STORAGE NAME: h1945a.hcs
DATE: April 13, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1945

RELATING TO: Long-term Care Community Diversion Pilot Projects

SPONSOR(S): Representative Jacobs

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 16 NAYS 0
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

The bill directs the Department of Elderly Affairs, in consultation with the Agency for Health Care Administration, to select and contract with "other qualified providers" to provide long-term care within community diversion pilot project areas. "Other qualified provider" is defined to mean an entity licensed under ch. 400, F.S., that meets all the financial and quality assurance requirements established by the agency for provider service networks as authorized in s. 409.912, F.S., is exempt from ch. 641, F.S., and can demonstrate a long-term care continuum.

The bill provides effect upon becoming law.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Legislative Commission on Long-term Care

The Florida Legislature's Commission on Long-term Care was created in proviso language during the 1994 Legislative Session to comprehensively address the programming and financing of long-term care services in the state. Its mission was to develop a framework for long-term care planning that would assure the highest possible quality of care in the most appropriate setting at the lowest reasonable cost, without unduly restricting the recipient's choice of providers and service settings. Included in the commission's recommendations were two fundamental reforms: integration of acute and long-term care and creation of a managed care system to achieve the integration of acute and long-term care.

The commission found that people in need of long-term care commonly cycle in and out of both acute and long-term care providers and environments. It concluded that an integral part of creating an effective and cost-efficient long-term care system lies in coordination and integration of acute and long-term care services. With public expenditures for such services dominated by Medicare and Medicaid, the commission recommended the pursuit of appropriate federal waivers necessary to achieve integration of acute and long-term care services.

The commission also found that the (then) present long-term care system was fragmented, uncoordinated, and inconsistent in its ability to provide recipients the array of services they needed at a cost affordable to the state. Based on its review of other state efforts, including the federal Social HMO and Program of All-Inclusive Care for the Elderly (PACE) demonstrations, the commission recommended that the Legislature implement a managed care system which integrates acute and long-term care.

Long-Term Care Community Diversion Pilot Projects

In 1995, the Department of Elderly Affairs (department), was awarded a grant from the Robert Wood Johnson Foundation (foundation) to develop a managed long-term care service delivery model designed to promote the integration of acute and long-term care services. In 1996, legislative funding and proviso language was provided for the department, in consultation with the Agency for Health Care Administration (agency), to

implement, in the form of pilot projects, a managed long-term care service delivery model to provide individuals with a feasible alternative to institutional care. A Medicaid waiver from the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, which is required to operate the project, was approved in March of 1997.

In 1997, the Florida Legislature enacted the Long-Term Care Community Diversion Pilot Project Act (ss. 430.701 - 430.710, F.S.), providing authority and guidance for the implementation of the pilot projects. Section 430.703, F.S., states the Legislature's intent that the pilot projects "test the effectiveness of managed care and outcome-based reimbursement principles when applied to long-term care."

Services

The pilot projects provide acute care services covered by Medicaid, home and community-based long-term care services, and when necessary, nursing home care through managed care organizations. Section 430.703, F.S., defines the pilot project as a service delivery system that places participants in the most appropriate care settings and provides comprehensive home and community-based services of sufficient quantity, type, and duration to prevent or delay the need for long-term placement in a nursing facility. In addition to providing home and community-based services, s. 430.705, F.S., requires pilot projects to provide skilled and intermediate nursing facility care for participants who cannot be adequately cared for in non-institutional settings.

Acute and Long-Term Integration

Integration of acute and long-term care services is an important strategy to preventing or delaying permanent placement in a nursing facility, and is an integral component of the pilot project service delivery model. Fragmentation of care, care decisions based on coverage not need, and a lack of accountability for outcomes contribute to unnecessarily high rates of hospitalizations and to nursing facility admissions.

Pilot project enrollees are dually eligible for Medicare and Medicaid and are an especially vulnerable population, often requiring substantial acute and chronic medical care and long-term care services. Dually eligible beneficiaries rely on Medicare as their primary payer for medical acute and chronic care, and on Medicaid as a Medigap policy to pay pharmacy and cost-sharing expenses and as the payer of long-term care services. Medicare and Medicaid may initially appear to provide distinguishable but complementary services to the dually eligible population. However, due to differences in administration, eligibility, financing, and overlapping coverages, as well as the overall failure to coordinate medical and long-term care throughout the health care system, the two programs do not provide the continuum of care required by the dually eligible population.

Section 430.705, F.S., requires pilot projects to integrate acute and long-term care services, and the funding sources for such services, as feasible. The model contract for pilot projects requires providers to have the capacity to integrate the delivery of acute and long-term care services to pilot project enrollees. To facilitate integration, the department has developed contracts with HMOs that also have Medicare managed care plans. The goal is to provide pilot project enrollees with a choice of joining the contractor's Medicare plan, thus making the HMO responsible for managing both the medical and long-term care of the enrollees.

Pilot Project Area

Section 430.705, F.S., provides for the department to select pilot project areas based on a variety of factors. The Palm Beach (Palm Beach, Indian River, Okeechobee, Martin and St. Lucie) and Orange County (Orange, Seminole, Brevard, and Osceola) areas were selected as the initial sites for the pilot projects.

Participant Eligibility

Section 403.704, F.S., directs the department to evaluate criteria for participant eligibility. As established in the Medicaid waiver, project participants must be age 65 or older, must meet Medicaid financial eligibility requirements up to the Institutional Care Program level, must meet special clinical eligibility criteria, and must be eligible for Medicare benefits.

Enrollment

Consistent with ss. 430.704 and 430.705, F.S., the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit staff of the department determine clinical eligibility for the program and serve as choice counselors, providing prospective pilot project participants with information regarding their long-term care options, including enrollment in the pilot projects. Financial and technical eligibility for Medicaid is completed by the Department of Children and Family Services. The managed care organization may not disenroll a person due to a change in health status or to placement in a nursing facility.

Project Providers

Section 430.707, F.S., directs the department to select and contract with managed care organizations to provide long-term care within pilot project areas. Section 430.703(6), F.S., defines “managed care organization” to mean an entity that meets the requirements of the Department of Insurance for operation as a HMO and meets the qualifications for participation as a managed care organization established by the agency and the Department of Elderly Affairs. In addition, the Medicaid waiver from HCFA requires managed care organizations to have, or have applied for, a health care provider certificate from the agency and a certificate of authority from the Department of Insurance (HMO licensure).

Section 403.704, F.S., directs the department to evaluate criteria for selecting managed care organizations, including, but not limited to, quality assurance processes, grievance procedures, service costs, accessibility, adequacy of provider networks, and administrative costs. The department relies on the HMO licensure process and standards to ensure financial soundness and minimum quality of care standards. These standards are supplemented by Medicaid prepaid plan requirements under ch. 409, F.S. The model contract requires all HMOs to meet all state and federal requirements to enroll as a Medicaid prepaid health services provider, as provided in ch. 409, F.S. HMOs also must have, or have a subcontractor that has, prior experience in providing home and community-based long-term care services in the pilot project service area.

Chapter 98-327, L.O.F., amended s. 430.707, F.S., to authorize the department to contract with entities which have submitted an application as a community nursing home diversion project as of July 1, 1998, to provide benefits pursuant to the “Program of All-Inclusive Care for the Elderly” as established in Pub. L. No. 105-33. The 1998 act exempted such entities from the requirements of ch. 641, F.S., if the entity is a private, nonprofit, superior-rated nursing home with at least 50 percent of its residents eligible for Medicaid. It should also be noted that the federal PACE regulations, which govern the operations of PACE, contain detailed financial and quality assurance standards.

The PACE program is modeled on the system of medical and long-term care services developed by On Lok Senior Health Services in San Francisco, CA. The model was tested through HCFA demonstration projects that began in the mid-1980s, and has set a standard for the integration of medical and long-term care services. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. The Balanced Budget Act of 1997 establishes the PACE model of care as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. The Medicaid state plan must include PACE as an optional Medicaid benefit before the State and HCFA can enter into program agreements with PACE providers. Florida has amended its state plan to include PACE as an optional Medicaid benefit.

Services/Reimbursement

Under the Long-Term Care Community Diversion Pilot Project, the HMO is paid a capitation payment with two components:

1. A component for the acute care services (prescription drugs, dental, hearing, visual, home health, and community mental health services) and for the supplementary costs paid by Medicaid for services covered under Medicare (cross-over payment); and
2. A component for the long-term care.

The acute care component is based on Medicaid's historical costs for the covered services under fee-for-service reimbursement. Section 430.704, F.S., requires the department to develop a capitation rate-setting methodology for the projects that assures sufficient savings from the Medicaid nursing home budget to fund the projects, and assures expenditures do not exceed the average nursing home costs in the project areas. For persons who join the HMO's Medicare plan, the managed care organization also will receive a capitation payment from HCFA covering Medicare benefits.

Quality Assurance and Improvement

The complex health care needs of the individuals served in the pilot projects require a coordinated quality assurance system to ensure that individuals are safely served. Section 430.706, F.S., requires the department, in consultation with the agency, to develop quality of care standards for pilot projects, including outcome measures, utilization review, grievance and conflict resolution, patient satisfaction, and care and service standards. As licenced HMOs, pilot project providers must meet quality of care standards included in ch. 641, F.S., as well as Medicaid managed care standards included in ch. 409, F.S. Additional quality of care standards are included in the contract with each HMO.

Pilot Project Implementation

Implementation of the pilot projects has been delayed by a lack of actuarial data HMOs depend on to measure financial risk and by concerns with Medicare capitated payment rates. Experience with managing and taking risk for long-term care is limited, and this has meant the time-line for typical new business development activities has been extended. The Medicare rate for persons who are chronically ill and very frail also has been a major

problem for HMOs from the beginning of the department's efforts to implement the pilot projects.

The passage of the Balanced Budget Act of 1997 (BBA) compounded the problem. Before the BBA changes, HMOs were expressing concern about the Medicare reimbursement rate for the very frail. The BBA changes, which limited the growth in HMO reimbursement rates and increased administrative costs, have compounded the problem by leading to a series of industry retractions from several geographic areas in the Medicare market.

The Pilot Projects' Operations

Pilot project operations began in the Orlando area in December 1998. United Health Care, under contract with the department and the agency, initiated enrollment and program operations in its pilot project, "Health and Home Connection," in Orange, Seminole and Osceola counties. In the fall of 1999, two Medicare HMOs, Beacon Health Plans and Physicians Healthcare Plans, began project operations in Palm Beach County with their respective programs, "Beacon Independence Plan" and "Summit Care Plan."

Both Beacon Health Plans and Physicians Healthcare Plans have Medicare plans. However, as part of the industry retractions from the Medicare market, United HealthCare withdrew from the Medicare market in the Orlando area. As a result, pilot project enrollees in the Orlando area do not have the choice of joining the same provider for both their acute and long-term care.

Although implementation of the Community-Based Diversion Project really has just begun, the pilot project already has yielded valuable insight. The eligibility criteria for the pilot project results in a case mix with high Medicare costs. Consequently, the current Medicare payment methodology creates disincentives for Medicare HMOs to enroll and serve frail beneficiaries like those eligible for the diversion project. The department has begun looking into developing alternative approaches, other than contracting with HMOs that also have Medicare plans, to achieve the integration of acute and long-term care services.

As of March, 2000, there were approximately 500 individuals enrolled in the diversion project throughout the Orlando and Palm Beach areas. Based on current enrollment projections, it is expected that by July 1, 2000, approximately 750 individuals will be enrolled in the pilot projects.

HMO Licensure Requirements

HMOs are regulated by ch. 641, parts I and III, F.S., and are exempt from all other provisions of the Florida Insurance Code. Ch. 641, part I, F.S., entitled the Health Maintenance Organization Act, requires an entity to obtain a certificate of authority from the Department of Insurance (DOI) prior to operating as an HMO, and authorizes DOI to regulate finances, contracting, and marketing of HMOs. Section 641.21, F.S., specifies information that must be submitted with an entity's application for a certificate of authority, including, but not limited to, the following financial information: an audited financial statement and a comprehensive feasibility study performed by a certified actuary in conjunction with a certified public accountant. Section 641.22, F.S., directs DOI to issue a certificate of authority to any entity filing a completed application in conformity with s. 641.21, F.S., upon payment of prescribed fees, and upon DOI's satisfaction that the entity has met specified standards and has obtained a health care provider certificate issued by the agency pursuant to ch. 641, part III, F.S.

The purpose of the health care provider certificate is to ensure that HMOs deliver high quality health care to their subscribers. Provisions in ch. 641, part III, F.S., allow for the agency to:

1. Require all HMOs to obtain and maintain accreditation with a nationally recognized accreditation organization having expertise in HMO quality of care issues;

2. Conduct follow-up examinations in those instances when the external accreditation reviews indicate that the HMO is out of compliance with accreditation standards;

3. Have full access to medical records of HMOs; and

4. Levy administrative fines in cases of continued non-compliance.

Ch. 641, part III, F.S., also includes provisions governing HMO quality assurance programs, subscriber grievance reporting and resolution, provision of emergency services and care, and internal risk management programs.

Medicaid Prepaid Plan Requirements

Section 409.912, F.S., authorizes the agency to contract with HMOs for the provision of Medicaid services to recipients, and establishes financial and quality assurance requirements for entities contracting with the agency on a prepaid or fixed-sum basis. Subsection (4) of s. 409.912, F.S., establishes quality and financial standards for Medicaid prepaid plans. Subsection (14) of s. 409.912, F.S., establishes surplus fund requirements in addition to those provided under HMO licensure requirements (641.225, F.S.), and subsection (15) of s. 409.912, F.S., authorizes the agency to require entities to establish restricted insolvency protection accounts. Subsection (24) of s. 409.912, F.S., provides for the agency to establish a health care quality improvement system for entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of HCFA as part of the quality reform initiative.

Provider Service Networks

The Provider Service Network (PSN) is a type of managed care plan run by the same doctors and/or hospitals that provide care to the enrollees. Section 409.912(3)(d), F.S. which establishes PSNs, limits the agency to not more than four provider service networks for demonstration projects to test Medicaid direct contracting. The demonstration projects are permitted to be reimbursed on a fee-for-service or prepaid basis. A PSN which is reimbursed by the agency on a prepaid basis is exempt from ch. 641, parts I and III, F.S., but must meet appropriate financial reserve, quality assurance, and patient rights requirements, as set forth by the agency. The agency awards contracts on a competitive bid basis and selects bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project are chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of s. 409.912, F.S. These demonstration projects are authorized for 2 years from the date of implementation.

PSN providers are reimbursed on a fee-for-service basis for medically necessary Medicaid covered services, are paid a monthly case management fee ($3 per enrollee), are allocated a monthly payment (6 percent) for administrative fees, and are required to provide comprehensive integrated health care delivery system of specialists, hospitals, and other providers. The categories of eligible recipients authorized to be enrolled in PSNs are

recipients of assistance under the Work and Gain Economic Self-sufficiency (WAGES) program, formerly the referred to as Aid to Families with Dependent Children (AFDC), individuals receiving AFDC-related Medical Assistance Only (MAO), Sixth Omnibus Budget Reconciliation Act (SOBRA) children, individuals receiving Supplemental Security Income (SSI) without Medicare Coverage, and children in foster care or subsidized adoption arrangements.

Statewide Provider and Subscriber Assistance Program

HMOs and Medicaid prepaid health plans are required to have internal grievance procedures for subscribers to protest a denial of services or payment for services. Under s. 408.7056, F.S., subscribers have a right to appeal any unresolved grievance to the Statewide Provider and Subscriber Assistance Panel, which was created to review enrollment/disenrollment, financial, contractual, and quality of care complaints against HMOs. The panel may review and consider subscriber and provider grievances and make recommendations to the agency and the DOI as to any action that should be taken concerning such grievances.

Other Department of Elderly Affairs Home & Community-Based Services

In addition to the pilot projects, the department operates several non-HMO based home and community-based services programs. These include:

Community Care for the Elderly: This program provides community-based services organized in a continuum of care to assist functionally-impaired older people to live in the least restrictive environment suitable to their needs. Individuals must be 60 years of age and be functionally impaired as determined by a standardized functional assessment instrument. Priority is given to individuals at risk of entering an institution, or those who have been abused, neglected, or exploited and referred by Adult Protective Services. Services are provided by 54 lead agencies (43 non-profit and 11 county/local government agencies) and their subcontractors.

Home Care for the Elderly: This program encourages the provision of care for older persons 60-plus in family living arrangements in private homes, as an alternative to nursing home or other institutional care. In addition to case management, a basic subsidy is provided for support and maintenance of the older person, including medical costs. A special subsidy may also be provided for needed services and supplies. An individual must be 60-plus, have income less than the Medicaid Institutional Care Program standard, meet the asset limitation, be at risk of nursing home placement, and have an approved adult caregiver living with them who is willing and able to provide or assist in arranging for services.

Medicaid Aged/Disabled Adult Services Waiver: These services are for older persons and disabled individuals assessed as frail, functionally impaired, and at risk of nursing home placement. Services which help a person remain at home are arranged by a case manager. The department has an interagency agreement with the agency for the administration of the waiver program. Individuals must be 60-plus or disabled, Medicaid eligible, and certified by a health professional to be in need of nursing home placement or in need of community care in lieu of nursing home placement, and meet additional clinical criteria.

Assisted Living for the Elderly Medicaid Waiver: These services are for clients age 60 plus who meet specific functional criteria and are in need of additional support and services to

remain in an Assisted Living Facility (ALF) setting, avoiding their being placed in more costly, less preferred, institutional care. Individuals must be Medicaid eligible, age 60 plus, and meet clinical eligibility criteria. The maximum amount allocated for services per individual is $850 per month. Clients may have a patient responsibility depending on income. For each participant, case managers receive a capitated rate of $100 per month. Facilities also are able to bill up to $125 per month per person for incontinence supplies.

Chapter 400, F.S., Licensed Entities

The following entities are licensed under ch. 400, F.S.:

- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Adult day care centers;
- Hospices;
- Adult family-care homes; and
- Intermediate, special services, and transitional living facilities.

C. EFFECT OF PROPOSED CHANGES:

The bill directs the department, in consultation with the agency, to select and contract with "other qualified providers" in addition to managed care organizations to provide long-term care services in the community diversion project areas.

The bill becomes effective upon becoming law.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Adds a new subsection (7) to s. 430.703, F.S., defining "other qualified provider" as an entity licensed under ch. 400, F.S., that meets all the financial and quality assurance requirements for a provider service network as specified in s. 409.912, F.S., and is exempt from ch. 641, F.S., and can demonstrate a long-term care continuum.

Section 2. Amends s. 430.707(1), F.S., adding "other qualified providers" as entities authorized to provide long-term care within community diversion pilot project areas.

Section 3. Provides for the act to take effect upon becoming law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

Department for Elderly Affairs

NON-RECURRING:	Year 1	Year 2	Year 3

Annual cost for 2 FTE, PG 26: (Sr. Mgt. Analyst II)			
General Revenue	$ 2,561	-0-	-0-
Operations & Maintenance TF	$ 2,531	-0-	-0-
OCO:			
General Revenue	$ 3,187	-0-	-0-
Operations & Maintenance TF	$ 3,187	-0-	-0-
RECURRING:			
Salaries and Benefits			
General Revenue	$ 54,334	$ 54,334	$ 54,334
Operations & Maintenance TF	$ 54,334	$ 54,334	$ 54,334
Expense			
General Revenue	$ 13,820	$ 13,820	$ 13,820
Operations & Maintenance TF	$ 13,820	$ 13,820	$ 13,820
LONG-RUN EFFECTS OTHER THAN NORMAL GROWTH			
Cannot be determined at this time.			
TOTAL REVENUES AND EXPENDITURES			
General Revenue	$ 73,902	$68,154	$ 73,513
Operations & Maintenance TF	$ 73,902	$68,154	$ 68,154

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

N/A

D. FISCAL COMMENTS:

Since the Department of Elderly Affairs already staffs the Community Care for the Elderly Pilot Project, it is unclear why more staffing is needed for the implementation of the bill.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

Agency for Health Care Administration: The agency is supportive of effects to promote the cost-effective provision of long-term care services financed under Medicaid. However, the agency opposes allowing entities not licensed under ch. 641, F.S., to enter into contracts containing prepaid, capitated payment methodologies for the provision of Medicaid services. Additionally, current law requires that diversion pilot projects "integrate acute and long-term care services, and funding sources for such services, as feasible." Current diversion pilot projects have been designed to integrate Medicare covered benefits by contracting with Medicare + Choice organizations. The integration of Medicare (primarily acute care) and Medicaid (primarily long-term care) benefits would not be feasible with entities licensed under ch. 400, F.S. Furthermore, not all entities licensed under ch. 400, F.S., are capable of providing the "skilled and intermediate nursing facility care," required under current law, which is integral to the design of diversion pilot projects.

By contrast, the Department of Insurance suggests deletion of the phrase "is exempt from chapter 641," as found on page 1, line 20, of the bill.

These agency and Department of Insurance concerns raise questions about the feasibility of provider service networks as appropriate providers for the community diversion pilot projects.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 13, 2000, the Committee on Health Care Services approved an amendment to the bill. The amendment: added to the definition of "other qualified providers" entities licensed under ch. 626, part VII, relating to insurance administrators, and ch. 400, F.S., that can demonstrate a long-term care continuum, and authorized other qualified providers of pilot project services to be reimbursed on a fee-for-service or capitated basis and to be exempt from certain provisions of the Florida Insurance Code.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams