The Florida Senate

Interim Project Report 2002-136 *November 2001*

Committee on Health, Aging and Long-Term Care Senator Burt L. Saunders, Chairman

LONG-TERM CARE ALTERNATIVES TO NURSING HOMES

SUMMARY

Although Florida has a higher proportion of elders than other states, Florida's elders are healthier, wealthier and are better positioned to provide for their own long-term care needs.

Although Florida is currently in a temporary slowdown in the rate of growth in the elderly, the state is facing a massive increase in the number of the "oldest" of the elderly. By 2020 the number of Floridians who are over 85 years of age will increase by 97 percent.

The current temporary "dip" in the growth rate of the numbers of elderly gives the state the opportunity to put in place a system of community and residential long-term care options, which can reduce the future need for additional nursing home capacity.

Florida has experimented with a variety of models of delivering care to the elderly, and has a strong base of experienced providers of community-based long-term care.

This report makes a number of recommendations regarding oversight and planning for the operations of long-term care services, control of the growth of nursing homes, and evaluation of service delivery models and innovative delivery systems

BACKGROUND

Long-term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. Unlike acute illness, chronic conditions are essentially permanent. Regimens of medical and personal care can sometimes control chronic conditions and the level of disability can often be mitigated through the use of assistive devices and re-training in self-care activities. The presence of disability, however, is not synonymous with the need for long-term care.

Over forty million Americans have a physical or mental disability. Of these, more than twelve million (30 percent) need long-term care, defined as a need for assistance with activities of daily living (activities necessary to live independently such as dressing, bathing, eating, using the toilet, transferring from a bed or wheelchair) and about a third of those with long-term care needs (approximately 4 million people in the community and in institutions) have substantial needs—that is, they need help with three or more activities of daily living. The elderly are much more likely than younger age groups to suffer from disabling conditions and to require long-term care. Almost a quarter of the elderly (6.4 million individuals) have some long-term care need.

Population Aging Dynamics

Life expectancy at age 65 has increased in every industrialized country, particularly in Japan, France, and Canada. The United States has experienced fewer relative gains, although life expectancy in this country now is approximately 5 percent greater at age 65 than it was in 1960. The aging of populations has created challenges in designing adequate and economical long-term care systems for governments worldwide. Increasing life expectancies, coupled with declining birthrates, mean that the proportion of populations that is aged is increasing. According to Congressional Budget Office estimates, U.S. expenditures for long-term care services will continue to rise each year through 2040, due mainly to the aging of the nation's population and the fact that the elderly receive the most long-term care services because they are far more likely to have some kind of functional limitation.

As life expectancy increases, disability becomes a crucial issue. Over the past several years, considerable concern has been expressed that an increase in life expectancy will also be accompanied by an increase in

the number of years that people are disabled and unable to care for themselves. If, on the other hand, increased life expectancy is accompanied by decreased disability, the elderly can lead more autonomous lives. Most recent studies indicate a clear decline in the rate of functional disability among the U.S. elderly population. Although rates of disability declined for both sexes, the most significant decline in disability is in men, with the largest decline in disability being in men over the age of 80.

Florida's Elder Demographics

The 2000 census indicated that, for the first time since the population in the United States has been counted, the population 65 years of age and older did not grow faster than the total population. In Florida, the proportion of the population over 65 declined from 18.3 to 17.6 percent. This decline was caused by a dip in the birthrate in the United States in the late 1920s and early 1930s. This dip will be much more than offset when the "baby boom" generation begins to reach age 65 in 2011, swelling the ranks of the elderly. In addition, more elderly people will reach advanced ages than in the past due to declining mortality rates. These trends will cause the proportion of the elderly in the state's population to rise from the current level.

Florida is home to nearly 3 million individuals over the age of 65. Of the ten places in the U.S. with 100,000 or more population having the highest median ages, five are in Florida: Cape Coral, St. Petersburg, Fort Lauderdale, Hollywood, and Clearwater. Clearwater had the highest median age at 41.8 years. Despite the drop in the proportion of the elderly in Florida's population over the past ten years, the number of Floridians over 85 years old increased by nearly 30 percent to 331,000.

Florida's elder population differs, however, from the elder population in other states in that Florida's elders are, on average, better able to care for themselves than the elderly population of most states, and significantly less disabled than the elderly population of other southern states.

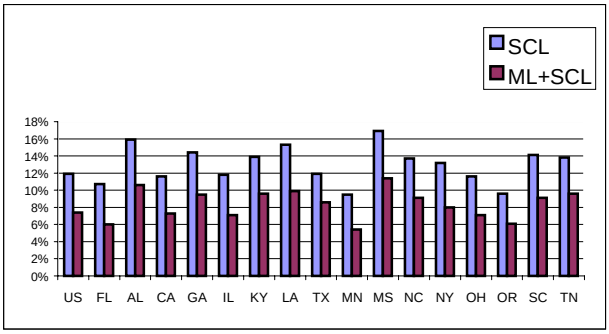

Figure 1. Percent of elderly with a self-care limitation, and percent of the elderly with both a self-care and mobility limitation in the U.S., Florida and selected states (AARP Public Policy Institute and U.S. Census)

Likewise, fewer elderly Floridians live in poverty than the rest of the US. Compared to other southern states, Florida's elderly population is significantly less economically disadvantaged.

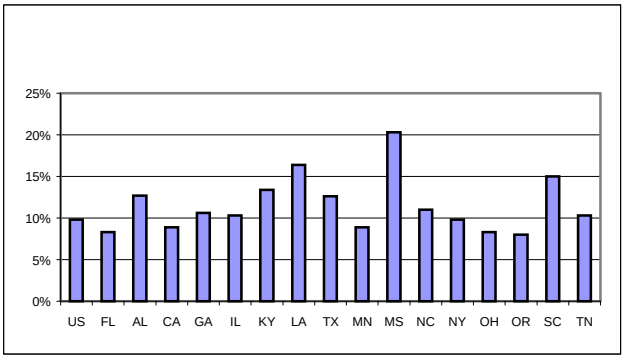

Figure 2. Percent of elderly living below the Federal Poverty Level in the U.S., Florida and selected states (US Census)

A significant factor in the demand for publicly supported long-term care services is the availability of informal caregivers. In Florida, fewer elderly individuals live alone, meaning that elderly Floridians have more opportunities to rely on family and spouses when they need assistance.

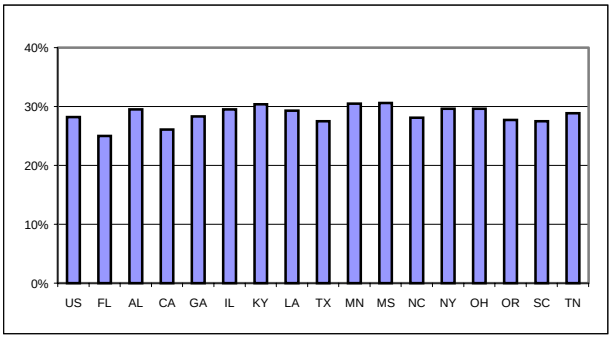

Figure 3. Percent of the elderly living alone in the U.S., Florida and selected states (US Census)

Florida, more than other states, however, faces large increases in the number of "oldest old", i.e., people over age 85. By 2020, Florida will be experiencing the full effect of the aging of its "baby boomer" residents, with an estimated 97 percent growth in its population over the age of 85.

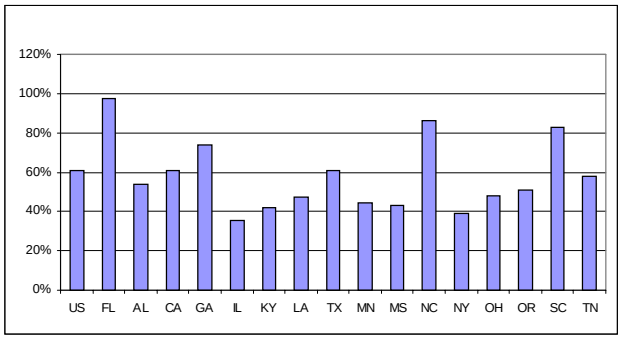

Figure 4. Projected twenty-year increases in population over 85 years of age in the U.S., Florida and selected states (US Census)

The Changing Characteristics of Nursing Home Residents

Changing public attitudes and public policy have produced a shift in the characteristics of nursing home residents away from individuals who need predominantly custodial care and assistance with activities of daily living to individuals who have substantial medical and nursing care needs. This trend was significantly accelerated with passage of the federal Omnibus Budget Reconciliation Act of 1989, which created financial incentives for hospitals to discharge Medicare patients earlier. The result is that an increasing proportion of nursing home admissions are for post-hospital treatment and recovery from acute medical conditions, rather than for the purpose of assisting with activities of daily living.

Who Pays for Long-term Care?

The federal government, through the Medicare program, pays for the majority of health care required by older people, including short-term nursing home care and recuperative home health care. The federal government also funds longer term community care services through the Older American's Act. States, through their Medicaid programs, finance the majority of nursing home bed days (long-term nursing home care), and the home and community-based care that serves as an alternative to nursing home placement.

The shift in hospital payment policy under Medicare has had a dramatic effect on the financing of stays in Florida nursing homes. In the 1980s, the predominant payer source at admission for nursing home care was the individual resident or family. By the end of the 1990s, government and insurance were the primary payers for individuals entering nursing homes.

Payer Source at Admission	**1988**		**1998**	
Medicaid	16,455	26%	18,989	11%
Medicare	16,544	26%	94,155	56%
Insurance/HMO	3,202	5%	41,073	24%
Private/Other	27,650	43%	14,802	9%

(Agency for Health Care Administration data)

There has likewise been a shift in the relative share of payment for nursing home care. Even though Medicare is the payer source at admission, the state Medicaid program finances most of the bed days in Florida.

Payer Source	**1989**	**1998**
Medicaid	63%	66%
Medicare	7%	12%
Insurance/HMO	1%	3%
Private/Other	29%	19%

(Agency for Health Care Administration data)

Nursing Home Capacity in Florida

Florida regulates the number of nursing home beds in the state via the Certificate-Of-Need (CON) program. The CON program is a regulatory process that requires health care providers to obtain state approval before offering new or expanded services. Need for additional nursing home beds is determined in 33 separate market areas. The factors considered in the nursing home CON formula are the elderly population in an area, existing beds per elder population, and the existing occupancy rate in the area.

Florida's CON program for nursing homes expands the supply of nursing home beds to meet demand as determined by the formula. The program ensures that the supply of beds does not greatly exceed demand, which serves to inhibit unbridled expansion of nursing home providers. For many years, the CON program has produced a ratio of nursing home beds to elders and to disabled elders in Florida that has been one of the lowest in the nation.

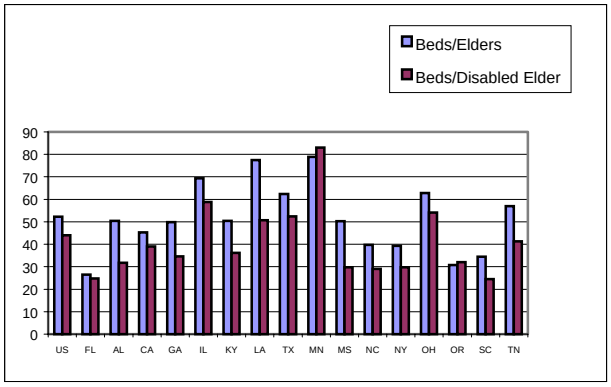

Figure 5. Nursing home beds per 1,000 elders and per 10,000 disabled elders in the U.S., Florida, and selected states (AARP, US Census)

The financial effect of constraints on nursing home bed supply in Florida has been dramatic when compared to other states. Application of other state's nursing home construction rates to Florida's elderly population, payment and occupancy rates indicates that, if Florida had allowed similar construction rates Florida could potentially be experiencing a much greater demand on Medicaid resources.

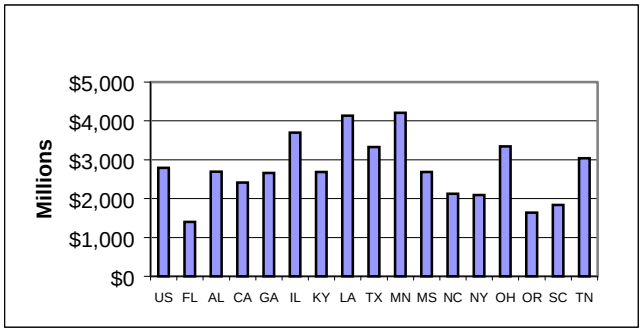

Figure 6. Potential Medicaid nursing home expenditures if Florida had constructed nursing home beds at rates similar to the U.S. and other states, using Florida Medicaid occupancy and payment rates (Computed from data provided by AARP, HCFA and US Census)

The 2001 Legislature imposed a 5 year moratorium on the issuance of new certificates of need for nursing home beds with the exception of non-Medicaid beds in Continuing Care Retirement Facilities. The intent of the moratorium is to enable the state to shift its emphasis from nursing home care to care that is community-based and more in keeping with the wishes of the state's elderly citizens. The Agency for Health Care Administration has imposed the moratorium and is no longer issuing certificates of need for nursing home beds, however, as of October 2001, there were 2,285 beds that had been approved but not yet built.

The Olmstead Decision

In July 1999, the U.S. Supreme Court issued the Olmstead v. L. C. decision. The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In doing so, the Supreme Court observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the state's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

The Court suggested that a state could establish compliance with the ADA if it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated.

METHODOLOGY

Staff conducted a review of pertinent national literature and interviewed staff of the state agencies that operate long-term care programs and staff of groups that represent consumers of long-term care services. Data on the characteristics of the elderly population and specifically the population of nursing home residents were gathered from the United States Census Bureau, Florida State University, the University of South Florida, Florida International University and the University of Florida. Additional data on service

utilization were gathered from the Rand Corporation, AARP, Medicaid, Medicare, the Kaiser Family Foundation, the Urban Institute, and the Robert Wood Johnson Foundation. The National Conference of State Legislatures provided information on long-term care in other states.

FINDINGS

What produces demand for nursing home care, particularly publicly financed nursing home care?

Demand for nursing home care is primarily the product of the level of disability in the older population and the availability of spousal care. Contributing to the level of nursing home utilization are the stringency of criteria imposed for nursing home entrance, the supply of available nursing home beds versus subsidized opportunities for alternative care, and the cost of nursing home care to the public versus the level of government subsidization of that cost.

Florida has a higher proportion of elderly citizens than any other state in the U.S., however, Florida's elderly population is less disabled than the elderly population in other parts of the U.S., and has a greater availability of spousal and family care. Florida has tightly constrained the supply of available nursing home beds. In addition, occupancy rates in Florida nursing homes have declined over the past several years and the state has experienced substantial growth in assisted living facilities.

Florida has experimented with a wide variety of programs that provide alternatives to nursing homes, however, some of these programs are operated only as pilot projects in selected counties in the state.

There is no formal mechanism in Florida's long-term care system to evaluate the relative strengths and weaknesses of the various models of long-term care delivery that have evolved in Florida, and there is no routine and rigorous evaluation of the cost-effectiveness of these programs in assisting people to remain in their homes.

The Long-term Care System in Florida

There is no single state agency in Florida with responsibility for oversight of the long-term care system. Operational responsibility for planning and management of the major long-term care programs is split between the Agency for Health Care Administration (AHCA or Agency), the Department of Elder Affairs (DOEA) and the Department of Children and Family Services. The Agency determines the need for additional nursing home capacity and regulates the operations of these facilities. The Agency operates the Medicaid program, which purchases 66 percent of the nursing home bed days in Florida and has responsibility for the policy control for Medicaid home and community-based waivers. The Department of Elder Affairs operates a variety of state and federally funded programs for the elderly; has rule-making authority for assisted living facilities, adult family care homes, and hospice programs; and operates the Aged/Disabled Medicaid waiver, the Assisted Living Medicaid waiver and the CARES nursing home pre-admission screening programs, under an inter-agency agreement with AHCA. The Department of Children and Family Services establishes Medicaid eligibility.

Alternatives to Nursing Homes

Provision of supportive services to disabled elderly persons can help them to remain in their own homes as an alternative to nursing home placement. Traditionally, the majority of the supportive services needed are assistance with the activities of daily living such as assistance with bathing, dressing, light housekeeping, adult day care, home delivered meals, and home repair (construction of wheelchair ramps, installation of grab bars).

Generally, home and community-based programs require an assessment of an individual's functional deficits and a prescription for the supportive services required to substitute for the individual's ability to provide self-care. The assessment is preformed by a "case manager", who arranges for the services, oversees delivery of the services, and modifies the plan of care as the individual's needs change.

Currently, Florida provides about $265 million in home and community-based services to elderly individuals through a variety of programs. These services are provided by programs operated by the DOEA and AHCA. The programs differ in the characteristics of their target groups and their payment methodologies and rates. Some of these programs are targeted at elderly people who meet nursing home admission criteria and who are in the process of entering a nursing home. Other programs serve people who have lesser levels of disability and who can be assisted in remaining in their homes with the provision of limited supportive services. There are other programs that provide supportive services to lessen isolation, keep elders healthy, or relieve the burdens and stresses placed on families caring for aged family members.

DOEA Programs

Community Care for the Elderly (CCE) is funded by state general revenue and provides a full range of supportive home and community-based care. The program is operated by lead agencies in each county. The lead agencies may be either non-profit organizations or units of local government. Area Agencies on Aging, in 11 planning and service areas, select and supervise the lead agencies. Area Agencies are in turn operated under contract from DOEA. The CCE program serves approximately 42,000 individuals annually at a total cost of $46 million. The average expenditure per person per year in the program is $1,100. Program participants must be frail elderly, but are not required to meet the nursing home level of care. The providers of services are not at financial risk to provide nursing home care or acute health care services. The CCE program had a waiting list as of October 2001, of 15,326 individuals.

The Aging/Disabled waiver is a Medicaid-funded program operated by DOEA under an interagency agreement with AHCA. In general, the waiver uses the same provider network as the CCE program. The wavier serves approximately 14,000 individuals annually at a cost of approximately $62 million. Participants must meet the same disability and financial criteria as Medicaid residents in nursing homes. The average expenditure under the program is about $4,400 per person per year. The Medicaid waiver program had a waiting list, as of October 2001, of 1,745, many of whom are being processed through the Medicaid eligibility system.

Home Care for the Elderly (HCE) is funded by state general revenue, and provides a financial subsidy to encourage the provision of care to individuals who have caregivers to assist them. The subsidy may be used for any purpose. In addition a special subsidy may be authorized to assist with the purchase of a variety of items to assist the older person in remaining in the home, including such items as medications, medical equipment, adult diapers, nutritional supplements and other services. Individuals served in the program must be "substantially similar" to individuals eligible for nursing home care. The HCE program serves 9,000 individuals per year at a cost of $13.5 million. The basic subsidy averages $106 per month. The HCE program had a waiting list, as of October 2001, of 1,664 individuals.

The Alzheimer's Disease Initiative is funded by state general revenue. The program provides: respite services to provide relief to family members who are caring for a person with Alzheimer's disease; memory disorder clinics which provide diagnosis, research, treatment and referral for services; model day care centers to test new care delivery systems; and a research database and brain bank to provide for medical research. The respite component provides services to approximately 3,500 individuals annually at a cost of $7.8 million; memory disorder clinics and model day care provide service to 4,800 individuals at a cost of $4.2 million; and brain banks perform between 60 and 90 autopsies per year at a cost of approximately $130,000. The Alzheimer's Disease initiative had a waiting list, as of October 2001, of 501 individuals.

Older American's Act Services (OAA) are provided using 100 percent federal funds from the federal Administration on Aging. OAA services are provided to individuals age 60 and over, and include home and community-based care, congregate and home-delivered meals, senior center services, health-related services and educational services. Florida provides about $22 million in Older American's Act supportive services per year, and delivered meals valued at $10.5 million. Generally, the provider network for OAA services is the same as for the CCE and Medicaid Waiver programs. As of October 2001, the waiting list for OAA services was 5,178 individuals.

The Assisted Living Waiver provides additional funding to assisted living facilities to reimburse additional supportive care required by individuals who are at risk of nursing home placement. The program is operated by DOEA under an interagency agreement with AHCA. Participants must meet the same eligibility criteria as Medicaid-funded nursing home residents, plus additional functional disability criteria. The assisted living waiver serves approximately 2,700 individuals annually at a cost of $21.5 million. The annul per person cost of care in the program is about $10,000. Assisted Living Waiver providers are assisted living facilities that hold either an extended congregate care license or a limited nursing services license. As of October 2001, there were 1,571 individuals on the waiting list for this program.

The Long-term Care Community Diversion Pilot Project is a managed long-term care pilot program operating in the Orlando and West Palm Beach areas. It was developed as a result of the 1995 recommendations of the Commission on Long-term Care in Florida. The diversion project pays a Health Maintenance Organization a monthly capitated rate which is based on the amount the state would have paid to provide

care in a nursing home. The HMO must provide all necessary long-term care services, including nursing home care if the individual requires such care. The cost of the individual's medical care is not part of the capitation rate and is paid by the Medicare program. Participants must meet nursing home care criteria, plus have additional disabling conditions, and must be able to be safely cared for at home. The program serves 814 individuals annually at a cost of $23 million. The cost per person per year is approximately $28,000.

The Program for All-inclusive Care for the Elderly (PACE) began as a Medicare demonstration model and is now an optional Medicaid state plan service. Under the PACE system, a provider is paid jointly by Medicaid and Medicare for both acute and long-term care, and is fully at risk to provide all medical and long-term care services needed by enrollees. The 1998 Legislature authorized DOEA to develop a single PACE model in Florida, however, promulgation of final rules by federal agencies delayed development activities for Florida's program. DOEA reports that the provider's application has been processed and is now in the federal review process.

The Social Health Maintenance Organization is a demonstration project that will integrate Medicare and Medicaid funding for both acute and long-term care. DOEA received a grant in 1998 from the Federal Health Care Financing Administration to develop the program which was projected to serve up to 70,000 individuals with varying levels of illness and nursing home risk, paying a single monthly rate that will be based on the level of an individual's disability. DOEA reports that development of this project is ongoing, and that staff are currently in the process of analyzing the results of the preliminary evaluation of the Long-term Care Community Diversion Pilot Project, upon which payment rates will be based.

AHCA Programs

The Channeling Medicaid waiver program has been operated by the Miami Jewish Home and Hospital for the Aged since 1985. The Channeling program provides a broad range of home and community-based services and is paid a single daily capitation rate that is negotiated each year with the provider based on the previous year's cost of serving program participants. The program is at risk to provide the level of service necessary to keep the participant safely at home, even if the level of service needed exceeds the rate paid. Channeling is not at risk to provide nursing home care if the enrollee needs such care. Participants must meet Medicaid financial and disability criteria. Channeling serves about 1,110 individuals annually at a per person cost of $13,600 per year. Total Channeling expenditures are about $10.5 million per year.

The Eldercare Program is operated by United Healthcare Corporation in Dade, Broward and Palm Beach Counties. Eldercare provides both the medical and long-term care services needed by enrollees. Enrollment is not limited to the elderly, however, most plan participants are over the age of 65. If a plan member requires placement in a nursing home, Eldercare must pay the cost of the care until the end of the contract period with the state (July of each year). At the end of the contract period, the Eldercare plan may disenroll the individual and Medicaid begins paying for the nursing home stay. Medicaid's payment rate to the Eldercare plan is calculated based on the state's historical payments for medical and nursing home care in the counties in which the plan provides services. The rate is adjusted for the partial risk of providing nursing home coverage. The rates vary from a high of approximately $2,200 per month for an individual with no Medicare to a low of $1,115 for an individual who has full Medicare coverage. The plan serves approximately 3,800 individuals at an annual cost of approximately $56.5 million.

Assisted Living

In general, the term "assisted living" is used for facilities that are not licensed as nursing homes but that provide housing, assistance with activities of daily living, and some nursing care for people who are too frail to live alone, but who are too healthy to need 24-hour nursing care. Generally, assisted living facilities attempt to provide the needed services and supervision in a manner that is as home-like as possible. For frail older persons and adults with disabilities who need some assistance to live independently, or who no longer wish to remain at home, assisted living provides an option for meeting their personal and supportive care needs.

Nationally, the number of assisted living beds is growing at between 15 and 20 percent per year. According to industry estimates, assisted living accounted for 75 percent of the new senior housing constructed in 1998. Since 1992, the number of assisted living beds in Florida has grown from 60,000 to 78,000 beds.

There is considerable variability within the assisted living industry in facility size, pricing patterns, and the level of services provided. Since most assisted living services are privately financed, the nature and

characteristics of facilities tends to be a factor of market conditions and consumer preferences, rather than a factor of government policy. There are no federal standards for assisted living, so regulation of assisted living facilities is a state responsibility. In Florida, assisted living facilities are a regulated in Part III of Chapter 400; all facilities must be licensed, and additional licensure beyond core requirements is available allowing facilities to provide additional nursing services and serve more disabled residents. When a resident requires 24-hour nursing supervision, the resident is not allowed to remain in an assisted living facility, unless the resident is terminally ill and additional care is rendered by a hospice. A facility is not required to retain a resident who requires more care than the facility is able to provide.

CARES

The CARES program (Comprehensive Assessment and Review for Long-term Care Services) is Florida's federally mandated pre-admission screening program for nursing home applicants to ensure that elder and disabled applicants for Medicaid-reimbursed nursing home care are medically appropriate. The CARES program identifies an individual's need for long-term care, establishes an individual's medical eligibility to receive Medicaid funding for long-term care, and recommends the least restrictive and most appropriate placement.

Prior to 1989, the CARES program was operated by the Medicaid program office within the Department of Health and Rehabilitative Services. In 1989, management of the CARES program was transferred to the Aging and Adult Services program office in an attempt to better integrate the nursing home pre-admission screening function with the state entity that managed the states elder services network. When the Department of Elder Affairs was created in 1992, CARES remained at HRS. In 1995, the CARES program was transferred to the Department of Elder Affairs.

Florida has significantly expanded the role and function of the CARES program beyond the certification of need for nursing services required by federal regulations. CARES attempts to provide early identification of individuals who are likely to become Medicaid-funded nursing home residents and encourages diversion of these individuals to community alternative placements by linking the potential resident with DOEA's community services system. Early on, these efforts often met with little success since the traditional home and community-based system had long waiting lists of referrals who, though not in the process of discharge from a hospital to a nursing home, appeared to have similar levels of need. In most cases, referrals from the CARES teams were put on program waiting lists to be assessed and served with other referrals as resources became available.

In 1996, DOEA began planning a pilot CARES program in preparation for implementation of the Long-term Care Community Diversion Pilot Projects in the Orlando and West Palm Beach areas. In the project, CARES staff were out-stationed in specific hospitals that had provided a significant proportion of the prior year's nursing home admissions. These staff were tasked with identifying individuals likely to require nursing home placement and attempting to arrange service packages that would prevent such placement. DOEA required Area Agencies and community service providers to identify and reserve resources to enable these individuals to be served without being placed on the traditional waiting list. This was justified based on the hypothesis that it was useless for the state to be attempting to identify individuals at risk for nursing home placement who could be served in alternatives if no alternative care was made available by the system.

Transitioning People out of Nursing Home

CARES approval for Medicaid payment of nursing home care is based on criteria defined in state rules. An individual may be admitted as a "skilled" resident if the recipient requires services that are medically complex and supervised by a physician. A resident may also be admitted as either "intermediate level I" or "intermediate level II". A resident at intermediate level I is incapacitated mentally or physically and receives extensive health-related care. Intermediate level II care is limited health-related care required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. In Florida, approximately 1/3 of the Medicaid funded nursing home residents are at a skilled level of care; approximately 2/3 of Medicaid funded residents are at intermediate level I. Less than half a percent of Medicaid-funded residents are at intermediate level II.

If CARES staff believe that an individual's stay in a nursing home will be short-term, the team recommends a "temporary nursing home" level of care. In fiscal year 2000-2001, DOEA reports that CARES issued approximately 4,600 temporary level of care recommendations. Department staff report that many of these temporary placements have lengths of stay that resemble permanent placements (for example nearly 60

percent of the temporary placements are in a nursing home for more than 6 months, and nearly 40 percent remain in a nursing home for a year or more). This is due, in part, to a lack of intervention to ensure that the resources of the home and community-based services system are used as soon as the individual is rehabilitated to assist the person in returning home or to an alternative setting as soon as possible.

The 2001 General Appropriations Act, however, provided $3.49 million for the Assisted Living Medicaid waiver program to transition residents in nursing homes at the Intermediate II level of care to assisted living facilities. In implementing this policy DOEA found that there were far fewer individuals at the Intermediate II level of care than anticipated, and therefore began to take a closer look at individuals currently at the "temporary" level of care, but who had nonetheless remained in nursing homes. As of October 1, 2001, DOEA has been able to arrange alternative placements for 84 individuals. All of the residents moved to the assisted living waiver program had been in a nursing home at least 60 days; the average length of stay prior to transition was 263 days. The full time equivalent of these 84 individuals in nursing homes, at Florida's average per diem rate would have been approximately $3 million. The cost of care in the Assisted Living Waiver for this population for a year will be $820,000.

Staff at DOEA report that several factors must be in place in order for an individual who has been in a long-term nursing home placement to move to a less intense care setting. First, someone must be available to follow up on the resident immediately after the nursing home placement, offer an alternative, and take responsibility for working with the individual, his family and the facility to prepare a transition plan. Second, an alternative placement resources (either in a less intensive assisted living facility or one of the state's community care programs) must be available. Third, the state must ensure that dedicated funds are available to support the cost of the alternative placement.

Summary

Florida is in a unique position. Although Florida has a higher proportion of elders than other states, Florida's elders are healthier, wealthier and are better positioned to provide for their own long-term care needs. Florida has experimented with a variety of models of delivering care to the elderly, and has a strong base of experienced providers of community-based care. Florida has constrained its nursing home growth, and currently has a moratorium on issuing certificates of need for additional beds, with the intent of investing in alternatives to nursing home care. Florida has instituted a number of enhancements to its nursing home pre-admission screening system that give the state the potential to use these staff to provide early identification and intervention for elderly individuals who are in need of long-term care services.

Florida statutes clearly articulate the intention of the Legislature to assist the elderly in avoiding costly institutional placement. Operationalizing the vision has, however, been difficult. The economic forces that drive the relative resource demands of nursing home care and alternatives have not been addressed holistically, and the relative strengths and weaknesses of the various programs models, delivery systems and payment structures in programs that serve as alternatives to nursing homes are not regularly evaluated to determine their effectiveness in reducing the need for nursing home care.

Although Florida's nursing home alternative programs serve similar target populations (people at some level of risk for nursing home placement) the system is a "patchwork quilt" which exhibits substantial geographic variation in terms of coverage, provider network, payment rates, payment methodology, and whether or not the programs are required to pay for nursing home placement if they are unsuccessful in providing an alternative.

Lessons learned in pilot projects are not shared between or applied in programs providing similar services. For example, the Eldercare project operated in southeast Florida has a robust quality improvement program to lessen adverse incidents in its frail population; similar quality improvement systems have not been adopted in other alternative programs. The experience of Miami's Channeling program in managing conflicts of interest and self-referral in home care programs has not been applied to DOEA's waiver programs. Payment rates in capitated programs are not evaluated in terms of actual provider expenditures for long-term care services and are not evaluated in comparison to the state's expenditures for similar services in the fee-for-service waiver and CCE programs. Service cost and utilization patterns are not evaluated and service cost data have not been compared across programs serving similar populations.

Although Florida is currently in a temporary slowdown in the rate of growth in its elderly population, by 2020 the number of Floridians who are over 85 years of age will increase by 97 percent. Despite the fact that

Florida's elderly tend to have fewer functional deficits, the sheer growth in the numbers of the "oldest" elderly will create additional demands on the long-term care delivery system. These demands will be met humanely and economically only by careful planning and broad application of knowledge gained from years of experience and experimentation in the delivery of eldercare services.

RECOMMENDATIONS

By December 1, 2002, Medicaid and DOEA should propose a plan to the Legislature to reduce the Medicaid nursing home caseload. DOEA and Medicaid should set a goal as a percentage of Medicaid-funded bed days which will be reduced, and propose changes to the long term care system necessary to achieve the reduction such as improving the nursing home preadmission screening process, enhancing diversion programs, enhancing program coordination, realigning existing programs or other strategies which will achieve the goal.

As part of development of the plan, executive agencies responsible for the administration of Florida's alternatives to nursing homes should evaluate the relative strengths and weaknesses of the programs and the extent to which the programs are achieving the goals of the state in diverting people from nursing homes. Agencies should formulate recommendations to the Legislature to ensure availability of effective programs for people at risk of being placed in nursing homes.

An executive branch mechanism should be established to oversee policy and operations of all long-term care services on an ongoing basis. Specifically, this entity should perform evaluations of the effectiveness and costs of all state long-term care programs to ensure that Florida is meeting the needs of the elderly in the most efficient manner possible. The entity should collect data regarding the current and projected needs for long-term care and make plans for future service delivery systems. The entity should make recommendations to the Legislature and executive agencies as to the structure and operation of long-term care programs, the entrance criteria for long-term care programs, and the design and positioning of programs to meet future long-term care needs.

The preliminary experience of the Department of Elder Affairs in re-evaluation of individuals classified as "temporary" placements indicates that there may be considerable numbers of Medicaid residents in nursing homes who, although they meet admission criteria, may be able to be cared for in less expensive settings with the proper supports. The Legislature should authorize a program to provide services assisting Medicaid recipients in nursing homes who have the potential to be served in less institutional and less expensive settings to move into such settings. Development of this program would require giving DOEA the ability to provide case management and supportive services while individuals are in nursing homes, and a dedicated source of funds to place these individuals in alternative settings.

The Legislature should require a thorough re-evaluation of Florida's level of care criteria for admission to nursing homes.

Florida should continue to closely constrain construction of additional nursing home capacity and, as the elderly population grows, construct beds only if there is an affirmative demonstration that additional alternative capacity can not meet the demonstrated need.

Florida should continue to expand models of care that integrate acute and long-tem care, however, state agencies should closely monitor the impairment levels of participants, service utilization, quality, and cost in these programs, in comparison to services that are delivered in community and nursing home settings. The agencies that are administratively responsible for oversight of these programs should submit regular evaluation reports to the Legislature.

The state should emphasize programs that support family-delivered care and that capitalize on and maximize individuals' self-care abilities.