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 Appropriations

BILL:	SB 916
INTRODUCER:	Senator Baxley
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	February 26, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kibbey	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.	McKnight	Kynoch	AP	**Pre-meeting**

I. Summary:

SB 916 codifies the Program of All-Inclusive Care for the Elderly (PACE) in section 430.84, Florida Statutes. First authorized in 1998, the PACE became operational in Miami-Dade County in 2003 but has not been codified in state law. More than 2,000 Medicaid managed care eligible recipients are currently enrolled in PACE organizations in eight counties. The bill:

- Establishes a statutory process for the review, approval, and oversight of future and current PACE organizations.
- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to federal regulations.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS.
- Provides that the AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations.
- Exempts all PACE organizations from the requirements of ch. 641, F.S., which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The bill has no fiscal impact on state revenues or expenditures.

The bill is effective July 1, 2020.

II. Present Situation:

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)[1] that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing mechanism. The model, which was tested through the federal Centers for Medicare and Medicaid Services (CMS) demonstration projects beginning in the mid-1980s,[2] was developed to address the needs of long-term care clients, providers, and payers.

The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which support Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[3]

The PACE is a unique federal/state partnership. The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process; however, the state is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve participants. An approved PACE organization must sign a contract with the federal CMS and the state Medicaid agency.

The PACE is administered by the Department of Elder Affairs (DOEA) in consultation with the Agency for Health Care Administration (AHCA). The DOEA oversees the contracted PACE organizations but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations.[4] The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature through the necessary appropriation of the state matching funds.

A PACE organization must be part of either a city, county, state, or tribal government; a private not-for-profit 501(c)(3) organization; or for-profit entity that is primarily engaged in providing PACE services and must also:

- Have a governing board that includes participant representation;

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[1] Specifically, services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[2] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Jan. 14, 2020).
[3] 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* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Jan. 14, 2020).
[4] *Id.*

- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.[5]

Eligibility and Benefits

The PACE participants must be at least 55 years of age, live in the PACE center service area, meet eligibility requirements for nursing home care, pursuant to a Comprehensive Assessment and Review for Long-Term Care Services (CARES) pre-admission screening, and be able to live in a community setting without jeopardizing their health or safety. The PACE becomes the sole source of services for these Medicare and Medicaid eligible enrollees. Additionally, by electing to enroll in the PACE, the participant agrees to forgo other options for medical services and receive all of their services through the PACE organization.[6]

Under the PACE, 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. In most cases, a PACE organization provides social and medical services in a health center with supplemental services through 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.[7]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[8]

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.[9] The site visit reviews include:

- A comprehensive assessment of an organization's fiscal soundness;
- A comprehensive assessment of the organization's capacity to provide all PACE services to all enrolled participants;
- A detailed analysis of the PACE organization's substantial compliance with all the federal statutory requirements and accompanying federal regulations; and

[5] *Supra* note 2.
[6] *Id.*
[7] *Id.*
[8] *Supra* note 3, at 4.
[9] *See* 42 U.S.C. s. 1395eee(e)(4)(A)(2020).

- Compliance with any other elements the Secretary of the U.S. Department of Health and Human Services (Secretary) or the state's administering agency considers necessary and appropriate.[10]

Review of the PACE organization may continue after the trial period by the Secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.[11] The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.[12]

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven Quality Assurance and Performance Improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. At a minimum, the plan should address the following areas:

- Utilization of services in the PACE organization, especially in key services;
- Participant and caregiver satisfaction with services;
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period;
- Effectiveness and safety of direct and contracted services delivered to participants; and
- Outcomes in the organization's non-clinical areas.[13]

Florida PACE

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida, under the administration of the DOEA operating in consultation with the AHCA.[14] Florida's first PACE organization, located in Miami-Dade County, 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.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed Care (SMMC) program.[15] Participation by the PACE in the SMMC program

[10] *Id.*
[11] *Supra* note 2.
[12] 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* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Jan. 14, 2020).
[13] *Id.*
[14] Chapter 2011-135, s. 24, L.O.F., repealed s. 430.707, F.S., effective October 1, 2013, as part of the expansion of Medicaid managed care.
[15] Chapter 2011-135, s. 24, L.O.F., repealed s. 430.707, F.S., effective October 1, 2013.

is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[16]

Currently, four PACE organizations[17] operate in Florida and provide services to participants within specific zip codes in Broward, Miami-Dade, Charlotte, Collier, Lee, Palm Beach, Sarasota, and Pinellas counties. There are 2,253 individuals enrolled in the four Florida PACE organizations.[18]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day 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 to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. PACE 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 PACE providers in the same geographic region are not 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 PACE center, staffing for key positions, and signed provider network contracts, the AHCA certifies to the federal CMS that the PACE site is ready. At that time, the federal 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.

Enrollment and Organizational Slots

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

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the GAA or through one of the GAA's accompanying implementing or conforming bills.[19] These directives provide specific slot increases or decreases by county or authorization for implementation of a new program. In 2013, Governor Rick Scott

[16] Section 409.981(4), F.S.
[17] *See* the Department of Elder Affairs, Program for All-Inclusive Care for the Elderly http://elderaffairs.state.fl.us/doea/pace.php (last visited Feb. 10, 2020).
[18] Agency for Health Care Administration, Florida Statewide Medicaid Monthly Enrollment Report Program Enrollment by Region (December 2019) available at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 10, 2020).
[19] Chapter 2013-40, L.O.F.

vetoed all county allocations with the exception of Palm Beach County, noting that the state's focus should be on the implementation of the SMMC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition was completed.[20]

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference for the PACE.

Medicaid

Medicaid is the health care safety net for low-income Floridians. 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 CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets are reviewed. Additionally, a personal needs allowance is applied as part of the eligibility determination process.[21] The current standard income limit in Florida for institutional care or services under the home and community based services waiver is $2,313 for an individual and $4,626 for a couple. There is also an asset limit for either category of $2,000 for an individual or $3,000 for a couple.[22]

In Florida, the Medicaid program is administered by the AHCA. The AHCA, however, 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 Services (HCBS) Waiver program, serving individuals with developmental disabilities.

Pursuant to s. 409.985, F.S., the DOEA assesses Medicaid recipients to determine if they require nursing home level of 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;

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[20] Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p. 28, *available at* http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf (last visited Jan. 14, 2020).

[21] The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. *See* Department of Children and Families, *Glossary (Chapter 4600) "Personal Needs Allowance," p. 19,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last visited Jan. 15, 2020).

[22] Department of Children and Families, *SSI-Related Program-Financial Eligibility Standards: January 2019*, http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last visited Jan. 15, 2020).

- 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.

Long-Term Care Managed Care

In 2011, HB 7107[23] was signed into law, increasing the use of managed care plans in Medicaid. The law required both Medicaid LTC services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

LTC Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home 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;
- Therapies, including physical, respiratory, speech, and occupational;
- Intermittent and skilled nursing;
- Medication administration;
- Medication management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response system.

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

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE) within the Florida Statutes. Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget.

Program Creation

The bill authorizes the AHCA, in consultation with the DOEA, to approve entities that have submitted the required application and data to the federal CMS as PACE organizations pursuant to 42 U.S.C. s. 1395eee (2019). Applications, as required by the federal CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must meet the following requirements:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by the federal CMS by the proposed implementation date;
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve;
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date;
- Show evidence of regulatory compliance and meet market studies requirements, if the applicant is an existing PACE organization which seeks to expand to an additional service area; and
- Submit its complete federal PACE application to the AHCA and the federal CMS within 12 months after date of initial state approval. If the organization fails to timely meet this requirement, the state approval of the application is void.

Quality and Reporting

All PACE organizations are required to meet specific quality and performance standards established by the federal CMS. The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and the federal CMS.

The bill exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law that regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

Section 2 provides 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:

Additional private sector providers that meet the criteria to be a Program of All-Inclusive Care for the Elderly (PACE) organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

In subsection (4) of section 430.84, the bill directs the AHCA to oversee and monitor the PACE program by using data and reports that the PACE organizations submit periodically to the AHCA and federal CMS. This subsection requires PACE organizations to meet standards established by the federal CMS. The AHCA is in the process of developing additional state standards for PACE organizations that will allow comparisons and evaluation between the PACE and the Statewide

Medicaid Managed Care Long-Term Care (LTC) program. The bill currently limits the AHCA's oversight to only federal CMS standards. The AHCA has indicated that it may not be able to compare PACE and the LTC managed care program and ensure comparable quality and patient outcomes.[24]

VIII. Statutes Affected:

This bill creates section 430.84 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.

[24] Agency for Health Care Administration, *Senate Bill 916 Analysis* (Nov. 4, 2019) (on file with the Senate Committee on Health Policy).