SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Health Care Committee

BILL: CS/SB 2364

SPONSOR: Health Care Committee and Senator Fasano

SUBJECT: Elderly Affairs

DATE: April 13, 2005 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Fav/CS**
2.			HA	
3.				
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I. Summary:

Committee Substitute for Senate Bill 2364 removes several requirements of CS/SB 1226, which passed in 2004, including:

- Deleting the requirement for the Agency for Health Care Administration (AHCA), in consultation with the Department of Elderly Affairs (DOEA), to integrate the Frail Elder Option program into the Nursing Home Diversion program and to develop uniform standards for case management in this newly integrated capitated system.
- Deleting the requirement for AHCA, in consultation with DOEA, to integrate the Aged and Disabled Adult (ADA) Medicaid waiver and the Assisted Living for the Frail Elderly (ALE) Medicaid waiver into one waiver program.
- Deleting the requirement for the DOEA Comprehensive Assessment Review and Evaluation Services (CARES) program staff to annually review at least 20 percent of case files of Medicaid nursing home residents to determine which nursing home residents are able to move to community placement.

In addition, the bill requires:

- DOEA and AHCA to reimburse providers for case management services on a capitated basis within the Aged and Disabled Adult Medicaid waiver program;
- DOEA to initially reimburse community care for the elderly lead agencies in the community care for the elderly lead agency risk assumption demonstration project on a pre-paid or fixed sum basis for all home and community-based services provided under the long-term care community diversion pilot project, and by the third year of operation, reimburse all services under the diversion pilot on a prepaid or fixed-sum basis.

- AHCA, in consultation with DOEA, to develop reimbursement rates based on the federally approved, actuarially certified rate methodology for the long-term care community diversion pilot project.
- DOEA to use modified financial solvency requirements for "other qualified providers" within the long-term care community diversion pilot projects (Nursing Home Diversion and PACE programs). The standards are rewritten in such a way as to ensure that the state can approve the financial viability of these other qualified providers, and allow them to remain diversion program providers for up to one-year, or until they meet the solvency requirements. Within this one-year period, these providers may post a performance bond in lieu of meeting the surplus requirement.

The committee substitute abolishes the Office of Long-Term-Care Policy in DOEA.

This bill amends ss. 430.205, 430.7031, 430.705, and 430.707, F.S., and repeals s. 430.041, F.S.

II. Present Situation:

CS/SB 1226: The Long-Term Care Service Delivery System

During the 2004 Session, the Legislature passed CS/SB 1226, which was enacted as Chapter 2004-386, L.O.F. This law implemented the recommendations contained in Senate Interim Project Report 2004-144, "Model Long-Term Care System/Analyzing Long-Term Care Initiatives in Florida."

This law made substantial changes to Florida's policies on long-term care; however, when the Governor signed the bill, he transmitted it to the Secretary of State with a letter outlining some of his concerns with the bill.[1] Specifically, the Governor wrote:

> "While the bill includes positive reforms, a number of provisions in the bill cause considerable concern. Chief among these is the merger of the Frail Elder waiver program with the Nursing Home Diversion waiver program. Although sharing similar goals, these two distinct programs involve different types of waivers, different eligibility criteria, and different funding sources, which will make integration difficult, if not impossible in the short term. During the transition, it is important to continue serving people from both programs who have come to rely on these services. The language in the bill concerning an enrollment cap for the Frail Elder program as of July 1, 2004 is problematic if interpreted as anything but a limitation on additional slots in the program and not a prohibition against filling open slots as they become available through attrition.
>
> I continue to be concerned about legislation that generates unfunded workload for agencies and provides overly detailed instructions that limit the executive branch's ability to respond flexibly and appropriately to new and developing situations. Committee Substitute for Senate Bill 1226 violates these principles by, first, generating an inordinate burden of compliance for AHCA, and second, by attempting to dictate a methodology for

[1] Letter from Governor Jeb Bush regarding Committee Substitute for Senate Bill 1226 to Secretary Glenda Hood, June 30, 2004, available at http://www.myflorida.com/myflorida/government/laws/2004legislation/pdfs/SB 1226_letter.pdf.

> setting the capitation rate that may violate actuarially sound principles. Consequently, I am asking AHCA and DOEA to work closely with my office and the Legislature to identify clarifications and refinements of these initiatives for the coming year."

Ultimately, the Governor determined that despite his concerns, he was convinced that CS/SB 1226 took important first steps in a direction that would improve service delivery and efficiency in long-term care. In particular, the statewide modification of Area Agencies on Aging (AAA) into Aging Resource Centers (ARCs) and the establishment of a capitation-based system of payment for the programs administered through these agencies were identified as substantial improvements in the organization of the service delivery system.

CS/SB 2364 seeks to address a number of the issues raised in the Governor's transmittal letter by deleting several requirements of the law, including those provisions related to merging certain waiver programs.

Nursing Home Diversion Pilot Project and the Frail Elder Program

The Nursing Home Diversion pilot project (Nursing Home Diversion) is designed to provide community-based services to people who would qualify for Medicaid nursing home placement. Services provided include long-term care services, and Medicaid-covered medical services. Managed care organizations and other qualified providers contract with the State and receive a capitated payment to provide, manage and coordinate the enrollee's full continuum of care. The objective is to provide frail elders with safe, appropriate community-based care alternatives in lieu of nursing home placement at a cost less than Medicaid nursing home care.

Since December 1998, the diversion pilot has operated in four counties: Orange, Osceola, Seminole, and Palm Beach. In September 2003, DOEA received approval from the federal Centers for Medicare and Medicaid Services (CMS) to expand the program to other areas of the state. The program is now administered in 25 counties in nine of the state's 11 planning and service areas.

The Frail Elder Option (Frail Elder) 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 a 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.

Section 430.205(6)(c)4, F.S., provides that DOEA and AHCA shall merge the Frail Elder Option into the Nursing Home Diversion pilot project to create one capitated program. According to DOEA, this mandate creates several implementation problems, including:

- Frail Elder is designed for individuals age 21 and older, while Nursing Home Diversion is designed for individuals age 65 and older who are dually eligible for Medicaid and Medicare.

Not all Frail Elder consumers will be Medicare-eligible. Eligibility for the new program will have to change, or existing customers will lose their services. Nursing Home Diversion, providers may not be interested in non-Medicare-eligible consumers since Nursing Home Diversion providers bill Medicare for numerous services. Inability to bill Medicare for these patients could negatively affect capitation rates.

- Nursing Home Diversion is operated under a separate Medicaid waiver and has its own line item appropriation in the General Appropriations Act each year. Frail Elder is operated out of savings from the annual Medicaid HMO appropriation. Combining the funds for these two programs will present significant accounting issues for the state.

- Nursing Home Diversion consumers are typically frailer than Frail Elder consumers. The Nursing Home Diversion Medicaid waiver provides for additional frailty criteria above and beyond a simple nursing home Level of Care determination for eligibility. This is intended to ensure that the Nursing Home Diversion waiver program serves only the frailest clients because the state is effectively prepaying for nursing home care for the life of the client within the capitation rate for Nursing Home Diversion. Lowering these frailty criteria will allow less-frail persons to enter the state's most expensive Medicaid waiver program.

- The average capitation rate for Nursing Home Diversion is roughly $700 per person per month higher than the average capitation rate for the Frail Elder program. Most current Frail Elder consumers are properly placed in that program at an average monthly capitation rate of approximately $1,430 per month. However, in the newly-mandated program, the state will be paying approximately $2,200 per month to provide care to the same persons. DOEA reports that this will result in a yearly cost impact to the state that may exceed $25,000,000.

Aged and Disabled Adult and Assisted Living for the Elderly Waiver Programs

The purpose of the Medicaid Aged and Disabled Adult (ADA) Waiver is to help individuals who are at risk of nursing home placement to remain at home or in a community setting. The ADA Waiver serves individuals aged 60+ years who are unable to care for themselves without assistance through the Department of Elder Affairs and disabled adults aged 18-59 through the Department of Children and Families.

The Medicaid Assisted Living for the Elderly (ALE) Waiver helps severely impaired residents of assisted living facilities remain in an assisted living setting to avoid or delay being placed in more costly institutional care. To be eligible for the ALE Waiver, individuals must be aged 60 and up, meet Medicaid financial criteria, and be at risk of nursing home placement. In addition, clients must meet at least one of several impairment criteria, such as requiring total help with one or more daily tasks essential for independent living (eating, dressing, bathing), having a diagnosis of Alzheimer's disease or other dementia, having a degenerative or chronic medical condition that requires nursing services, or being a nursing home resident who can be served in an assisted living facility but not in a private residence.

The ALE Waiver provides services to residents with heavy care needs that exceed the cost of standard services provided in assisted living facilities (ALFs). While ALFs provide housing, meals, and one or more supportive services to persons who are unable to live independently, they

often cannot fund the additional personal assistance and supervisory services that are necessary to keep a person out of a nursing home. Thus, the ALE Waiver makes available these additional services to meet the needs of the recipient, including personal care, medication administration, physical therapy, and intermittent nursing services.

Section 430.205(6)(b)2., F.S., provides that DOEA and AHCA shall integrate the ADA and ALE Waiver programs into one program. DOEA reports that the integration of these two programs will likely have no evident positive benefit for the state or the waiver clients, and is expected to have some adverse effects, including:

- The ADA waiver serves both aged persons (ages 60+) as well as disabled adults (ages 18-59). The ALE waiver program serves only those aged 60 and older. Thus, the two programs serve different populations.
- The federal Centers for Medicare and Medicaid Services (CMS) has informed AHCA that if it intends to move forward on the integration of these Medicaid waiver programs, Florida will be required to offer assisted living facility and other services provided under the ALE waiver to all clients on the ADA waiver, including those aged 18-59 who were previously not eligible for ALF services.

As of February 28, 2005, there were 1,658 persons ages 60 and older awaiting a slot in the ALE waiver. Of these, 223 were assessed at priority levels 4 or 5 (the frailest clients). The Department of Children and Families maintains the waiting list for services for the ADA waiver for those aged 18-59.

Section 430.205(6)(b)3., F.S., provides that DOEA and AHCA shall develop a program which allows Community Care for the Elderly (CCE) lead agencies to transition over a period of time into full providers of service under the nursing home diversion program. The first step prescribed by the Legislature is to integrate the ADA and ALE waivers prior to proceeding with implementation of this project. Because CS/SB 2364 eliminates the integration of those two waiver programs, the bill includes language that allows DOEA to move forward on implementation of the pilot.

CS/SB 2364 revises the current prescribed method for development of capitation rates for this project. DOEA states that the method as prescribed in current law is not likely to achieve an actuarially sound rate that will be approved by CMS. The bill requires that the agency use a federally approved, actuarially certified rate methodology to develop reimbursement rates for the long-term care community diversion pilot project.

Comprehensive Assessment Review and Evaluation Services

The DOEA Comprehensive Assessment Review and Evaluation Services (CARES) program performs the federally-mandated medical/functional assessment component to determine eligibility for Medicaid nursing home and other long-term care waiver programs. Persons applying for Medicaid nursing home care are assessed by either a CARES nurse or social worker, with medical review by a physician prior to approval.

CS/SB 1226 made several revisions to the duties of the CARES program, including putting in place a requirement that CARES staff annually review at least 20 percent of the case files of all Medicaid nursing home residents to see which ones might be eligible to transfer to community-based settings. The agency reports that, to carry out this mandate, the CARES program would require significant staff increases, which were not appropriated.

In addition, DOEA notes that it is highly unlikely that the state will ever be able to achieve a rate of nursing home transition that mirrors the 20 percent case file review requirement. The vast majority of Medicaid nursing home residents are too frail to move to community placements. Further, if CARES does locate someone who can safely move to the community, often the person declines to leave because they have lived in the nursing home for an extended period of time and feel it is their home, or because they have no viable community option to which to move. The state cannot force the person to transition out of the nursing home.

Financial Solvency Requirements

In CS/SB 1226, the Legislature also passed additional financial solvency requirements for "other qualified providers" within the long-term care community diversion pilot projects (Nursing Home Diversion and PACE programs). These standards were increased due to growing concern that providers were accepting more risk in these capitated programs than many of them were financially capable of accepting. Because the Nursing Home Diversion waiver program's capitation rate in essence "pre-pays" for all services that the client may require during the upcoming month, including nursing home care, the Legislature sought to ensure that the state is protected in case the provider can no longer financially sustain the risk associated with the program.

However, according to DOEA, the Department of Financial Services (DFS) reviewed the new financial standards, in consultation with DOEA, pursuant to s. 430.705(2), F.S. DFS staff reported to DOEA that the standards, as currently written, could not be implemented by their agency. The departments worked collaboratively, along with AHCA and the Office of Insurance Regulation (OIR), to ensure that the standards were rewritten as specified in this committee substitute in such a way as to ensure that the state could approve the financial viability of those other qualified providers, and allow them to remain diversion program providers. The departments state that these new standards ensure financial solvency and available surpluses, while eliminating additional insurance requirements that did not apply to providers that are not licensed health maintenance organizations (HMOs).

Office of Long-Term-Care Policy

CS/SB 1276 (2002) created the state Office of Long-Term-Care Policy (s. 430.041, F.S.). The purpose of the office is to:

- 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 Florida;
- Review current programs providing long-term-care services to the elderly, including those in home, community-based, and institutional settings, and review program evaluations 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;

- Develop specific implementation strategies and funding recommendations for promoting and implementing cost-effective home and community-based services as an alternative to institutional care, when appropriate, which coordinate and integrate the continuum of care needs of the elderly; and
- Recommend roles for state agencies that are responsible for administering long-term-care programs for the elderly and an organization framework for the planning, coordination, implementation, and evaluation of long-term-care programs for the elderly.

The Director of the Office of Long-Term-Care Policy is appointed by the Governor and, until 2004, was under the general supervision of the Secretary of DOEA. In 2004, the Legislature changed this arrangement and required DOEA to serve in an administrative supportive role to the Office of Long-Term-Care Policy. The 2002 Legislature funded three full-time equivalents (FTEs) and $350,000 in General Revenue for the office for FY 2002-2003. This was recurring for FY 2003-2005.

Since its creation in 2002, the Office of Long-Term-Care Policy has seen significant turnover in its senior administration. The position of Director of the Office of Long-Term-Care Policy has been vacant for most of the time since its creation in 2002. The most recent director was only in the position for five months until being appointed as Secretary of DOEA in March 2005. At this time, the position is, once again, vacant.

III. Effect of Proposed Changes:

Section 1. Amends s. 430.205, F.S., to: delete the requirement that, during the 2004-2005 state fiscal year, AHCA and DOEA develop an implementation plan to integrate the Frail Elder Option into the Nursing Home Diversion pilot project; to delete the requirement that, during the 2004-2005 state fiscal year, AHCA and DOEA integrate the Aged and Disabled Adult Medicaid waiver program and the Assisted Living for the Elderly Medicaid waiver program into one fee-for-service Medicaid waiver program serving the aged and disabled; require, for the 2004-2005 state fiscal year, that AHCA and DOEA reimburse providers for case management services on a capitated basis and develop uniform standards within the Aged and Disabled Adult Medicaid waiver program; provide AHCA specific authority to adopt rules necessary to administer this section; require that in the community care for the elderly lead agency risk assumption demonstration area, the lead agency shall initially be reimbursed on a prepaid or fixed-sum basis for all home and community based services provided under the long-term care community diversion pilot project, and by the end of the third year, the lead agency shall be reimbursed on a prepaid or fixed-sum basis for all services provided under the pilot; require AHCA and DOEA to develop reimbursement rates in accordance with a federally-approved actuarially certified rate methodology for the long-term care community diversion pilot project; delete the requirement that certain payment rates be negotiated and the cap on such payments; make the evaluation of the lead agency demonstration project subject to appropriation; delete reference to an obsolete report; and delete the requirement that AHCA and DOEA integrate the Frail Elder Option into the Nursing Home Diversion pilot project.

Section 2. Amends s. 430.7031, F.S., to delete the requirement that CARES program staff annually review at least 20 percent of case files of nursing home residents to determine which nursing home residents are able to move to community placements.

Section 3. Amends s. 430.705, F.S., requiring DOEA to select and contract with long-term care community diversion program providers who:

- Demonstrate the ability to provide enrollees with a choice of providers by contracting with multiple providers offering the same type of service;
- Demonstrate the capacity for prompt payment as specified under s. 641.3155, F.S.;
- Maintain an insolvency protection account with a balance of at least $100,000, into which monthly deposits are made equal to at least five percent of premiums received until the balance equals two percent of the total contract amount;
- Maintain a surplus of at least $1.5 million as determined by DOEA; furnish initial and annual unqualified audited financial statements that certify the surplus requirement; and existing diversion providers may maintain a $1.5 million performance bond in lieu of meeting the surplus requirement until June 30, 2006.

These requirements do not apply to community care for the elderly lead agencies selected to provide services in the integrated care delivery demonstration project created in s. 430.205, F.S. For these entities, DOEA must develop by rule minimum solvency and reporting standards based on the level of risk assumed by the entity.

The department, in consultation with AHCA, may adopt rules necessary to administer the long-term care community diversion pilot projects authorized under ss. 430.701-430.709, F.S.

Section 4. Amends s. 430.707, F.S., to require all long-term-care diversion providers to report quarterly to DOEA on their compliance with all financial and quality assurance requirements of their contracts.

Section 5. Repeals s. 430.041, F.S., to abolish the Office of Long-Term-Care Policy.

Section 6. Provides an effective date of upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

DOEA asserts that the bill will save money in the state's Medicaid program in two ways.

First, by changing the law and allowing less-frail consumers currently enrolled in the Frail Elder program to continue to be served in that program at an approximate rate of $1,430 per month. Moving all these clients into the Nursing Home Diversion program would require an average increase of approximately $700 per client per month.

This bill eliminates the necessity to move these clients out of the Frail Elder program. There are currently 2,885 clients enrolled in Frail Elder. There are currently six different capitation rates for this program: one for Medicare Parts A&B eligibles, one for Medicare Part B eligibles only, and one for non-Medicare eligibles, for each of Miami-Dade and Broward Counties.

DOEA asserts it is somewhat difficult to compare Frail Elder clients to Nursing Home Diversion clients because the eligibility criteria are vastly different; however, for purposes of this analysis, DOEA examined 2,353 clients currently enrolled in the Frail Elder program who are eligible for Medicare Parts A&B (which is required by Nursing Home Diversion eligibility standards) and who reside in Miami-Dade County.

Current capitation rate for these FE clients = $1,395/month
Current capitation rate for NHD clients in Miami-Dade = $2,231/month

Fiscal impact of placing these clients into NHD **(which will be required if this bill is <u>NOT</u> passed)**:

(2,353 FE clients * $2,231)	=$5,249,543	–> future NHD payment
(2,353 FE clients * $1,395)	=$3,282,435	–> current FE payment
	=$1,967,108 per month	
$1,967,108/mo * 12 months	= $23,605,296 per year	

(Note: There are 532 additional clients served by Frail Elder who are not included in the 2,353-sample population used above, so the costs to move these clients into Nursing Home Diversion would increase this figure even more.)

Second, the bill will save money by deleting the necessity to hire additional CARES staff to complete the mandated review of at least 20 percent of case files of nursing home residents. In order to complete this current mandate, at least 10 new CARES assessors (FTEs) would need to be hired. (No fiscal analysis was provided by DOEA for the cost of adding 10 new CARES staff.)

Abolishing the Office of Long-Term-Care Policy would produce an estimated cost savings of $350,000, although the exact amount is indeterminate at this time, and a reduction of three full-time equivalent (FTEs) positions.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.