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:	SB 1544
INTRODUCER:	Senator Albritton
SUBJECT:	Elderly Care
DATE:	February 3, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1544:

- Creates s. 409.9022, F.S., to allow an applicant for Medicaid services to exempt the value of his or her life insurance policies if the applicant collaterally assigns the face value of the life insurance policy to the State for an amount that is not greater than the amount of Medicaid benefits to be provided to the applicant.
- Amends s. 409.979, F.S., to provide additional clarity for individuals on the Medicaid long term care managed care waitlist regarding the likelihood that he or she will be eligible for services through the program.
- Amends s. 430.04, F.S., to require the Department of Elder Affairs (DOEA) to develop, and adopt by rule, a tool for comprehensive assessment of long-term-care supports and services needed by family and friend caregivers for elderly and disabled adults.
- Amends s. 430.205, F.S., to allow a community-care-for-the-elderly service provider to dispute a referral from protective investigations of an elderly adult determined to be in need of services or to be the victim of abuse.

The bill is effective July 1, 2020.

II. Present Situation:

Statewide Medicaid Managed Care

The Statewide Medicaid Managed Care (SMMC) program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all

health care services, rather than various entities.[1] The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds.[2] Eligibility for the SMMC program is determined by the Department of Children and Families (DCF).[3]

Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees. The Long-Term Care Managed Care (LTC) Program provides services to frail elderly or disabled Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home.

Implementation of the LTC Program required approval by the federal Centers for Medicare & Medicaid Services (CMS) by virtue of 1915(b) and (c) waivers submitted by the AHCA. The waivers were approved on February 1, 2013, and authorized the LTC Program to operate effective July 1, 2013, through June 30, 2016.[4] Initial enrollment into the LTC Program began August 1, 2013.

Long-Term Care Program

The LTC Program provides long term care services, including nursing facility and home and community based services, to eligible Medicaid recipients.

Federal law requires state Medicaid programs to provide nursing facility services to individuals, age 21 or older, who are in need of nursing facility care.[5] States are prohibited from limiting access to nursing facility services, but the provision of home and community based services is optional.[6] Home and community based services in Florida are delivered through a federal 1915(c), home and community based services waiver.[7] The waiver establishes that home and community based LTC services are available to qualified recipients, subject to an enrollment cap. As such, the LTC program is managed based on a priority enrollment system and a waitlist for individuals who are not high-priority clients. Delivery of home and community based services to eligible recipients is dependent on the availability of annual funding.

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[1] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.
[2] Section 409.963, F.S.
[3] *Id.*
[4] Letter from U.S. Department of Health and Human Services, Disabled and Elderly Health Programs Group to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (February 1, 2013), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited Jan. 31, 2020).
[5] Medicaid.gov, *Nursing Facilities*, available at https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html (last visited Jan. 31, 2020).
[6] *Id.*
[7] Section 409.906(13), F.S.

As of December 31, 2019, there were 116,507 individuals enrolled in the LTC Program, including 65,822 individuals enrolled in the home and community based services portion of the LTC Program, and 50,685 individuals receiving nursing facility services.[8]

Long-term care managed care plans are required to, at a minimum, cover the following:

- Nursing facility care;
- 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;
- Occupation therapy;
- Speech therapy;
- Respiratory therapy;
- Physical therapy;
    - Intermittent and skilled nursing;
    - Medication administration;
    - Medication Management;
    - Nutritional assessment and risk reduction;
    - Caregiver training;
    - Respite care;
    - Transportation; and
    - Personal emergency response systems.[9]

LTC Program Eligibility

To be eligible for the LTC Program, an individual must:

- Be age 65 or older and eligible for Medicaid, or age 18 or older and eligible for Medicaid by reason of a disability;
- Have annual income at or below 222 percent of the federal poverty level (FPL);[10] and,
- Be in need of nursing home care, as determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program.[11]

In addition, an individual seeking Medicaid eligibility must demonstrate that he or she meets limits on personal assets. Both federal and state law set parameters for Medicaid LTC eligibility

[8] Agency for Health Care Administration, *SMMC LTC Enrollment by County/Plan Report* (as of December 31, 2019), *available at* http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 31, 2020).
[9] Section 409.98, F.S.
[10] This equates to $28,327 for an individual and $38,273 for a family of two. For 2020 FPL standards, see U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2020* (January 8, 2020), *available at* https://aspe.hhs.gov/poverty-guidelines (last visited Jan. 31, 2020).
[11] Section 409.979(1), F.S.

based on personal property, such as a home or vehicle, and on financial assets, such as bank accounts, stocks and bonds, and life insurance policies.[12] Life insurance policies with a cash value greater than $1,500 may not be retained by individuals seeking Medicaid eligibility. Generally, assets above certain cash thresholds must be divested at least 60 months prior to a period of Medicaid eligibility.[13]

When determining the need for nursing facility care, the DOEA considers the nature of the services prescribed, the level of nursing or other health care personnel necessary to provide such services, and the availability of and access to community or alternative resources.[14] Imminent risk of nursing home placement can be evidenced by the need for medical observation throughout a 24-hour period and the need for care performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional. An individual at risk of nursing home care requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation.[15]

LTC Program Enrollment

The DOEA administers programs and services for elders through 11 Area Agencies on Aging (AAAs), which also operate Aging and Disability Resource Centers (ADRCs). The ADRCs provide information and referral services to individuals seeking long-term care services and also screen individuals for eligibility for long-term care services.

The LTC Program enrollment process is administered by the DOEA, the DCF, and the AHCA. An individual in need of services or seeking services must contact the appropriate ADRC to request a screening. The screening is intended to provide the ADRC with information describing the individual's level of frailty. During the screening, the ADRC gathers basic information about the individual, including general health information and any assistance the individual needs with activities of daily living. Based on the screening, the individual receives a priority score, which indicates the level of need for services and reflects the level of the individual's frailty. Using the priority score, the individual is then placed on the waitlist. An individual seeking LTC services may request a rescreening any time his or her circumstances change. In addition, ADRC staff are required to rescreen waitlisted individuals on an annual basis.[16]

The prioritization of the waitlist is not described in statute but rather in administrative rule promulgated by the AHCA.[17] The rule sets five frailty-based levels based on the priority score calculation by the DOEA. The levels rank the individual's level of need in ascending order,

[12] U.S. Department of Health and Human Services, *Financial Requirements – Assets* (last modified October 10, 2017), *available at* https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets.html (last visited Jan. 31, 2020).
[13] 42 U.S.C. §1396p. See also Agency for Health Care Administration, *Medicaid State Plan Attachments – Eligibility Conditions and Requirements*, available at https://ahca.myflorida.com/medicaid/stateplan_attach.shtml (last accessed visited Jan. 31, 2020).
[14] Section 409.985(3), F.S.
[15] Section 409.985(3), F.S.
[16] Section 409.979(3), F.S.
[17] Rule 59G-4.193, F.A.C.

meaning that an individual with a priority score of "1" has very low needs and an individual with a priority score of "5" has very high needs.

When funding becomes available, the frailest individuals are taken off the waitlist first, based upon priority score. The individual must then go through a comprehensive face-to-face assessment conducted by the local CARES staff.[18] After CARES confirms the medical eligibility of the individual, the DCF determines the financial eligibility of the individual. If the individual is approved for both medical and financial eligibility, the AHCA must notify him or her and provide information on selecting a long-term care managed care plan.

Because the waitlist is prioritized, it is highly unlikely that individuals with low priority scores will actually receive services. It is the DOEA's current practice to add any individual who completes the initial needs screening to the wait list, even if he or she has very limited need for services and is unlikely to qualify for services in the near future. This approach may be confusing to individuals with low priority scores, giving the impression that services will become available at some point in time. In practice, only individuals with high priority scores will receive services. Current law stipulates an individual may request a rescreening if his or her circumstances change, which allows individuals with low priority scores the ability to move up the waitlist if need can be demonstrated.

Community Care for the Elderly

The Community Care for the Elderly (CCE) program provides community-based services in a continuum of care to help elders with functional impairments to live in the least restrictive and most cost-effective environment suitable to their needs.[19]

The CCE program provides a wide range of services to clients, depending on their needs. These services include, but are not limited to, adult day care, chore assistance, counseling, home-delivered meals, home nursing, legal assistance, material aid, medical therapeutic services, personal care, respite, transportation, and other community-based services. [20]

The DOEA administers the program through contracts with AAAs, which subcontract with CCE Lead Agencies. Service delivery is provided by 52 Lead Agencies around the state. The CCE program is not a component of Medicaid but rather is funded by a combination of state general

[18] Florida Department of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, available at http://elderaffairs.state.fl.us/doea/cares.php (last accessed Jan. 24, 2020). Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. A registered nurse or assessor performs client assessments. A physician or registered nurse reviews each application to determine the level of care that is most appropriate for the applicant. The assessment identifies long-term care needs, and establishes the appropriate level of care (medical eligibility for nursing facility care), and recommends the least restrictive, most appropriate placement. Federal law also mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through Medicaid waivers.

[19] Section 430.202, F.S.

[20] Florida Department of Elderly Affairs, *2019 Summary of Programs and Services – Section C: State General Revenue Programs* (January 2019), *available at* http://elderaffairs.state.fl.us/doea/sops.php (last visited Jan. 31, 2020).

revenue and client contributions. Clients are assessed a co-payment based on a sliding scale developed by the DOEA.[21]

To be eligible for the CCE program, an individual must be age 60 or older and functionally impaired,[22] as determined by an initial comprehensive assessment and annual reassessments. Primary consideration for services is given to elders referred to the DCF's Adult Protective Services (APS) and determined by APS to be victims of abuse, neglect, or exploitation and in need of immediate services to prevent further harm.[23] Individuals not referred by APS may still receive services, but according to a prioritization which is based upon the potential recipient's frailty level and likelihood of institutional placement. The DOEA is also required to consider an applicant's income when prioritizing services. Those less able to pay for services must receive higher priority than those with a greater ability to pay for services.[24]

III. Effect of Proposed Changes:

Section 1 creates s. 409.9022, F.S., to exempt the cash surrender value of a whole or universal life insurance policy from being considered an asset for the purpose of determining an applicant's eligibility for Medicaid if:

- The applicant:
  - Is in need of services of a licensed nursing facility;
  - Meets the nursing facility's level of care;
  - Does not have an income that exceeds 300 percent of the Supplemental Security Income[25] standard;
  - Owns one or more whole or universal life insurance policies; and
  - Would meet the assets standards for Medicaid eligibility except for the cash surrender value of such policies.
- Collaterally assigns the face value of the life insurance policy to the state for an amount that is not greater than the amount of Medicaid benefits to be provided to the applicant. The assignment:
  - Must be a written agreement submitted to and recorded by the issuing company of the life insurance;
  - Must provide for the issuer to notify the DCF before a potential lapse in the policy;
  - Must be completed and accepted by the DCF as part of the application process before Medicaid benefits may be authorized or provided; and
  - Is void if the application for Medicaid benefits is not approved.

The bill requires that the Medicaid recipient, or his or her guardian or legal representative, must continue to pay premiums on any life insurance policy that is subject to assignment and that such premiums must be deducted from the recipient's income for the purposes of calculating his or her assets.

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[21] *Id.*
[22] Section 430.203(7), F.S.
[23] Section 430.205(5)(a), F.S.
[24] Section 430.205(5)(b), F.S.
[25] Supplemental Security Income (SSI) is a federal income supplement program. It is designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter. SSI is not funded from Social Security taxes.

Upon the Medicaid recipient's death:

- The AHCA is required to file a claim for the death benefit under the policy, up to the costs expended to provide Medicaid services to the recipient, to be remitted to the state.
- The state must pay to the recipient's estate a funeral expense benefit of $7,500 or 5 percent of the policy's face value, whichever is less.
- Any remaining balance of the death benefit must be paid by the issuer of each policy to other beneficiaries under the policy.

The bill deems a transfer of a life insurance policy for less than the net present value of the death benefit within a 60 month period preceding the Medicaid application as an improper asset transfer unless the applicant collaterally assigns the face value of the policy pursuant to the above requirements.

The bill requires the DCF and the AHCA, in collaboration with the OIR, to adopt rules to administer these requirements and allows the AHCA to seek any federal waivers necessary to implement the section.

Section 2 amends s. 409.979, F.S., to specify that ADRC personnel are required to administer Medicaid long term care managed care eligibility screenings annually for individuals with a priority score of 3, 4, or 5. After completing a screening or rescreening, the DOEA is required to place all individuals with a priority score of 3, 4, or 5 on the wait list and individuals with a priority score of 1 or 2 on a registry of interest which must be established and maintained by the DOEA. ADRC personnel must inform individuals who are placed on the registry of interest of other community resources that may be available to assist them and shall inform them that they may contact the ADRC for a new assessment if they experience a significant change in circumstances. Placement on the registry of interest does not prohibit an individual from receiving services, if available. The DOEA must notify an individual or his or her representative when the individual is placed on the registry of interest.

Section 3 amends s. 430.04, F.S., to require the DOEA to develop, and adopt by rule, a tool for comprehensive assessment of long-term-care supports and services needed by family and friend caregivers for elderly and disabled adults. The tool must be used by persons administering state funds for such supports and services in determining eligibility and which supports and services are appropriate for service recipients and their caregivers.

Section 4 amends s. 430.205, F.S., to allow a community-care-for-the-elderly service provider to dispute a referral from protective investigations of an elderly adult determined to be in need of services or to be the victims of abuse by requesting that the adult protective services program negotiate the referral placement of, and services provided to, the adult. If an agreement cannot be reached with the adult protective services program, the program's determination controls.

Section 5 establishes an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1544 may have an indeterminate positive fiscal impact on a Medicaid applicant who is able to receive Medicaid services under the provisions in Section 1 of the bill and who would not otherwise be eligible for such Medicaid services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Lines 246-251 of the bill republish current statutory language requiring vulnerable elderly persons to begin to receive services from the community-care-for-the-elderly services provider within 72 of being referred to the provider by protective investigations. Lines 252-259 create new law that allows the service provider to dispute such referral, however, it is unclear whether the bill would require this dispute to be resolved within the 72-hour time frame established in current law. The bill may need to be clarified on this point.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.979, 430.04, and 430.205.

This bill creates section 409.9022 of the Florida Statutes.

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.