The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 748
INTRODUCER:	Senators Bean and Gibson
SUBJECT:	Program for All-inclusive Care for the Elderly
DATE:	March 8, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Hendon	CF	**Pre-meeting**
2.			HP	
3.				
4.				
5.				
6.				

I. Summary:

SB 748 authorizes an additional Program of All-inclusive Care for the Elderly (PACE) site to serve Duval, St. Johns, Baker, and Nassau Counties with up to 300 slots.

This bill will have a significant fiscal impact on the state and provides an effective date of July 1, 2013.

This bill creates an undesignated section of the Florida Statutes.

II. Present Situation:

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

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model, which was tested through Centers for Medicaid and Medicare (CMS) demonstration projects beginning in the mid-1980s,[1] was developed to address the needs of long-term care clients, providers, and payers.

A PACE organization is a not-for-profit, private or public entity that is primarily engaged in providing PACE services and must:

- Have a governing board that includes community representation;

[1]CMS Manual *available at* http://www.cms.gov/Medicare/Health-Plans/pace/downloads/r1so.pdf (last visited Feb. 7, 2013)

- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

PACE participants must be at least 55 years old, live in the PACE service area, and be certified eligible for nursing home care, but able to live safely in the community. The PACE program becomes the sole source of services for these Medicare and Medicaid eligible enrollees.

Under the PACE program, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. A PACE program provides social and medical services primarily in an adult day health center, which are supplemented by in-home and referral services as necessary. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the state and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with CMS and the state Medicaid agency. Rates for PACE providers are developed based on a county level actuarial analysis of the costs associated with the service population.

Florida PACE Project

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida and is codified in s. 430.707(2), F.S., under the administration of the Department of Elder Affairs (DOEA), operating in consultation with the Agency for Health Care Administration (AHCA).[2] The initial program was located in Miami-Dade County and began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the General Appropriations Act or general law.

[2] Chapter 2011-135, s. 24, L.O.F, repeals s. 430.707, F.S., effective Oct 1, 2013, as part of the expansion of Medicaid managed care.

The 2006 General Appropriations Act contained proviso language authorizing an additional 150 slots in the Miami-Dade County program and 200 slots each at new programs in Martin/St. Lucie Counties, and Lee County.[3] In 2008, the Legislature reallocated equally 150 unused PACE slots to Miami-Dade, Lee, and Pinellas Counties.[4] The 2010 General Appropriations Act funded an additional 100 slots in Pinellas County and authorized and funded a new program with 100 slots in Hillsborough County.[5] That same year, the Legislature, by general law, authorized an additional 50 slots in Miami-Dade and 150 slots for a program serving Polk, Hardee, Highlands, and Hillsborough Counties.[6] In 2011, the Legislature authorized a program with 150 slots in Palm Beach County,[7] and funded, through the General Appropriations Act, 50 additional slots in Lee County and 150 slots for a program serving Polk, Hardee, and Highlands Counties.[8] In 2012, the Legislature authorized two new programs of up to 150 slots each for a program in Broward County and a program serving Manatee, Sarasota, and DeSoto Counties.[9] The 2012 – 2013 General Appropriations Act funded 100 additional slots in Miami-Dade and 150 additional slots in Lee County.[10]

Not all authorized PACE slots are currently in operation, and not all slots that have been authorized are currently funded. According to DOEA, of the 2,225 slots the Legislature has authorized since 2003, 1075 are funded and operational; 250 are funded and will be operational in 2012, and 450 are not funded or operational.[11] The Legislature appropriated $26,578,951 for PACE in the 2012 General Appropriations Act.[12]

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

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

[3] Chapter 2006-25, L.O.F.
[4] Chapter 2008-152, L.O.F.
[5] Chapter 2010-152, L.O.F.
[6] Chapter 2010-156, ss. 14, 15, L.O.F.
[7] Chapter 2011-61, s. 17, L.O.F.
[8] Chapter 2011-69, L.O.F.
[9] Chapter 2012-33, ss.18, 19, L.O.F.
[10] Ch. 2012-118, L.O.F.
[11] E-mail from Marcy R. Hajdukiewicz, Division Director, Statewide Community Based Services, Florida Department of Elder Affairs, (Feb. 28,2013) (on file with the Senate Children, Families, and Elder Affairs Committee).
[12] Chapter 2012-118, L.O.F..

then begin enrolling members, subject to an appropriation to fund the slots. In total, the process to become a PACE provider and begin serving enrollees typically takes at least one year.[13]

In 2011, the Legislature moved administrative responsibility for the PACE program from DOEA to AHCA as part of the expansion of Medicaid managed care.[14] Participation by PACE is not subject to the procurement requirements or regional plan number limits now applicable to the Medicaid program. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.[15]

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.3 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies.

In Florida, the program is administered by the Agency for Health Care Administration (AHCA). AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. AHCA has overall responsibility for the program and qualifies providers, set payment levels, and pays for services. The Department of Children and Families is responsible for determining financial eligibility for Medicaid recipients. The Agency for Persons with Disabilities operates one of the larger waiver programs under Medicaid, the Home and Community Based Waiver program serving individuals with disabilities. The DOE assesses Medicaid recipients to determine if they require nursing home care. Specifically, DOEA determines whether an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24 hour period and requires care to be performed on a daily basis under the direct supervision of a health professional of medically complex services because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

[13] Agency for Health Care Administration, *Senate Bill 748 Bill Analysis & Economic Impact Statement* (Received Mar. 9, 2013) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[14] Chapter 2011-135, s. 24, Laws of Fla, repeals Section 430.707, F.S., effective Oct. 1, 2013.
[15] Section 409.981(4), F.S.

The February 25, 2013 Social Services Estimating Conference estimated that expenditures for Medicaid for FY 2012-2013 would be $20.77 billion. One of the most important and expensive components of Medicaid is long-term care. The conference estimated that $4.75 billion will be spent on long-term care under Medicaid in FY 2012-2013.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance. According to the 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average cost of a nursing home was $78,110 per year for a semi-private room in 2011. Persons needing nursing home care are determined to be eligible for Medicaid based on financial assets and monthly income.

Long-Term Managed Care

In 2011, the Legislature passed and the Governor signed into law HB 7107[16] to increase the use of managed care in Medicaid. The law requires both long-term care services and other Medicaid services to be provided through managed care plans. Long-term Care Managed Care component of the law will be implemented first. Implementation of the program began July 1, 2012 with full implementation by October 1, 2013.

AHCA has chosen the plans that may participate in the program through a competitive bid process. AHCA considered many factors when choosing plans. AHCA chose a certain number of long-term care managed care plans for each region to ensure that enrollees in the program to ensure that recipients have a choice between plans. After AHCA has chosen the plans that may participate in the Florida Long-Term Care Managed Care Program, AHCA will begin to notify and transition eligible Medicaid recipients into the program. It is anticipated that the Florida Long-Term Care Managed Program will be available in certain areas of the State beginning the first quarter of 2013 and will be in all areas by October 1, 2013.

Participating managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans will be free to customize and offer additional serves. The minimum benefits include:

- Nursing home
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational

[16] Chapter 2011-134, L.O.F.

- Intermittent and skilled nursing
- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

On February 1, 2013, the Federal Centers for Medicare and Medicaid Services, approved AHCA's request for a Home and Community Based Care Services waiver for individuals 65 and older and individuals with physical disabilities ages 18 through 64 years of age. This approval will allow Florida to implement managed care for long-term care services under Medicaid.

III. Effect of Proposed Changes:

Section 1 directs AHCA to contract with a not-for-profit organization that has been jointly formed by a lead agency that is licensed as a nursing home diversion program provider and by a not-for-profit hospice that has been licensed for more than 30 years to serve residents in Duval, St. Johns, Baker, and Nassau Counties to provide PACE services to frail elders in those counties. The organization is directed to utilize existing community-based care providers and healthcare organizations in the delivery of services. The bill exempts the organization from ch. 641, F.S., relating to health maintenance organizations. The bill authorizes 300 slots, subject to an appropriation.

Section 2 provides an effective date of July 1, 2013.

Other Potential Implications:
The bill expands an existing carve out of long term care services from the Medicaid managed care program. Statewide long term managed care is estimated to serve 85,000 residents who are 18 years or older; whereas, the combined PACE enrollees is under 2,000 and limited to eligible residents who are 55 years of age and older. This bill would be inconsistent with one of the purposes of expanding Medicaid managed care – to standardize the delivery of Medicaid services by eliminating the waivers and carve outs.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Frail elders in need of comprehensive home and community-based long-term care services in Citrus, Hernando, and Pasco Counties will have additional choices of programs to serve their needs.

The new PACE providers would compete with other providers of long-term care services in those counties who have participated in the competitive procurement process required by Medicaid managed care.

C. Government Sector Impact:

AHCA reviews all new and expansion PACE applications, handles communication with CMS, and participates in all monitoring activities, including all federal and state on-site reviews. AHCA is also responsible for providing technical assistance, as needed. In order to implement the bill, AHCA would need one FTE for Fiscal Year 2013-2014.

The DOEA provides oversight of established PACE sites. The fiscal impact to DOEA would come in FY 2014-2015 as it takes at least a year for the application approval and the readiness certification.

The bill conditions the new PACE site contingent upon an appropriation by the legislature. Typically, PACE slots cost approximately $25,000 per member per year. The estimated cost of the 300 new PACE program slots authorized in the bill would be $7.5 million per year, if an appropriation to cover those expenditures is provided.

Fiscal Impact	**Fiscal Year 2013-14**		**Fiscal Year 2014-2015**
AHCA	**FTE**	**Total**	**Total**
Application process	1	$71,128	
Operation of 300 slots			$7.5 million
Total	1	$71,128	$7.5 million

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.