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 Health Policy

BILL: CS/SB 748

INTRODUCER: Children, Families, and Elder Affairs Committee; and Senators Bean and Gibson

SUBJECT: Program of All-inclusive Care for the Elderly

DATE: March 15, 2013 REVISED:

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

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE..... [x] Statement of Substantial Changes

B. AMENDMENTS........................ [ ] Technical amendments were recommended

[ ] Amendments were recommended

[ ] Significant amendments were recommended

I. Summary:

CS/SB 748 authorizes two additional Program of All-inclusive Care for the Elderly (PACE) sites, each with up to 300 slots. One site is authorized to serve Duval, St. Johns, Baker, and Nassau Counties. The second is authorized to serve Alachua, Bradford, Clay, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties.

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

This bill creates two undesignated sections of the Florida Statutes.

II. Present Situation:

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

The 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;
- 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.

The PACE participants must be at least 55 years of age, 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.

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

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 (GAA) or general law.

The 2006 GAA 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] In 2009, the Legislature authorized 100 slots for a program in Hillsborough County.[5] The 2010 GAA funded an additional 100 slots in Pinellas County and authorized and funded a new program with 100 slots in Hillsborough County.[6] 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.[7] In 2011, the Legislature authorized a program with 150 slots in Palm Beach County,[8] and funded, through the GAA, 50 additional slots in Lee County and 150 slots for a program serving Polk, Hardee, and Highlands Counties.[9] 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.[10] The 2012 – 2013 GAA funded 100 additional slots in Miami-Dade and 150 additional slots in Lee County.[11]

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 approximately 2,325 slots the Legislature has authorized since 2003, 1,075 are funded and operational; 250 are funded and will be operational in 2012, and 450 are not funded or operational.[12] The Legislature appropriated $26,578,951 for PACE in the 2012 GAA.[13]

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

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[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.
[3]Chapter 2006-25, L.O.F.
[4] Chapter 2008-152, L.O.F.
[5] Chapter 2009-55, s. 20, L.O.F.
[6] Chapter 2010-152, L.O.F.
[7] Chapter 2010-156, ss. 14, 15, L.O.F.
[8] Chapter 2011-61, s. 17, L.O.F.
[9] Chapter 2011-69, L.O.F.
[10] Chapter 2012-33, ss.18, 19, L.O.F.
[11] Ch. 2012-118, L.O.F.
[12] 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).
[13] Chapter 2012-118, L.O.F..

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.

The AHCA and the 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 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.[14]

In 2011, the Legislature moved administrative responsibility for the PACE program from DOEA to AHCA as part of the expansion of Medicaid managed care.[15] Participation by PACE is not subject to the procurement requirements or regional plan number limits applicable to the statewide Medicaid Managed Care program. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[16]

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

[14] 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).
[15] Chapter 2011-135, s. 24, Laws of Fla, repeals Section 430.707, F.S., effective Oct. 1, 2013.
[16] Section 409.981(4), F.S.

- 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.

The February 25, 2013 Social Services Estimating Conference estimated that expenditures for Medicaid for fiscal year 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 fiscal year 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[17] to increase the use of managed care in Medicaid. The law requires both long-term care services and Medicaid medical assistance to be provided through managed care plans. The 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.

The AHCA has chosen the plans that may participate in the program through a competitive bid process. The AHCA considered many factors when choosing plans. The AHCA chose a certain number of long-term care managed care plans for each region to ensure that recipients have a choice between plans. After the AHCA has chosen the plans that may participate in the Florida Long-Term Care Managed Care Program, the 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:

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

- 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
- 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 the 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 directs the AHCA to contract with a hospice with 30 years' experience that currently serves residents in Clay, Alachua, Bradford, and Putnam Counties to provide PACE services to frail elders in Alachua, Bradford, Clay, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties. 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 3 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 of age 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.

D. Other Constitutional Issues:

The bill may violate article III, section 10 of the Florida Constitution, relating to special laws. The Constitution states: "No special law shall be passed unless notice of intention to seek enactment thereof has been published in the manner provided by general law" Publication is not required if the law becomes effective only after referendum approval. Section 11.02, F.S., requires that notice of the intent to pass special or local legislation be published in a newspaper as defined in ch 50 in each affected county: The bill was filed as a general bill without prior publication. It proposes to create an exception to general law authorizing two providers to operate PACE programs in specified counties.

In general, a special law relates to or operates on persons or things, or on classified persons or things when classification is not permissible or is illegal. A local law relates to or operates only on one part of the state when there is no valid basis to distinguish that location from others, or within classified territory when the classification is illegal. A general law operates universally throughout the state, or uniformly upon subjects as they may exist throughout the state, or uniformly within permissible classification by population of counties or otherwise. *State ex rel. Landis v. Harris,* 120 Fla. 555, 163 So. 237, 240 (Fla. 1934) (citations omitted). A statute may be a general law even if it was enacted for the benefit of a single business entity or a single geographic area, provided the classification regulated by the statute remains open. *Department of Legal Affairs v. Sanford-Orlando Kennel Club, Inc.*, 434 So. 2d 879, 882 (Fla 1983).

A Supreme Court decision is instructive in considering the potential constitutional violation of the CS. In *St. Vincent's Medical Center, Inc. v. Memorial Healthcare Group,*

Inc,[18] the Court was asked to review a statute creating a specific exemption from the requirement to obtain a Certificate of Need to establish an open heart surgery program in a new hospital. The exemption applied only if the new hospital was being established "in the location of an existing hospital with an adult open-heart surgery program, the existing hospital and the existing adult open-heart surgery program are being relocated to a replacement hospital, and the replacement hospital will utilize a closed-staff model."[19] The law was enacted during the 2003 Session and by its terms was repealed January 1, 2008. At the time of the law's enactment, two hospitals met the criteria of having both an open-heart surgery program and closed medical staff, but only one hospital was actively seeking to establish a new hospital with an open-heart surgery program.

The statute was challenged on the grounds that it was a special law enacted in violation of the notice requirements of the Constitution.[20] The trial court heard testimony on whether the law could apply to another hospital, specifically, whether a hospital could convert to a closed medical staff in time to take advantage of the law. The trial court concluded that only the one already identified hospital could utilize the statute saying:

> The Exemption Provision is nothing more than a description of the situation involving St. Vincent's and St. Luke's. The Court concludes that the constitutional requirements governing special laws cannot be avoided by merely utilizing generic language in a complicated classification scheme that is intended to address a special circumstance.[21]

On appeal, the First District Court held that the trial court correctly applied the law when it concluded there was no "reasonable possibility" that the exemption could apply to another party before the exemption expired.[22] The Supreme Court affirmed, relying on the rule set forth in *Florida Department of Business Regulation v. Gulfstream Park Racing Ass'n,*[23] holding that "whether a law has general application turns on whether its application to others is reasonable or practical, not theoretical or speculative."[24]

The bill creates exemptions from general law that apply to providers in two separate geographic areas of the state. In one case, the provider is a not-for-profit formed between a lead agency designated pursuant to s. 430.205, F.S., and licensed as a nursing home diversion program provider, and a hospice licensed for 30 years to provide service in Duval, St. Johns, Baker, and Nassau Counties. The second is described as a health care organization that is a hospice with 30 years experience and currently licensed to serve Clay, Alachua, Bradford, and Putnam Counties. Currently, there are two not-for-profit hospice providers licensed to serve Duval, St. Johns, Baker, and Nassau Counties; only one of those has been licensed in those counties for 30 years. Only one hospice provider is licensed currently in Clay, Alachua, Bradford, and Putnam Counties. Thus, on its face,

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[18] *St. Vincent's Medical Center, Inc. v. Memorial Healthcare Group, Inc*, 967 So.2d 794 (Fla. 2007),
[19] *Id,.* at 796.
[20] *Id,.* at 797.
[21] I*d*., at 798 *(*quoting the trial court order*).*
[22] *Id* (citing *St. Vincent's Medical Center, Inc. v. memorial Healthcare Group, Inc.,* 928 So.2d. *43*0, 435 (Fla. 1st DCA 2006).
[23] *Florida Department of Business Regulation v. Gulfstream Park Racing Ass,* 967 So.2d 802 (Fla. 2007)
[24] *St. Vincent's* 967 So.2d at 801.

the bill authorizes contracts directed at the only two providers in the state who currently meet its terms, and for programs that will operate in only specified counties. It is possible – whether or not "a reasonable possibility" – that other hospice providers could eventually qualify under the terms of the bill. It is not presently possible, however, for a new provider to qualify as a licensed nursing home diversion program provider because the Legislature has sunset that program as part of the transition to statewide Medicaid managed care.

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 Duval, St. Johns, Baker, Nassau, Alachua, Bradford, Clay, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union 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:

The 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. The AHCA is also responsible for providing technical assistance, as needed. In order to implement the bill, the 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.

CS/SB 748 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 for each program, for a total of $15 million, if an appropriation to cover those expenditures is provided. The PACE slots are intended as an alternative to nursing home care, which is separately funded in the budget. If the funding for nursing home services were to be reduced as a result of the addition of the new PACE slots, then the actual fiscal impact to the state could be less.

Fiscal Impact	Fiscal Year 2013-14		Fiscal Year 2014-2015
AHCA	FTE	Total	Total
Application process	1	$71,128	
Operation of 300 slots			$15 million
Total	1	$71,128	$15 million

VI. Technical Deficiencies:

The bill directs the AHCA to contract with a "health care organization" that is licensed as a hospice provider. Although the term has been used in the past in other bills authorizing PACE programs, it is not a term that is defined in law."

The title incorrectly indicates that the contracted organizations are required to enroll a specified number of patients in the program. In fact, the bill requires AHCA and DOEA to approve up to 300 slots, but does not contain a specific mandate for enrollment.

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.)

CS by Children, Families, and Elder Affairs on March 12, 2013:
The bill was amended to add a second PACE program with up to 300 slots that is authorized to serve Alachua, Bradford, Clay, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.