluation of the program and supervision of the practitioners.

Evercare is also contracting with a consulting medical director for the Up or Out Program with a background in geriatrics, understanding of regulatory issues facing nursing homes, and strong clinical skills related to palliative care, pain management, and end-of-life issues. The consultant medical director is providing assistance in educating facility physicians regarding the Up or Out program and weekly oversight. Finally, Evercare is subcontracting with the Florida Health Care Association to provide assistance and oversight for the demonstration with a review of : 1) selected MDS Quality Indicators as well as the significant risk factors associated with a decline in quality of care (i.e., history of substandard Quality of Care citations, Administrator and Director of Nurses turnover and performance issues); 2) pool utilization; 3) increases in state complaint visits (e.g., two in one month, three in two months); and 4) staffing.

The three facilities (located in Hillsborough and Polk Counties) that volunteered to participate are currently working with Evercare for the project. They came on board in that order and are at various stages in their development. Evercare is still collecting baseline data, but all of the facilities have had at least some assessment/planning and some training scheduled, and the first two facilities have already had some training conducted. Training topics included the “Resident Assessment Instrument” and the “Role of the Physician in the Quality Indicators and Survey Process.”

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.

The nursing homes visited by AHCA staff agreed that having the extra nurse practitioner onsite benefits the facility.

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. If the intervention is successful, this may be one proposed model to consider when looking at how care is provided in nursing homes in the future.

One option could be to revoke the Medicaid certification of facilities that continue to perform below standards even after having been involved in the Up or Out program. This follows recommendations made by AHCA in 2002. According to AHCA, there are a number of poor performing facilities with low occupancy that could be considered for termination of their Medicaid agreements. Because there may be no other institutional or community alternatives for people other than the nursing home in some areas, the state must be cautious in making decisions to close facilities or terminate Medicaid agreements.

One stipulation of AHCA terminating the Medicaid 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.

2001 OPPAGA Recommendations

State law directs OPPAGA to complete a justification review of each state agency that is operating under performance-based program budgeting. DOEA began operating under a performance-based program budget in FY 1999-2000. OPPAGA conducted a review of DOEA's Services to Elders program, which was published in December 2001. The report assessed elder services and identified alternatives to increase the efficiency and effectiveness of program operations. Three topics discussed in the report were particularly relevant to the provision of long-term care services in Florida: integration of Medicare and Medicaid Services, evaluation of the Nursing Home Diversion program, and CARES co-location with service providers and DCF eligibility staff.

Integrating Medicare and Medicaid Services

OPPAGA recommended that DOEA petition CMS to pursue waivers that achieve the integration of Medicaid and Medicare services under one provider. OPPAGA suggested that this integration may make it easier for the program to find providers for managed long-term care.

CMS Dual-Eligible Beneficiaries Grant

In 1998, DOEA received a grant to develop a dual-eligible beneficiaries program for long-term care services in Florida. The grant provided funding over a 6-year period to develop a program for dual-eligible beneficiaries. Some of the main objectives of the grant were to:

- Develop a managed medical and long-term care delivery system that links Medicare and Medicaid and is available to all Medicare beneficiaries;
- Promote collaboration between Medicare and Medicaid on integrating the financing, service delivery, and quality assurance functions for managed care organizations;
- Integrate care through the use of interdisciplinary care management teams;
- Develop broadly available consumer information systems that assist Medicare beneficiaries in making informed decisions about their health care and long-term care coverage options;
- Expand access to a variety of Medicare managed care options to all regions of the state;
- Use Medicare payments to cover front-end managed long-term care;
- Use Medicaid savings to subsidize extended long-term coverage for individuals defined as pre-dual;

- Work with the insurance industry to develop affordable long-term care insurance products to cover catastrophic care in the managed care context;
- Encourage managed care organizations to use state-of-the-art geriatric care protocols;
- Employ a risk-adjusted rate cell methodology for Medicare and Medicaid capitation to encourage managed care organizations to serve high cost beneficiaries; and
- Factor quality indicators into the payment system for managed care organizations.

Few of the proposed objectives for the project were met. This is due in part to changes in DOEA administration and priorities over the 6-year period. Between 1998 and 2002 the grant activities were relatively stagnant. In 2002, with the passing of Legislation mandating the creation of a managed integrated long-term care pilot project (CS/SB 1276), DOEA used funding from the grant to comply with the legislative mandate; one that was similar to the original grant objectives. Funds from the grant were also used to contract for a preliminary evaluation of the cost-effectiveness of five of Florida's Medicaid long-term care programs and to develop capitation rates for the Nursing Home Diversion program. These activities should be beneficial in helping make decisions about changes to the long-term care service delivery system, but they fall short of meeting the stated goals of the grant.

Program for All-Inclusive Care for the Elderly

DOEA worked with AHCA to develop a program that integrated Medicare and Medicaid services through the PACE program. PACE specifically targets frail elderly persons eligible for nursing home care, but who are living in the community. PACE seeks to help individuals continue to live at home and not be admitted to a nursing home facility. PACE integrates social and medical services through adult day health care. The program uses a multidisciplinary team approach, with care provided by physicians, nurses, social workers, nutritionists, occupational and speech therapists, and health and transportation workers. Through preventative and rehabilitative services, participants' chronic conditions can be stabilized and medical complications prevented. Community living is usually the overwhelming choice of participants. However, should nursing home placement become necessary, PACE also provides that service. PACE enrollees receive all health services through PACE, including physician services, hospitalization, therapies, pharmaceuticals, and equipment.

PACE is a niche program that serves small elderly populations well. Evaluations of the PACE model around the country have found cost savings relative to other service providers such as nursing homes, managed care organizations, and behavioral health organizations. Participant and family member/caregiver satisfaction levels with PACE are very high. However, Florida has a large and growing elderly population which makes a program such as PACE a less viable

model for integrating Medicare and Medicaid services statewide. The PACE model provides comprehensive integration of Medicare and Medicaid services, yet, it is one of the most expensive models per capita. PACE centers can be very expensive to build and finance. This limits the feasibility of having PACE providers available in many areas of the state. Enrollment in PACE is slow because elders have to give up their primary physicians and receive all services through the PACE center. PACE can only serve 200-300 people at any given time because people must be served through the PACE site. PACE centers typically develop in urban areas where elders have better access to transportation to get to and from the PACE site. These centers would be more difficult to develop in rural areas.

Evaluation of the Nursing Home Diversion Pilot Project

OPPAGA recommended that the legislature require DOEA to closely monitor contract providers to ensure that the elder enrollees are receiving the adequate care they need to delay or avoid nursing home placement and properly sanction contractors that do not meet this desired outcome. To date, no providers have been sanctioned. DOEA does conduct annual monitoring reviews of the appropriateness of care plans and does issue corrective actions to providers.

OPPAGA also recommended that the program contractually require providers to report cost information. When the issue of cost reporting was raised with the managed care plans, they argued that cost reporting would interfere with their ability to negotiate competitive contracts with their service providers. If the managed care plans report the cost they pay their providers for the service, they cannot maintain a competitive advantage to negotiate their best price. On the other hand, with extensive and coherent service utilization reporting (encounter data), and the help of an actuary, the state would be in a better position to determine an adequate reimbursement methodology and estimate the cost of providing services to the providers.

Finally, OPPAGA recommended that DOEA contract for a comprehensive evaluation for the Long-Term Care Nursing Home Diversion Pilot Project that addresses the areas required by law. At a minimum, the evaluation should include:

- A cost comparison of pilot participants with Medicaid waiver and nursing home clients;
- Client-specific outcomes, such as whether clients' desires are being met in terms of choice of services and providers and their right to privacy;
- Continuity of security, and whether the client is getting the necessary support from case management to meet desired outcomes;
- A comparison between the pilot's frequency of incidents of preventable hospitalization and the national average; and
- An actuarial analysis of the capitation rate of the pilot project.

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 1998 and 1999 was completed in November 2001 by the Florida Policy Exchange Center on Aging at the University of South Florida. At the time of the Florida Policy Exchange Center on Aging evaluation, these projects had been in operation from 21 to 31 months.

The evaluation found that enrollees in the waiver 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. At this point, no funds have been appropriated to evaluate this program.

An actuarial analysis of the Nursing Home Diversion capitation rate was completed in September 2003. DOEA contracted with Milliman USA to help develop actuarially certified rates for the Diversion program. DOEA presented the new rates to Nursing Home Diversion providers on September 17, 2003. The rate study is discussed in detail on page 65 as it relates to the expansion of the Nursing Home Diversion program.

Co-Location of CARES and DCF Eligibility Staff

To improve the efficiency of CARES staff assessments and increase client diversions from nursing homes, OPPAGA recommended that the CARES program should make it a priority to fully implement the laptop computer pilot project so that assessment information from the laptops can be downloaded to the main computer system. In addition, 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.

Determining Eligibility

The purpose for co-locating medical eligibility staff (DOEA) with financial eligibility staff (DCF) was to significantly reduce the time for determining financial and medical eligibility for Medicaid home and community-based

services. One of the complaints that state policymakers continue to hear is that the determination of eligibility for long-term care programs takes too much time. The belief is that, if the medical and financial assessment staff are co-located, there will be better communication and applications will be processed more quickly. DCF staff were cited as taking too long to process individual applications.

There are three distinct time periods in the eligibility process that must be considered when looking at the time it takes to begin providing services to an individual: 1) the time it takes for CARES to finish the medical assessment, 2) the time it takes for DCF to work with an individual and put together a completed application, and 3) the time it takes for DCF to process an application after it has been completed. Often these three time periods are combined into one time period, thus making it difficult to determine where delays are occurring. Data provided by DCF show that the state average for what are defined as “agency days” is 24.1 days, meaning that it takes just over three weeks to complete the CARES medical assessment and for DCF to work with an individual to complete the financial part of the application to begin processing it. The state average for “processing days” is 42.3, which means that it takes approximately six more weeks to finish processing the application after it is complete.

DCF has specific Federal guidelines [42 CFR 435.911 (a)(1) and (2)] it must follow for processing applications, once they are complete. Individuals age 65 or older have a 45 day processing time standard. If the individual is under 65 and disability is a factor in eligibility, the time standard is 90 days.

Completing the Application

It is important to look more closely at the time it takes to make sure an individual’s application is complete and ready to process. Understanding the length of time it takes to process an application is difficult because it varies by each area. CARES staff claim that it takes an average of 12 days to complete the medical assessment and provide it to DCF staff so that DCF staff can begin working with an individual on the financial portion. Once the Medical assessment is completed, CARES staff mail the medical assessment to DCF staff. This would mean that it is taking another 12 days on average to finish the financial part of the application once the medical assessment is completed. Also, in some areas, CARES works on the medical assessment at the same time that DCF is working on the financial eligibility and, in some cases, DCF finishes the financial part of the application and then CARES does the medical assessment. There is no uniform process in place for how applications get completed and processed.

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. However, 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 went 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. Individuals waiting for eligibility 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, this is an extra month of capitation payment and they also can start managing the person's care more quickly, in the hopes of delaying nursing home placements.

Processing the Completed Application

The application process can also take a long time. One of the main reasons for this is the eligibility requirement that an applicant's assets not exceed specified amounts. DOEA and AHCA did communicate with CMS to see if the asset requirement could be waived for certain Medicaid long-term care programs. According to DOEA, CMS said that the asset test could not be waived for a Medicaid-specific program, rather it could only be waived for a category of eligibility. For example, if the state wanted to waive asset requirements for individuals enrolled in the Nursing Home Diversion program, because individuals must meet Institutional Care Program requirements to be eligible for the Diversion program, this means that all regular Institutional Care Program participants (Medicaid nursing home) would also have to have asset requirements waived.

Although some argue that income is a good indicator of the assets people have, this is not always the case. One case in point is the Silver Saver prescription drug program. Many individuals meet the income eligibility requirements for the Silver Saver program, but do not meet the asset requirements for the Medicaid waiver programs. The state might want to consider doing an analysis of the populations in these programs to see how they compare on income and assets, and whether waiving the asset requirement for initial eligibility determination is feasible.

Co-location of CARES and DCF staff does not necessarily mean that applications will be processed at a faster rate. DCF reported that in three of the five collocated sites, processing days and agency days are greater than the state average. Simply moving physical locations will not improve the application process for individuals in need of services. Rather, it is the coordination and communication between the various entities involved in the process that will help ensure individuals get the

services they need in a timely manner. One concern about co-location is who will manage staff from the two different agencies.

During the 2003 Session, DCF was directed to develop a plan to achieve efficiencies contained in Specific Appropriations 359 and 360 in carrying out the eligibility determination process. From the funds in Specific Appropriation 359, DCF was directed to work with the appropriate federal agencies to obtain any required federal approvals or waivers of current federal regulations which may presently restrict the state from fully outsourcing these functions. DCF will issue a request for proposals around December 1, 2003 to contract out for eligibility determination services. If the DCF eligibility determination is privatized, questions are raised as to how the private entity will coordinate with CARES staff in the determination of eligibility for long-term care services.

Medical Assessments: CARES and CIRTS

The medical assessment portion of eligibility determination provides the information necessary to develop a care plan and for case management purposes, functions typically performed by the lead agencies. Medical need is determined either through a CARES (Comprehensive Assessment and Review for Long-Term Care Services) assessment for Medicaid programs or a CIRTS (Client Information, Registration Tracking System) assessment for state-funded programs.

CARES is Florida's pre-admission screening program for nursing facilities and is federally mandated (see 42 CFR 456.372) for any person seeking financial assistance through the Medicaid program for nursing home care. AHCA has regulatory oversight for CARES and has delegated responsibility for determining level of care to DOEA. CARES staff at DOEA handles the medical component of eligibility determination for nursing home care through on-site assessment of the people who apply for Medicaid reimbursement for their nursing home care. Assessments must comply with the 1987 Federal Nursing Home Reform Act, which requires additional screening for applicants with certain mental illness or mental retardation diagnoses. CARES staff also are responsible under 42 CFR 441.391 (3)(b)(1)(ii) for determining whether applicants meet eligibility criteria for most of Florida's Medicaid home and community-based waiver programs.

CIRTS was developed in 1992 as a tool to gather information about elder Floridians who are receiving or may desire state-funded long-term care services. This information is maintained in a statewide database. The lead agencies typically do the CIRTS assessments. CIRTS was modified in September 2000 so that DOEA could prioritize elders who wanted services according to their frailty level. This prioritization became an issue because of the increase in program waiting lists. Prior to 2000, persons requesting services who had been screened and assessed were either enrolled in a program and began receiving services or were put on a program waiting list. After the modifications to CIRTS, the waiting list was modified to act as an assessed priority consumer list, which allowed resources to be used to serve the frailest elders.

The same form is used for the CARES and CIRT databases; however, more of the information on the form is filled out for individuals receiving a CARES assessment because Medicaid requires more information to be collected. For example, a level of care determination is needed for the Medicaid programs. Even though CARES and CIRT use the same form, separate databases for the CARES and CIRT assessments are maintained. There is much difficulty moving between the databases. Tracking individuals who move from the state-funded programs to a Medicaid program is difficult because of the need to move from one database to another, and the databases do not interface at all.

According to DOEA, the CIRT database holds more information on an individual. CIRT tracks all programmatic information, providing a programmatic history on an individual. The database holds the initial assessment on an individual as well as annual reassessments and updates. CIRT information may be updated with financial information or if an individual has a catastrophic event in between assessments. The CARES database is limited to the level of care and medical assessment information on an individual.

Financial Eligibility: The FLORIDA System

The FLORIDA system is an integrated computer system that determines eligibility for TANF, Food Stamps and Medicaid. Functions include client intake, eligibility determination, benefit calculation, and case maintenance. The FLORIDA system is operated by the central office of DCF. Workers access the system directly in order to input a client's demographic and financial information.

Medicaid Claims System: FMMIS

The Florida Medicaid Management Information System (FMMIS) is the information system for the State's Medicaid Program. FMMIS is used by the Medicaid program fiscal agent to pay Medicaid program claims and provide services and reports to AHCA as well as to Medicaid program recipients and providers.

Currently, the systems used to track medical and financial eligibility, care plans, and paid services, have limited interfacing capabilities and limited flexibility. This makes it difficult for the entities developing care plans to track the services that have been prescribed and the services that have been paid for. AHCA and DOEA are also limited in their ability to monitor how services are allocated, provided, and paid for.

2002 Initiatives

During the 2002 Session, a number of bills were passed that were subsequently signed into law affecting long-term care in Florida. In response to what was seen as fragmentation and disorganization across long-term care programs and services, the Florida Legislature passed CS/SB 1276. This bill mandated a number of activities aimed at improving long-term care in Florida.

Health and Human Services Access Act

CS/SB 1276, "Florida Health and Human Services Access Act," gave authority to AHCA to implement a pilot project to demonstrate the feasibility of developing a comprehensive, automated system for access to health care services through an integrated information and referral system that would be accessed by dialing the telephone number 211. Although the initial pilot project was for health care services, the legislation provided for future expansion to include other social services, including elder services.

The enhanced eligibility determination process would allow an individual who is seeking access to publicly funded health care programs to access the programs via the Internet, an office visit, or a 211 telephone operator. The individual would be screened for potential eligibility for programs. Viable applications would be submitted to DCF for final eligibility determination. All other applicants would receive additional information and referrals to the appropriate resources.

The Florida 211 Network is to serve as the single point of coordination for health and human services information and referral provided by the state. The goal was to establish a cost-effective and comprehensive information and referral source that electronically connects local information and referral systems, state and local service providers and consumers to one another. The Florida 211 Network would standardize and integrate information and referral services, thus streamlining the eligibility and case-management processes.

AHCA contracted with the United Way of Northwest Florida to implement the pilot project. The project was to operate in Duval and the surrounding counties. The eligibility system was designed and tested; however, before it was implemented the funding for the pilot project was cut during the 2003 legislative session. Due to lack of available funds and the budget authority required to continue during state fiscal year 2003-2004, AHCA terminated all contracts and activity associated with the Health and Human Services Eligibility Access Pilot Project effective June 30, 2003. AHCA did successfully implement a certification process that will allow it to certify all #211 information and referral providers across the state of Florida. This process will ensure consistent and quality access to health and human services provided at the state and local level.

Consumer Directed Care Act

CS/SB 1276 required AHCA to establish the consumer-directed care program, based on the principles of consumer choice and control. AHCA was required to implement the program upon federal waiver approval. The bill provided that AHCA establish interagency cooperative agreements with DOEA, DOH, and DCF to implement and administer the program. The program was to allow enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs. The program was mandated to operate within the funds appropriated by the Legislature.

This legislative mandate authorized the statewide expansion of the Cash and Counseling demonstration grant that DOEA received from the Robert Wood Johnson Foundation. With the expansion of the program, Cash and Counseling is still under an 1115 research and demonstration waiver, however, the experimental design no longer has to be followed. That is, there is no longer a control group. Those individuals enrolled in the program and assigned to the control group would begin receiving a stipend to hire their own care workers. The expansion of the program has not yet been fully approved by CMS. AHCA is currently working with DOEA to develop the operational protocols for the program. AHCA and DOEA are aiming to enroll the control group and new individuals into the program by January 2004, contingent on CMS's approval of the state's operational protocol. Currently, only those in the experimental group are receiving funds to direct their own care.

Services under the program could include, but are not limited to, the following: personal care; homemaking and chores, including housework, meal preparation, shopping, and transportation; home modifications and assistive devices which may increase the consumer's independence or make it possible to avoid institutional placement; assistance in taking self-administered medication; daycare and respite care services, including those provided by nursing home facilities pursuant to s. 400.141(6), F.S., or by adult day care facilities licensed pursuant to s. 400.554, F.S.; as well as personal care and support services provided in an assisted living facility.

An operational audit of the Consumer Directed Care program was completed by the Auditor General in August of 2003. Key findings of the report were related to the Fiscal Intermediary hired to provide fiscal services to consumers, as well as appropriate documentation of services rendered to consumers. The report recommended that DOEA:

- Strengthen its monitoring of consultants who help manage the consumer's care, as well as provide education to consultants so that they can better identify the care needed by consumers;
- Modify its contract with the Fiscal Intermediary to include review of timesheets and provider invoices before payments, procedures to identify consumers who continually submit inaccurate provider invoices, changes in monitoring procedures that allow for a comprehensive review of the Fiscal Intermediary's accounting controls, and assurance that the Fiscal Intermediary develops timesheets that identify relatives and live-in caregivers;
- Implement procedures to monitor paid timesheets for approval by a competent consumer or independent representative and setting a limit on the amount of cash assistance consumers can receive in their budget; and
- Clarify the appropriate methodology for effectively documenting compliance with the terms and conditions of the waiver regarding informal care services.

Managed Integrated Long-Term Care Pilot Project

CS/SB 1276 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 age 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 and payment and the provider actually providing the services.

A key element of the design was to locate the eligibility determination for Medicaid (which is handled by DCF) and the needs assessment (which is handled by DOEA) in the same place, so these determinations could be expedited. Information and referral services would also be located at this intake point. Care plan development and case management would be performed independently of the service providers. Services would be supplied through vendors under contract with the administering entity, with rates of reimbursement having been negotiated as part of the contract.

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, including access; assessment and care plan development; integrating long-term and acute care; issues of finance, administration, and risk; and program evaluation.

From the start, various stakeholders across the state raised doubt about the feasibility of the project. A report summarizing the findings and comments from these meetings was published in June 2003 by the Pepper Institute on Aging at the Florida State University. Although comments were offered on many different topics, participants made seven primary recommendations for DOEA to consider. These key recommendations were to:

- Simplify and expedite the eligibility process;
- Ensure excellent assessments as the basis for both quality care and cost savings;
- Exclude acute care from this project;
- Be sure that the project is adequately funded;

- Develop the methodology for a good program evaluation and implement protocols for data collection as the project is developing;
- Realize that whenever a new program is introduced, there can be disruption for clients. Frail clients are particularly vulnerable to disruptions; and
- Not to underestimate the cost of providing training and building infrastructure or the importance of a well-trained labor force and a smoothly operating, technologically efficient, information management system to the ultimate success of this program.

The most frequently noted concerns helped identify ambiguities in the original legislation as well as the advisability of proceeding within the specific design framework provided in statute. Concerns about the primary goals for this program included:

- A fear that the emphasis was on saving money when the current long-term care system is significantly under-funded;
- The charge to integrate long-term care with acute care, when the long-term care system itself is not adequately integrated;
- A design that emphasized a ‘medical model’ of care in place of a ‘social service’ model of care without sufficient thought being given to how the two models might complement each other;
- A time frame that calls for too much to happen too quickly, putting consumers at risk and inviting destruction of an existing network without reasonable assurances that this new program can be successful;
- A desire to take this program statewide in a state with significant differences across counties and between rural and urban areas; and
- A time frame which requires implementation without sufficient thought being given to consumer protections and transitioning consumers from the current system to the new system.

Participants in the meetings had many questions about the new program that could only be addressed by turning to the statute. However, 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.

National experts also provided feedback on more appropriate design and implementation strategies for the pilot project. Concerns were raised as to: 1) who should be included in the integrated model, 2) whether the model should include both Medicare and Medicaid funding in its early phases, 3) the limited timeline to implement and evaluate the model, 4) the necessary buy-in for the model, and 5) how state General Revenue funded programs would figure into the model.

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 and AHCA's focus on mandates from 2003 that required immediate action. These are discussed in the next section.

Moving toward a more integrated system will require many changes in the long-term care service delivery system, not least of which is an increased investment in state resources. Significant efforts will have to be made by multiple entities including the state agencies involved in the provision of long-term care services.

Office of Long-Term Care Policy

Included in CS/SB 1276 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 Director of the Office of Long-Term Care Policy is appointed by the Governor and is under the general supervision of the Secretary of DOEA. The 2002 Legislature funded three FTEs and \$350,000 in General Revenue for the office for FY 2002-2003. This was recurring for FY 2003-2004.

The office has a 13-member advisory council, whose chair was originally the director of the office. The role of the council is to provide assistance and direction to the office and ensure that the appropriate state agencies are properly implementing recommendations from the office. DOEA provides administrative support and services to the office.

The council is made up of the state agency heads involved in the provision of long-term care services as well as individuals appointed by the Governor from around the state who have experience in long-term care service delivery. During state fiscal year 2002-2003, the council held monthly meetings to discuss the current long-term care system and ways to improve it. The agency heads rarely

attended meetings, sending representatives in their place. Since February 2003, the furthest back that attendance was available; there has not been full attendance at council meetings by council members.

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 established 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 and DOEA staff 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.

Plan to Reduce Medicaid-Funded Nursing Home Days

CS/SB 1276 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 stated that reducing Medicaid-funded nursing home expenditures will be challenging due to the basic facts about Florida's population and Florida's long-term care system. These include:

- Continued growth in older age groups, particularly those age 85 and older, will inevitably increase demand for all long-term care services in Florida.
- Florida has had one of the lowest rates of nursing home utilization in the United States for many years.
- Florida's nursing homes already serve a very frail population.
- The rate of growth in Florida Medicaid nursing home bed days has slowed over the last ten years, with an absolute decline in 2001. There is little left in the system to cut.
- The state may be able to stabilize or reduce the proportion of nursing home bed days it pays through Medicaid, although long-term growth in the aged population may increase the absolute numbers of nursing home bed days that Medicaid pays for.

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.

Some of the specific proposals included:

- Continuing the nursing home CON moratorium, but allow limited expansions in rural areas where overall occupancy is 95 percent or greater;
- Establishing a priority system for the renovation or replacement of existing nursing home beds;
- Allowing nursing homes to voluntarily convert underutilized space to assisted living, adult day health care, or other uses through bed banking;
- Increasing regulatory oversight of assisted living facilities and adult day health care;
- Investing in subsidized housing and transportation for at-risk elders;
- Funding home improvements for families;
- Expanding home care for the elderly and increase support for caregivers;
- Promoting volunteer caregiver or guardianship programs;
- Expanding and improving the CARES program;
- Evaluating current waiver and pilot programs as well as consolidating beneficiaries in the most effective waiver programs to the greatest extent possible;
- Giving residents transitioning out of nursing homes first priority for appropriate waiver programs, and transferring the resulting savings

out of the Medicaid nursing home budget and into the waiver to allow reduced waiting lists;

- Establishing a pilot project for selective nursing home contracting;
- Terminating Medicaid agreements with poor performing facilities and redirecting Medicaid funds to waiver programs in cases when people can be transferred to these programs;
- Giving Medicaid priority to receive funds from the proceeds of qualified income trusts;
- Developing a marketing program that targets long-term care insurance for Baby Boomers; and
- Developing a pilot for public-private long-term care insurance that allows private premiums to increase federal match.

CARES Program

CS/SB 1276, directed AHCA to submit to the Governor and the Office of Long-Term Care Policy a report regarding the operation of the CARES program, Florida's federally mandated nursing facility preadmission screening program. The report was to describe:

- Rate of diversion to community alternative programs;
- CARES program staffing needs to achieve additional diversions;
- Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;
- Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and
- Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

In its report, AHCA made a number of recommendations regarding the program, including:

- Assessing the feasibility of requiring individuals to be assessed prior to admission to a nursing facility regardless of the funding source;
- Requiring CARES to perform a greater number of follow up reviews than the current 10 percent sample of Medicaid resident records completed semi-annually. A larger sample would help to identify residents no longer appropriate for nursing home placement who could be served in a less restrictive setting;
- Requiring DOEA to retain a percentage of appropriated service dollars to be accessed for immediate service provision in community settings;
- CARES should seek to co-locate with DCF Economic Self Sufficiency offices in as many locations as possible; and

- Requiring that anyone found through a desk review to meet Intermediate II level-of care criteria receive a follow-up face-to-face visit to verify the determination. This includes all applicants for home and community-based service waiver programs.

2003 Initiatives

Expansion of the Nursing Home Diversion Program

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. With the mandated expansion of the Nursing Home Diversion program, the focus appears to have shifted away from the integrated long-term care pilot project contained in CS/SB 1276 from the 2002 Session, as described above.

DOEA has identified areas for expansion that would achieve the greatest impact on enrollment based on anticipated need, population density, and the effectiveness of current nursing home diversion efforts. DOEA has prepared a standard application packet and invited existing and new potential nursing home diversion program providers to a meeting to discuss the expansion of the program, the application process, and data collection issues. DOEA, in consultation with DCF also initiated statewide training of CARES staff and increased the capacity of staff in the current Nursing Home Diversion service areas to enroll individuals. In order to expand the diversion program statewide, AHCA and DOEA had to seek approval from CMS. CMS wanted to see a fee-for-service option offered to potential diversion program enrollees as an alternative to the managed care option. After negotiations with AHCA and DOEA, CMS agreed to allow expansion of the program into specific areas of the state, but would not agree to allow the program to go statewide.

New Providers and Expansion Areas

Currently, the program will expand into Dade, Broward, Seminole, Osceola, Brevard, Hernando, Sarasota, Manatee, Hillsborough, Pinellas, Indian River, Okeechobee, and Martin Counties. According to DOEA, 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 program at a faster rate. Staff in new areas will have to receive training on how to

enroll participants in this program. This training has already 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 process and pay claims as well as develop quality data collection techniques, especially with the new HIPAA requirements.

The Legislature may want to consider establishing minimum standards and rule authority for AHCA for providers under the waiver. AHCA currently has rule authority for most of its waivers and is in the process of promulgating Coverage and Limitations Handbooks for each waiver based on this authority. Minimum qualifications could include the following:

- Services: an entity would need to be able to show that they could contract with enough of a specific type of service provider (must be at least two to provide choice) to be sure that participants are served;
- Ability to process and pay claims in 45 days or less;
- A plan administrator dedicated to the project;
- Administrative staffing standards: staff who can perform necessary administrative functions such as data collection and analysis;
- An entity could not have outstanding liens;
- Financial solvency standards;
- Entities licensed under ch. 641, F.S., would need to show that they have the liquid assets, a bond, or reinsurance to cover a specified number of months (3 months?) of capitation; and
- Data collection technology capabilities.

A number of entities have shown interest in becoming Nursing Home Diversion program providers. Enrollment of entities who currently provide services in the traditional fee-for-service system as Nursing Home Diversion program providers does raise some questions. In the traditional fee-for-service long-term care system there are multiple entry points where providers have direct access to the individuals they wish to serve. Individuals unable to be served are assessed and placed on an appropriate program waiting list.

Unlike the fee-for-service system, the Nursing Home Diversion project model does not permit face-to-face marketing by providers. Instead, according to DOEA, the Nursing Home Diversion program model uses a single entry point (CARES) to assess and provide choice counseling to individuals on all their long-term care options, including the Nursing Home Diversion project. Individuals are given a choice by CARES. Providers must remain at arms length from the client's choice for their long-term care. CARES is the independent entity having no vested interest in where the individual is placed.

If an entity is providing traditional waiver and state-funded services and is also acting as a Nursing Home Diversion program provider, this presents an issue where the role of the entity in one service delivery system is different from and potentially conflicts with its role in another delivery system. Will entities operating in both systems be prevented from referring the individuals who come to them for services directly to their own Nursing Home Diversion program?

Entities that provide services through more than one program need to have consistent monitoring standards. If an entity is a provider under more than one program and the entity fails to meet requirements in one of the programs, are there penalties for this entity and are there any restrictions placed on their other programs? With a capitated system comes flexibility in service provision. With this flexibility comes the responsibility to manage client risk. The state needs to be sure that entities in the traditional service system are capable of handling this added responsibility.

DOEA will need to be sure to maintain the appropriate number of Nursing Home Diversion program plans in each area. A large member base allows managed care organizations to spread risk. If there are too many providers, the providers will not be able to maintain enough of a client base for it to be financially viable to participate. DOEA and AHCA should determine the number of plans appropriate for the eligible population in each area where the providers are operating.

Changes to the Nursing Home Diversion Program Capitation Rate

In spring 2003, DOEA, in consultation with AHCA, contracted with Milliman USA (an actuarial firm) to study the capitation rate for the Nursing Home Diversion program and to develop an actuarially certified rate. AHCA is now required under federal law [42 CFR 438.6(c)] to have actuarially certified rates for all payments under risk contracts. The contracts must specify the payment rates and any risk sharing mechanisms, and the actuarial basis for the computation of the rates and mechanisms. Rates must be based only on services covered under the Medicaid state plan. Thus, all managed care programs in the state must have actuarially certified rates that are recertified each year.

The Milliman USA actuarial analysis used individuals enrolled in the Aged/Disabled Adult waiver program and the Assisted Living for the Elderly waiver program who had the characteristics of Nursing Home Diversion program enrollees as the population from which to develop rates. These populations were used because AHCA and DOEA did not have usable encounter data from the Nursing Home Diversion program providers. The analysis took one year of plan experience and included only those individuals who had six months in the community; the assumption being that Diversion program enrollees mostly come from the community. By including only those with six months in the community, the analysis excluded any individuals who were in nursing homes during that year for more than six months. This eliminated from the rate base group the high-cost individuals the Nursing Home Diversion program is supposed to serve. If the analysis had tracked individuals over a longer period, for example three years, this

might have provided a better picture of enrollee experience in the community and in an institutional setting.

The actuarial analysis did include a “nursing home adjustment factor” based on nursing home admission rates of individuals enrolled in the Aged/Disabled Adult and Assisted Living for the Elderly waivers, but there is concern that nursing home admission rates for these programs will be lower since these programs are supposed to be serving a less frail population. If all of the programs are serving the same population, then this raises another issue - some of the programs are not doing what they were designed to do.

Theoretically, recipients in the Aged/Disabled Adult waiver are not supposed to be the same category of people who are served in the Nursing Home Diversion program. The Aged/Disabled Adult waiver program is supposed to serve Medicaid-eligible Community Care for the Elderly program recipients, who are much less at risk of nursing home entry and are likely substantially less disabled. The nursing home admission rate of Aged/Disabled Adult waiver program enrollees should be tracked for an additional one to two years to determine how the costs of the population change. This further step would use three to four years of data while the current study looked at one year of data. Second, care for participants in the Aged/Disabled Adult waiver program is already managed and limited by each individual’s case plan, which is in turn limited by allocations and a number of management processes. There is considerable variation across areas as to how many services individuals enrolled in the Aged/Disabled Adult waiver program receive.

Another issue with the Aged/Disabled Adult waiver is that these waiver program enrollees typically were in Community Care for the Elderly before going into the waiver program. They have prior case-managed experience, whereas the Nursing Home Diversion enrollees typically come from the community directly. There is no control for Community Care for the Elderly enrollment/service utilization and how this might influence their waiver experience, versus someone entering a program directly from the community.

The Nursing Home Diversion program was limited geographically and in enrollments until this past Session. Individuals who could have been served in the Diversion program would likely have been served in the other waiver programs, especially if the Diversion program was not an option in their area. In areas where the Diversion program was in place, there were a limited number of slots available to serve potential enrollees. Also, individuals still have the choice as to which program they want to go into in areas where the Aged/Disabled Adult waiver and the Diversion program are options. Thus, there could be individuals who look much like Diversion enrollees in the Aged/Disabled Adult waiver program.

The Assisted Living for the Elderly waiver program is already capitated and managed and does not reflect utilization or costs of an unmanaged fee-for service

population, although some would argue that it does operate in a fee-for-service mode with a daily rate for participants. The rationale behind using the Assisted Living for the Elderly waiver program population was for comparison purposes - the Diversion program serves people in assisted living facilities so an actuarial analysis really had to take assisted living facility utilization into account. AHCA and DOEA did not want to suppress rates by not including assisted living facility utilization. Consequently, the rates looked very similar, with or without the Assisted Living for the Elderly waiver program participants added in.

Tracking individuals over a longer period of time and adding in their Medicare experience, would give a better picture of individuals enrolled in the Nursing Home Diversion program. However, the Medicare data is difficult to manage and getting access to, as well as analyzing the Medicare files, is costly and time consuming. The state should consider moving towards the inclusion of Medicare experience in the near future. The Medicare data can tell us more about someone's overall health care history and cost history over time.

The expansion of the Nursing Home Diversion program could serve as the impetus for getting the Diversion program providers to submit better encounter data to the state, which would allow for actual plan experience to be considered in the rate methodology. The current methodology is a starting point. The rates have to be certified each year, so there is room for making changes to the rates over time. Some important questions to be considered as the rate methodology is reevaluated and solidified for the next contract period include:

- 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 the Assisted Living for the Elderly waiver program service delivery systems that are not accounted for in the current rate methodology?
- Do Nursing Home Diversion 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?

Evaluation of Monthly Nursing Home Diversion Program Enrollments

SB 2-A mandated that AHCA, in consultation with DOEA, provide a concurrent evaluation of the nursing home diversion placements each month and report by December 31, 2003, and March 31, 2004, to the House and Senate Appropriations Committees and the Executive Office of the Governor. This concurrent evaluation will include level of frailty or risk of the patients placed in the program, patient satisfaction and other outcomes.

DOEA is in the process of developing a database that will be used to track and trend enrollment and disenrollment information for the Nursing Home Diversion

program on a monthly basis. Currently, a spreadsheet is in place tracking those assessed by CARES and awaiting DCF eligibility determination, as well as new enrollments by month. From July through October 2003, there were 550 new enrollees in the Nursing Home Diversion program. The database is not fully functional at this point. The database should be a useful tool for tracking enrollee characteristics and experience over time, such as hospital and nursing home use. This mandate could also be the impetus for a comprehensive evaluation of this program with an emphasis on consumer satisfaction and quality of care.

The mandate to expand the Nursing Home Diversion 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 program did. Opportunities for change are in the capitated reimbursement system; reimbursement shapes how long-term care services are delivered.

Reduction of Medicaid Nursing Home Bed Days

Proviso language in Specific Appropriation 198 in SB 2-A 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," will involve 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 in order to identify those with the greatest potential for transition to a community setting.

To coordinate the transition process, AHCA proposes to contract with an organization that has experience in providing community care supports and managing the transition of individuals from the nursing home to the community. The contractor will be responsible for establishing transition teams statewide. The transition teams will be composed of nurses, social workers, and other appropriate staff, such as behavioral health specialists, physicians, and other consulting staff. The contractor will also be responsible for:

- Identifying from nursing home resident assessments where the greatest potential for transitioning is;
- Providing outreach to nursing homes and nursing home residents;

- Conducting resident assessments and interviews to determine the feasibility of transitioning;
- Developing transition assistance education materials;
- Coordinating waiver eligibility;
- Providing care planning;
- Coordinating resident transitions;
- Conducting monitoring once a person is transitioned; and
- Collaborating with nursing homes, hospitals, associations, and assisted living facilities.

The areas of the state where comprehensive programs will be implemented will include those with large numbers of nursing home residents with characteristics indicative of the potential for relocation to a community setting.

This plan is one step necessary in the process of reducing Medicaid nursing home days, however, it will be important to develop other efforts as well. There are numerous challenges to transitioning individuals out of nursing homes, including, lack of appropriate housing, lack of funding for relocation, and individuals not wanting to make the move.

The Legislature could consider trying to target 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 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.

This plan still does not address the issue of dealing with high nursing home occupancy in rural areas. The state still needs to consider developing community-based alternatives in rural settings.

Medicaid Alzheimer's Disease Waiver

Section 26 of CS/SB 2568 directed AHCA and DOEA to seek a Medicaid home and community-based waiver targeted to persons with Alzheimer's disease, to test the effectiveness of Alzheimer's specific interventions to delay or to avoid institutional placement. DOEA is responsible for implementing the waiver program. The bill provided that AHCA and DOEA:

- Ensure that providers are selected that have a history of successfully serving persons with Alzheimer's disease;
- Develop specialized standards for providers and services tailored to persons in the early, middle, and late stages of Alzheimer's disease and designate a level of care determination process and standard that is most appropriate to this population;
- Include in the waiver services designed to assist the caregiver in continuing to provide in-home care; and

- Submit their program design to the President of the Senate and the Speaker of the House of Representatives for consultation during the development process.

As mandated, AHCA submitted an implementation plan to the Legislative Budget Commission on September 12, 2003. The plan provided information on the eligibility criteria for enrollment in the waiver, the services to be provided under the waiver, and an implementation timeline.

In order to participate in the Medicaid Alzheimer's Disease waiver program, individuals will have to be:

- Age 60 or older;
- Medicaid eligible (up to 300% of the Supplemental Security Income level – Medicaid Institutional Care program income standard);
- Have a diagnosis of Alzheimer's disease or related dementias (multi-infarct dementia, Parkinson's disease, Huntington's disease, Creutzfeldt-Jakob disease, Pick's disease, and Lewy body dementia) made or confirmed by a Memory Disorder Clinic;
- Have an assessment completed by the DOEA CARES staff and meet nursing home level of care criteria; and
- Live with a capable caregiver in a private home or apartment.

The Medicaid Alzheimer's Disease waiver program will be operated in one or more designated regions of the state. The criteria to be considered in selection of the region(s) for the program include: 1) network of service providers, 2) concentration of individuals diagnosed with Alzheimer's disease or related dementia, and 3) the presence of existing community resources for individuals with Alzheimer's disease or related dementia.

AHCA will conduct a competitive procurement to select a single vendor in each pilot area to serve as the Alzheimer's home and community-based services model waiver vendor. Unlike some programs where any qualified provider of a particular service is allowed to enroll as a waiver provider, AHCA believes that a competitive procurement in which the best qualified vendor is selected will provide a better test of a model waiver program and one that will provide the greatest information for possible statewide replication of the Alzheimer's disease project. Services provided under the waiver will include:

- | | |
|--|--|
| • Case management | • Behavioral assessment and intervention |
| • Adult day health care | • Incontinence supplies |
| • Respite | • Personal care |
| • Wandering alarm system | • Environmental modification |
| • Wander identification and location program | |
| • Caregiver training | |

AHCA is in the process of submitting the waiver application to CMS and issuing a request for proposals for a provider. AHCA hopes to begin providing services to enrollees by the beginning of February 2004.

Changes to the Office of Long-Term Care Policy

CS/SB 642 removed the Director of the Office of Long-Term Care Policy from the office's advisory council. The bill requires the council to elect a chair from among its membership to serve for a 1-year term. The chair of the council may not serve more than two consecutive terms. A new chair was elected in early 2003.

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 report that is due to the Governor in December 2003. 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.

The office held a series of public hearings throughout the state during August 2003, as well as a two-day workshop for some members of Florida's elder services networks. The workshop was held in Tampa on August 6 and 7, 2003. Participants included the Office of Long-Term Care Policy, DOEA, the Florida Association of Area Agencies on Aging, the Community Care for the Elderly Coalition, the Florida Association of Service Providers, the Alzheimer's Disease Association, and the Florida Association of Nutrition Providers. According to DOEA, the meeting provided a format for service integration of long-term care services. Two key elements of the format were a single entry system with multiple access points, and a unified protocol to provide referrals and determine eligibility for publicly funded services. Other characteristics discussed included customer centered care and serving all seniors regardless of economic need with mechanisms such as capitation and prioritizing services based on standard criteria. The public meetings took place in Panama City, Jacksonville, Tampa, and Ft. Lauderdale. Staff collected comments from the public and providers of long-term care services.

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.

Aging and Disability Resource Center

In June 2003, the U.S. Administration on Aging sent out a call for proposals for states to develop Aging and Disability Resource Center programs that provide citizen-centered “One Stop Shop” entry points into the long-term care support system and are based in local communities. The grant program requires the resource centers to serve the elderly population and at least one of the following groups: individuals with physical disabilities; individuals with serious mental illness; or individuals with mental retardation/developmental disabilities. The Administration on Aging would fund the demonstrations for up to \$800,000 over a 3-year period.

DOEA applied for the grant funding. In its grant proposal, DOEA sought funding for an Aging and Disability Resource Center (ADRC) grant to serve: 1) elders age 60 and older; and 2) individuals with severe mental illness. The ADRC grant would link DOEA and DCF to coordinate efforts related to these populations. The proposal discussed a “single point of access” for information, counseling, referrals, assessment, and eligibility functions for privately and publicly funded services. The grant proposal specified that the Office of Long-Term Care Policy would be charged with oversight and coordination of the ADRC grant. The office would establish a statewide workgroup to plan and oversee the grant activities. DOEA would initiate a request for proposals to select entities to act as ADRCs. DOEA did not receive the AOA grant; however, they are planning on moving forward with the ADRC concept.

As DOEA moves forward in the development of an ADRC, some concerns about the original proposal should be addressed. The proposal did not give much detail as to the functions of the resource center or 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. Minimum qualifications could include the following:

- Expertise in the needs of each target population the center proposes to serve, and thorough knowledge of the providers that serve these populations;
- Strong connections to service providers, volunteer agencies, and community institutions;
- Expertise in information and referral activities;

- Knowledge of long-term care resources, including those designed to provide services in the least restrictive setting;
- Financial solvency and stability;
- Ability to collect, monitor, and analyze data in a timely and accurate manner, with systems that meet standards;
- A commitment to adequate staffing by qualified personnel to effectively perform all functions;
- The ability to meet all performance standards established by DOEA.

Also, there was little detail provided as to how the ADRC would actually transition to an operating entity. There was discussion of 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 rolls 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.

2003 Auditor General Recommendations

The Auditor General performed operational audits of DOEA Medicaid waivers and DOEA pilot projects and reported findings in 2003. The two audits are discussed below.

DOEA Pilot Projects

This audit focused on identifying all DOEA pilot projects, determining the length of time the projects were in existence, the amount spent on each project, and the Department's procedures for evaluating project outcomes and determining continuance.

During the audit period of July 2001 through January 2003, the pilot projects administered by DOEA had expenditures totaling \$31 million. In order to improve DOEA's administration and evaluation of pilot projects, the Auditor General recommended that DOEA should:

- Improve procedures for tracking pilot projects and the identification of related costs;
- Enhance the strategic planning and selection process of certain projects; and

- Strengthen the evaluation process to ensure the continuation and expansion of worthy pilot projects and the timely conclusion of ineffective pilot projects.

DOEA Medicaid Waivers

This audit focused on the administration of four Medicaid waiver programs for the elderly (Consumer Directed Care, Assisted Living for the Elderly, Nursing Home Diversion, and Aged/Disabled Adult waiver programs). The audit found that:

- Consultants under the Consumer Directed Care program did not always document required contact with consumers;
- DOEA should improve its administration of its contract with the Fiscal Intermediary that provides fiscal services to consumers under Consumer Directed Care;
- DOEA should improve controls related to the authorization and expenditure of funds to ensure independent approval of employee timesheets and to provide adequate guidance on cash expenditures for consumers under Consumer Directed Care;
- Case files for Aged/Disabled Adult and Assisted Living for the Elderly waiver clients did not always contain documentation to evidence compliance with DOEA policies regarding client visitations and the services provided;
- Documentation requirements were not adequate enough to ensure compliance with Federal regulations that prohibit the use of funds for room and board payments;
- Department contracts included a capitated rate that significantly exceeded projected cost; and
- Improvements are needed in DOEA's prioritization of individuals waiting for Medicaid waiver services.

The Auditor General recommended:

- DOEA should implement procedures to require assisted living facilities to document room and board costs for Assisted Living for the Elderly waiver program clients. Case managers should monitor rates to ensure that Medicaid funds are not used to pay for room and board costs;
- DOEA should continue to work toward developing a lower capitated rate for use in future Nursing Home Diversion program contracts; and
- To ensure waiting lists are equitably administered, DOEA should develop procedures which consider the level of frailty and the length of time the client has waited for services as the basis for determining the order in which to enroll clients on the waivers.

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. Each area is discussed below with specific recommendations laid out in each section.

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 it is recognized 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 recommends 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 for entities to become Nursing Home Diversion program providers. Minimum qualifications could include any of the following:

- Services: an entity must be able to demonstrate that they could contract with enough of a specific type of service provider to be sure that participants are served and are given a choice of providers;
- The ability to process and pay claims in 45 days or less;
- A plan administrator dedicated to the project;

- Administrative staffing standards: staff who can perform necessary administrative functions such as data collection and analysis;
- An entity can not have outstanding liens;
- Financial solvency standards;
- An entity must show that they have the liquid assets, a bond, or reinsurance to cover a specified number of months of capitation; and
- Data collection technology capabilities.

Capitation Rates

AHCA, in consultation with DOEA, should secure Medicare data to be used in the development of Nursing Home Diversion 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, 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 program enrollees achieve better outcomes than either the Aged/Disabled Adult waiver program or the 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 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. The evaluation 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. 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 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. Rule language should 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. The coordination of acute care services could be included in the case management capitated rate.

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 (ADRC). 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. Minimum qualifications could include the following:

- Expertise in the needs of each target population the center proposes to serve, and thorough knowledge of the providers that serve these populations;
- Strong connections to service providers, volunteer agencies, and community institutions;
- Expertise in information and referral activities;
- Knowledge of long-term care resources, including those designed to provide services in the least restrictive setting;
- Financial solvency and stability;
- Ability to collect, monitor, and analyze data in a timely and accurate manner, with systems that meet standards;
- A commitment to adequate staffing by qualified personnel to effectively perform all functions; and
- The ability to meet all performance standards established by DOEA.

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 should 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 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.

An obstacle that new provider networks or organizations face in developing managed care programs is how to manage and protect themselves from the financial risks associated with capitated payments. This may be of particular concern in rural areas where the number of people enrolling in plans is low, making it difficult to spread risk. 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.