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:	SPB 7124
INTRODUCER:	For Consideration by the Health Policy Committee
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	March 27, 2014
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**

I. Summary:

SPB 7124 creates the Program of All-Inclusive Care for the Elderly (PACE) in statute. The bill establishes definitions for the PACE program, authorizes the Department of Elder Affairs (DOEA), in consultation with the Agency for Health Care Administration (AHCA), to contract for services and creates a two-step selection process for providers.

The bill establishes an eligibility confirmation status requirement for both new providers and those in existence as of May 1, 2014. Documentation of compliance with federal requirements, accreditation status, financial stability, fidelity bond, insurance coverage, prior experience and a business plan of operation is required to achieve eligibility confirmation status. Each provider must serve a unique and defined service area without duplication of services or target populations.

The PACE providers will be selected on a regional basis using the regions under s. 409.966, F.S., and no more than one provider can be selected per 3,000 potential eligible enrollees in a region.

Annually, the AHCA and the DOEA will review the list of existing providers, the projected enrollment and costs for existing providers, and the list of entities with a confirmed eligibility status. The AHCA and the DOEA shall develop an annual funding priority list by January 1 for submission to the President of the Senate and the Speaker of the House of Representatives. Besides enrollment and cost projections, the priority funding list must also include recommendations for any discontinuation of providers or policy changes that require statute modifications. The AHCA and DOEA are also directed to take into consideration several factors when developing their recommendations, such as the services being offered, the proposed plan of operation, the outreach plan, the anticipated costs and enrollment and any supplemental benefits.

All PACE providers will be required to meet quality and performance standards developed by the AHCA and DOEA, as well as unique standards mutually developed between the provider and the DOEA.

Enrollment in PACE is voluntary and on a first-come, first served basis. Based on the General Appropriations Act (GAA), the AHCA shall define a cap on the number of PACE slots; however, the number available statewide may not exceed 3 percent of the total enrollees in the long-term care managed care program.

The bill provides for the negotiation of rates between the PACE provider and the AHCA as part of the application and contract renewal process. Capitation rates and enrollment caps are subject to the GAA. Payment rates will reflect historic utilization and case mix of PACE enrollees.

SPB 7124 requires the contract between the PACE provider and the AHCA include a lock-in provision that holds the PACE provider financially responsible for a designated period of time if an enrollee disenrolls and subsequently enrolls or transfers to a nursing home.

Annual capitation rates to a PACE provider may not result in an increase to the capitation rate paid under the Statewide Medicaid Managed Care Program - Long-Term Care (SMMC - LTC) by more than 3 percent over the prior fiscal year, as certified by the AHCA's chief financial officer.

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,

[1]CMS Manual *available at* http://www.cms.gov/Medicare/Health-Plans/pace/downloads/r1so.pdf (last visited Mar. 27, 2014)

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 PACE enrollee must accept the PACE center physician as their new Medicare primary care physician, if enrolled in Medicare.[2]

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 DOEA, operating in consultation with the AHCA.[3] 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 GAA or general law. Currently, active PACE programs exist in 6 Florida counties: Lee, Charlotte, Collier, Miami-Dade, Palm Beach, and Pinellas.

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.[4] In 2008, the Legislature reallocated equally 150 unused PACE slots to Miami-Dade, Lee, and Pinellas Counties.[5] In 2009, the Legislature authorized 100 slots for a program in Hillsborough County.[6] The 2010 GAA funded an additional 100 slots in Pinellas County and authorized and funded a new program with 100 slots in Hillsborough County.[7] That same year, the Legislature, by general law, authorized an additional 50 slots in Miami-Dade and 150 slots

[2] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last visited Mar. 27, 2014).
[3] 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.
[4] Chapter 2006-25, L.O.F.
[5] Chapter 2008-152, L.O.F.
[6] Chapter 2009-55, s. 20, L.O.F.
[7] Chapter 2010-152, L.O.F.

for a program serving Polk, Hardee, Highlands, and Hillsborough Counties.[8] In 2011, the Legislature authorized a program with 150 slots in Palm Beach County,[9] and funded, through the GAA, 50 additional slots in Lee County and 150 slots for a program serving Polk, Hardee, and Highlands Counties.[10] 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.[11] The 2012–2013 GAA funded 100 additional slots in Miami-Dade and 150 additional slots in Lee County.[12]

The Legislature appropriated $30,402,775 for PACE in the 2013-2014 GAA.[13] The appropriation proviso language included specific slot increases in Lee County by 100, in Hillsborough County by 75, in Palm Beach County by 100, and in Broward County by 50. The Governor vetoed the allocations in all counties, except Palm Beach, noting that the state's focus should be on the implementation of the SMMC-LTC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition is completed.[14]

Slots are authorized by the Legislature for a specific PACE program area; however, those slots may not always be fully funded in the same year as the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures or to finalize operations.

PACE Organizations and Enrollee Counts[15]

PACE Organization Name	Year Began Operating	County	Current Enrollees Mar-2014	Total Slots Funded
Hope Select Care	2010	Charlotte	37	100
Hope Select Care	2010	Collier	17	50
(No Provider Currently)[16]	2011	Hillsborough	0	150
Hope Select Care	2010	Lee	220	250
Florida PACE	NA	Broward	Vetoed	Vetoed
Florida PACE	2003	Miami-Dade	395	450
Suncoast Neighborly	2012	Pinellas	161	225
Morse PACE	2013	Palm Beach	35	100
TBA	NA	Manatee, Sarasota, DeSoto	0	0
Total Enrollees - Statewide:			865	1,325

[8] Chapter 2010-156, ss. 14 and 15, L.O.F.
[9] Chapter 2011-61, s. 17, L.O.F.
[10] Chapter 2011-69, L.O.F.
[11] Chapter 2012-33, ss.18 and 19, L.O.F.
[12] Chapter 2012-118, L.O.F.
[13] Chapter 2013-40, L.O.F.
[14] Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p.28, http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf (last visited Mar. 27, 2014).
[15] Agency for Health Care Administration and Department of Elder Affairs, *SPB 7124 - Relating to the Program of All-Inclusive Care for the Elderly (PACE) Bill Analysis and Background Information* (Mar. 28, 2014) on file with the Senate Health Policy Committee.
[16] The Hillsborough PACE provider, Chapters PACE, discontinued services as of August 31, 2013. Enrollees were transitioned to other home or community based setting options.

The 2013 Legislature also directed the AHCA and DOEA to provide a comprehensive report describing PACE's organizational structure, scope of services, utilization, and costs; comparing those findings with similar information for managed long-term care, and evaluating alternative methods for integrating PACE with SMMC-LTC.[17] The report's findings noted a difference in the average age (81.1 years in SMMC versus 75.5 in PACE),[18] prevalence of severe emotional problems (PACE enrollees are more likely to report) and affliction with cognitive impairments such as dementia (higher with SMMC-LTC).[19]

An entity that seeks to become a PACE provider must submit a comprehensive PACE application to the 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 so 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, the 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 the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

In 2011, the Legislature moved administrative responsibility for the PACE program from DOEA to AHCA as part of the expansion of Medicaid managed care.[20] 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.[21]

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 19 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.

[17] Chapter 2013-40, L.O.F., line 424.
[18] Department of Elder Affairs, *Supra* note 2 at 20.
[19] *Id* at 19.
[20] Chapter 2011-135, s. 24, L.O.F., repeals Section 430.707, F.S., effective Oct. 1, 2013.
[21] Section 409.981(4), F.S.

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, sets 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, the DOEA determines whether an individual:

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

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance. According to the 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, the national average cost of a nursing home was $81,030 per year for a semi-private room in 2012.[22] 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[23] 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 was implemented first. Enrollment began in Region 7 effective August 1, 2013, and concluded with Regions 1, 3, and 4 on March 1, 2014.[24]

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[22] 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs, https://www.metlife.com/assets/cao/mmi/publications/highlights/mmi-market-survey-long-term-care-costs-highlights.pdf (last visited Mar. 27, 2014).

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

[24] Agency for Health Care Administration, *Medicaid - Long Term Care Home*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC (last visited Mar. 27, 2014). Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton. Region 3 includes Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union. Region 4 includes Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia. Region 7 includes Brevard, Orange, Osceola and Seminole.

The AHCA procured the long-term managed care plans through a competitive bid process. The AHCA considered many factors when selecting 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. PACE organizations were eligible to bid to become comprehensive long-term care program plans, but no PACE organizations elected to bid.[25] However, pursuant to s. 409.981, F.S., PACE plans are authorized to continue to provide services to individuals as authorized annually in the General Appropriations Act through a contract with the AHCA. Following the procurement process, seven different contracts were awarded and each region has at least two SMMC-LTC plans.

Participating managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans were free to customize and offer additional services. 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
- 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 allows Florida to implement managed care for long-term care services under Medicaid.

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and establishes, in statute, the Program of All-Inclusive Care for the Elderly (PACE). Currently, the program does not have a specific implementing statute and has been operationalized through annual appropriations, proviso and implementing bill language. The bill creates the following definitions for the PACE program:

[25] Department of Elder Affairs, *See Supra* note 2, at 7.

- Agency;
- Applicant;
- Department;
- Eligible entity;
- Enrollee; and
- Provider.

The DOEA is authorized to contract, in consultation with the AHCA, with entities that have submitted applications to provide benefits pursuant to PACE under 42 U.S.C. s. 1395eee and that have met specific requirements. Provider selection is to be conducted through a two-step process developed by the AHCA and the DOEA for both new and existing PACE sites. A PACE provider is exempt from the requirements of chapter 641, requirements relating to health maintenance organizations, prepaid health clinics, and prepaid provider service networks.

Applications will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA. To be considered for funding, an applicant must receive an eligibility confirmation status and be placed on the annual funding priority list by the AHCA, in consultation with the DOEA. For PACE providers in existence as of May 1, 2014, the agency must document the provider's continued eligibility confirmation status in the provider's contract file by the provider's next contract renewal date, but no later than January 1, 2015.

The minimum components for an eligibility confirmation status are documentation by the applicant of the following:

- Ability to meet all federal requirements for participation as a PACE provider by the proposed implementation date;
- Confirmation of accreditation status or ability to attain the status within 1 year of the proposed implementation date;
- Evidence of financial stability, including insurance at a level determined by the AHCA or evidence that such level will be attained before the proposed implementation date;
- Evidence of a fidelity bond in the PACE provider's own name and in the name of its officers and employees in an amount to be established by the AHCA and the DOEA, or ability to acquire such coverage before the proposed implementation date;
- At least 20 years' prior experience in providing similar services to the frail elderly population; and
- Evidence of a business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

If applications are received from more than one entity, the AHCA may notify the applicants and request that the parties collaborate on a single application if the region cannot support more than one PACE provider. Each provider must serve a unique and defined area without duplication of services or target population.

The AHCA will notify an applicant of their status and may request additional information for updates or to support its annual report. Providers will be selected based on the 11 regions under s. 409.966, F.S., and no more than one PACE provider per 3,000 eligible enrollees will be selected in a particular region.

The AHCA and DOEA must review the list of providers annually along with the projected enrollment and costs of existing providers and the list of entities with confirmed statuses seeking implementation. To remain on the priority funding list, a provider must continuously maintain its status. The AHCA and DOEA shall develop recommendations for the President of the Senate and Speaker of the House of Representatives no later than January 1 each year. The report must include, at a minimum, the following:

- Existing providers recommended for continuation;
- The estimated or proposed capitation rates and enrollment by existing provider for the next state fiscal year, including recommendations for discontinuation of any providers;
- A priority funding list for implementation of any new providers which includes, in priority order, all eligible entities with the estimated or proposed capitation rates and enrollment for each site; and
- Any recommended policy changes that require statutory modifications;

In developing the recommendations, the AHCA and DOEA are directed to take into consideration the following factors:

- The services being offered or proposed to be offered to the frail elderly population;
- The proposed plan of operation for implementation or continuation of services;
- An outreach plan to potentially eligible enrollees;
- The anticipated costs and enrollment projections; and,
- Any supplemental benefits offered to enrollees.

Every PACE provider will be required to meet specific quality and performance standards established by the DOEA. Each site will be monitored and additional quality standards unique to each site will be mutually developed.

The provisions of ss. 409.967 and 409.983, F.S., relating to Medicaid managed care accountability and long-term care plan payment are applicable to the PACE program, except to the extent that subsections (3) on the unique PACE selection process, (6) on the voluntary PACE plan enrollment process, and (7) on the PACE plan payment process have modified those requirements.

Enrollment in PACE is voluntary and will be based on a first-come, first-served basis until any enrollment cap is reached. The AHCA shall define any cap on PACE slots; however, the statewide cap shall not exceed 3 percent of the total number of enrollees in the SMMC-LTC program.

The PACE plan payments shall be negotiated between the provider and the AHCA as part of the negotiation and contract renewal process. Rates will be re-negotiated each year. Both capitation rates and enrollment caps are subject to the GAA. Payment rates must reflect historic utilization and spending for covered services and be adjusted based on the case mix of enrollees in each plan.

The contract between the AHCA and the PACE provider must include a lock-in provision that holds the provider financially responsible for a designated period of time for any PACE enrollee

that disenrolls and transfers to nursing home care within 6 months of disenrollment. The terms of the lock-in provision are to be negotiated between the AHCA and each provider.

Annual capitation rates paid under PACE may not result in a corresponding increase of more than 3 percent over the prior fiscal year in the SMMC-LTC program, as certified by the AHCA's chief financial officer.

Section 2 provides an effective date of July 1, 2014.

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:

Subject to the availability of funds and slots, additional private sector providers that meet the criteria to be a PACE provider and achieve eligibility confirmation status could be approved as a PACE site. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

C. Government Sector Impact:

The potential expansion of the PACE program may result in an increased workload for the AHCA and the DOEA. The bill requires both entities to review applications, monitor performance and make annual recommendations to the Legislature.

The AHCA estimates that at least one additional FTE would be required to manage the new contracts with the PACE providers. The FTE requested by the AHCA has a fiscal impact, for salary only, of $40,948.18.

VI. Technical Deficiencies:

The bill references a contract with the PACE provider in several provisions but varies with whom the contract is with, either the AHCA or the DOEA. On Lines 41-42, the provision references a contract between the DOEA and the eligible entities, but on Line 151, the reference is to a contract between the AHCA and the provider. The bill should be consistent and since the AHCA is the lead agency for Medicaid and the SMMC-LTC, the contracting entity should be the AHCA.

VII. Related Issues:

The bill extends and potentially expands an existing long-term care services program separate from the SMMC-LTC program in an environment where the Legislature has sought to combine similar programs and eliminate waivers and carve outs. The SMMC-LTC program is expected to have an enrollment of over 90,000 once fully implemented while the PACE program currently has less than 800 enrollees statewide.

VIII. Statutes Affected:

This bill creates the following section of the Florida Statutes: 430.54.

IX. Additional Information:

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

None.

B. Amendments:

None.

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