Table of Contents

Executive Summary ........................................................................................................... ii
Introduction ....................................................................................................................... 1
Section I:    Assessments and Rate of Diversion ............................................................ 2
Section II:   CARES Program Staffing ............................................................................. 3
Section III:  Nursing Home Transitions ......................................................................... 4
Section IV:  Barriers to Placement in Less Restrictive Settings ...................................... 5
Section V:   Statutory Changes ....................................................................................... 7
Section VI:  Status of 2011 Recommendations .............................................................. 8
Section VII: Recommendations for 2012 ...................................................................... 10
Appendix A: CARES Planning and Service Area Map ................................................... 11
**Executive Summary**

Section 409.912(14)(e), Florida Statutes, requires the Agency for Health Care Administration (AHCA) to submit a report to the Legislature each year regarding the operations of the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program. CARES, which is housed in the Department of Elder Affairs (DOEA), is Florida’s federally mandated pre-admission screening program for nursing facility applicants seeking Medicaid funding for their care. In addition to pre-admission screening, the CARES Program determines medical eligibility for individuals applying for Medicaid-funded home and community-based services.

This tenth annual report to the Legislature covers the period from July 1, 2010, to June 30, 2011, and examines each area required by statute: the rate of diversion to community alternatives, the CARES program staffing, barriers to placement in less-restrictive settings, and recommendations for improvements to the CARES Program. In addition, the recommendations made in the ninth annual report covering state fiscal year (SFY) 2009-2010 are presented, along with a brief update on the status of each.

For 2012, the following recommendations are made to the Legislature:

1. AHCA, DOEA, and the Department of Children and Families (DCF) should work together to evaluate fiscal and workload impacts of transitioning the existing Institutional Care Program (ICP) recipient population into the new managed long-term care system. This evaluation should review the medical and financial eligibility process as well as the impact on demand for CARES assessments.

2. CARES, along with its partner agencies, should explore options for developing data collection abilities that will allow for the electronic transmission and physician signature of the medical certification form or AHCA MEDSERV-3008. Currently, this form is used to capture complete medical information regarding all Institutional Care Program (ICP) applicants so that CARES may make a level of care determination. In addition to electronic transmission of medical certification information for ICP applicants, modernization of data collection and transfer for the AHCA MEDSERV-3008 should be coordinated with nursing facility and hospital providers to improve data transmission and information sharing during care transitions.

3. DOEA and AHCA should work together to transition all enrollment, disenrollment and month-to-month plan change functions for the Nursing Home Diversion waiver program from the CARES Program to the enrollment broker that will be contracted to handle these functions under the new Statewide Medicaid Managed Care (SMMC) program’s long-term care component. This is essential to replace existing manual and paper driven processes with standard enrollment broker electronic and telephonic capabilities.

4. DOEA should identify existing resources, or submit a legislative budget request, for CARES to procure and implement a single statewide database that would permit hospital discharge planners, CARES staff and nursing facility staff to determine whether clients had been properly screened for mental illness or mental retardation as required by the Preadmission Screening and Resident Review (PASRR) process. A single statewide PASRR database would achieve greater compliance with the Centers for Medicare and Medicaid Services reporting requirement for Medicaid reimbursement. This will also replace current paper driven processes and manual data entry by CARES staff which is essential to ensure an efficient and compliance driven PASRR Program for the State of Florida.
Introduction

Section 409.912 (14)(e), Florida Statutes, requires the Agency for Health Care Administration (AHCA) to submit a report each year to the Legislature describing the operations of the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program. The report must describe:

1. *Rate of diversion to community alternative programs;*

2. *CARES Program staffing needs to achieve additional diversions;*

3. *Reasons the program is unable to place individuals in less-restrictive settings when such individuals desired such services and could have been served in such settings;*

4. *Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and*

5. *Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.*

This is the tenth annual report prepared by AHCA, in cooperation with the DOEA, regarding the CARES Program. CARES is Florida’s federally mandated pre-admission screening program for nursing home and waiver applicants seeking Medicaid funding for their care. The functions of the CARES Program include identification of an individual’s need for long-term care, determination of the individual’s medical eligibility to receive Medicaid funding for long-term care, and recommendations for the least restrictive and most appropriate placement for the individual. AHCA retains administrative oversight of the Program through an interagency agreement with the DOEA. The DOEA operates the CARES program including oversight of 19 CARES offices throughout the State.

The period of study for this report is SFY 2010-2011 (July 1, 2010 to June 30, 2011). Extensive background information and operational details about CARES have been reported in previous reports and are not reiterated here.
Section I: Assessments and Rate of Diversion

Medicaid requires an assessment or comprehensive evaluation of an individual's psychological and emotional well-being, physical health, financial resources, social functioning and environmental safety for the purpose of determining the individual's need for Medicaid reimbursement of long-term care services. CARES assessments are completed in a variety of locations, such as private residences, hospitals, nursing facilities, jails, etc., prior to admission to a nursing facility. In the table below (entitled Total of Assessments), the number of CARES assessments equals the number of evaluations CARES performs statewide during the fiscal year.

Continued Residency Reviews (CRR) are federally mandated re-assessments conducted by CARES staff on nursing facility residents in Medicaid designated beds [42 Code of Federal Regulation 456.360]. These re-assessments are conducted on a continuous basis throughout the year to verify that residents continue to meet level of care. In the table below, CRRs are listed as the number of CRRs performed statewide by CARES during the fiscal year.

New Admission Reviews are performed by CARES staff, as required by Chapter 409.912(14)(d), Florida Statutes. CARES staff counsel and assess a sample of Medicare new nursing facility admissions to provide these individuals with information on alternatives to nursing facility long-term care. The intent of this process is to avoid unnecessary conversion to Medicaid subsidized long-term care nursing facility placement after Medicare coverage for nursing facility care ends. The number of new admission reviews is not a statewide total but is the number of new admission reviews performed in several pilot areas. These pilot areas are CARES Planning and Service Areas (PSA) 1 in Pensacola; PSA 2A in Panama City; PSA 2B in Tallahassee; and PSA 3A in Gainesville.

### Total of Assessments
#### SFY 2009-2010 and SFY 2010-2011

<table>
<thead>
<tr>
<th>Type of Assessments</th>
<th>SFY 2009-2010</th>
<th>SFY 2010-2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARES Assessments</td>
<td>96,458</td>
<td>98,036</td>
<td>1,578</td>
</tr>
<tr>
<td>Continued Residency Reviews</td>
<td>8,591</td>
<td>9,891</td>
<td>1,300</td>
</tr>
<tr>
<td>New Admission Reviews (Pilot Areas Only)</td>
<td>168</td>
<td>192</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total Assessments</strong></td>
<td><strong>105,217</strong></td>
<td><strong>108,119</strong></td>
<td><strong>2,902</strong></td>
</tr>
</tbody>
</table>

Diversion occurs when a person is found to meet nursing home level of care criteria through CARES assessment and successfully remains in a community-based setting through CARES staff intervention. If the person remains in the community for at least a 30 day period after receiving a nursing home level of care, CARES considers the placement a “diversion.” These diversions include two groups of individuals: 1) Individuals who have transitioned from a nursing facility to a community-based setting; and 2) Individuals who resided in the community and have been diverted from nursing facility placement after receiving a nursing home level of care. For the purposes of calculating a rate of diversion, these two groups are combined. In SFY 2010-2011, of the individuals assessed who were candidates for diversion, 21,953 were diverted or transitioned from nursing facility care resulting in a rate of diversion of 39.2 percent. This is 9.2 percent above the targeted diversion rate of 30 percent established in the DOEA’s legislatively approved Long Range Program Plan.
During SFY 2010-2011, CARES staff reported completing a total of 108,119 assessments, an increase of 2,902 in the number of assessments reported in the previous fiscal year (N=105,217). The total number of assessments includes individuals seeking nursing facility placement, persons already living in nursing facilities, individuals applying for and served by home and community-based service waiver programs, those in assisted living facilities, and persons hospitalized in acute care hospitals who are projected to require long-term care. Of the 108,119 assessments conducted, approximately 52 percent (N=55,955) were performed for persons who were candidates for either diversion from nursing facility placement or transition from a nursing home to the community.

### Comparative View of Assessments and Diversions SFY 2009-2010 and SFY 2010-2011

<table>
<thead>
<tr>
<th></th>
<th>SFY 2009-2010</th>
<th>SFY 2010-2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Assessments Conducted</td>
<td>105,217</td>
<td>108,119</td>
<td>2,902</td>
</tr>
<tr>
<td>Number of Candidates for Diversion</td>
<td>61,499</td>
<td>55,955</td>
<td>(5,544)</td>
</tr>
<tr>
<td>Number of Persons Diverted</td>
<td>21,069</td>
<td>21,953</td>
<td>884</td>
</tr>
<tr>
<td>Percentage of Candidates Diverted</td>
<td>34%</td>
<td>39%</td>
<td>5%</td>
</tr>
</tbody>
</table>


As the number of Medicaid beneficiaries enrolled in home and community-based services programs increases each year, the number of federally required annual reassessments also increases. For Medicaid waiver programs, both the lead agency and Nursing Home Diversion case managers conducted annual reassessments for enrolled clients in SFY 2010-2011.

### Section II: CARES Program Staffing

As of SFY 2010-2011, the CARES Program staffing included 273.5 Full-Time Equivalent (FTE) positions and 49.5 Other Personnel Service (OPS) positions for a total of 323 statewide positions. Between SFY 2005-2006 and SFY 2010-2011, the demand for CARES assessments or medical eligibility determinations increased by 24 percent with increases in both demand for home and community-based waiver assessments and facility based assessments.

Because of the significant increases in demand for facility based and home and community-based assessments, the 2010 Florida Legislature appropriated $1,453,474 to establish an additional 24 CARES FTE positions beginning in SFY 2010-2011. As a result of the staffing increase, the CARES Program was able to meet demand for the 108,119 assessments completed by CARES Program staff in SFY 2010-2011. Sufficient CARES Program staffing is essential to both divert individuals from nursing home placement and transition current nursing home residents to the community, if they can be safely served in a community setting. Adequate CARES Program staffing is also essential to ensure completion of federally mandated Continued Residency Reviews as well as nursing home Pre-Admission Screening and Resident Review (PASRR) activities.
Section III: Nursing Home Transition

Nursing Home Transition is defined as the voluntary transfer of an eligible Medicaid individual who has resided in a nursing home for a minimum of 60 days, to a community setting such as a family member’s home, individual’s apartment or home, an assisted living facility, or adult family care home. A person would be considered successfully transitioned if he or she were able to live in the community for a minimum of three months following the date of transition.

In the past, transition programs have been prompted by several factors including the cost of Medicaid nursing home reimbursement versus the typically lower cost of home and community-based care and consumers’ overwhelming preference to remain in a community-based setting versus nursing home care.

DOEA has a history of transitioning individuals from nursing home to community-based settings as listed below.

February 2009, through June 2011: The Department’s efforts have resulted in the transition of 2,392 individuals from nursing home placement. Of these transitioned individuals, 2,270 transitioned to DOEA operated and Medicaid funded home and community-based waiver programs. The current transition effort began after the 2009 Florida Legislature authorized the transfer of Medicaid funds from the nursing home line item to five home and community-based waiver programs for the purpose of transitioning eligible nursing home residents to the community. Three of the five home and community-based waiver programs are operated by the Department of Elder Affairs, another by the Department of Children and Families (DCF), and another by the Department of Health. The CARES Program works closely with each agency to support the transition of eligible individuals into home and community-based settings. Both the 2010 and the 2011 Florida Legislatures have continued to authorize the transfer of funding to support nursing home transition activities.

August 2005, through June 2006: DOEA/CARES Program staff identified approximately 520 potential residents for transition using the program named Passport to Care. Of this total, 112 residents successfully transitioned back to their homes with services from the Aged/Disabled Adult Waiver, and 167 residents successfully transitioned to an assisted living facility with services from the Assisted Living for the Frail Elderly Waiver.

September 2001 through November 2003: DOEA/CARES Program staff identified approximately 512 potential residents for transition. Of this total, approximately 386 residents were successfully transitioned to assisted living facilities throughout the state. An evaluation of this transition program was conducted by the Florida State University, Pepper Institute on Aging and Public Policy. The report dated April 18, 2003, stated that this program saved approximately $3,573,828 in combined state and federal Medicaid funds.
Section IV: Barriers to Placement in Less Restrictive Settings

Section 409.912(14)(e)(4), Florida Statutes, requires AHCA to track barriers to community placement. There are barriers to individuals being diverted from initial placements in nursing facilities and barriers to those who desire to transition out of nursing facilities and return to community living. These barriers include the limited availability of appropriate assisted living facilities and affordable housing, caregiver-related barriers, barriers due to eligibility issues, refusal-related barriers, and barriers caused by waiting lists.

During SFY 2010-2011, 11,539 individuals could not be diverted or transitioned to Medicaid-funded community-based care due to reasons documented by CARES staff. Because these reasons may change over time, CARES staff offer reassessments when needed to reevaluate individuals' ability to transition from nursing facilities to community-based care.

Comparison Between CARES Diversion Barrier Report SFY 2009-2010 and SFY 2010-2011

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Number of Persons Not Diverted from NF*</th>
<th>Number of Persons Not Transitioned Out of NF*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SFY 2009-2010</td>
<td>SFY 2010-2011</td>
</tr>
<tr>
<td>Eligibility Issues</td>
<td>10,707</td>
<td>9,607</td>
</tr>
<tr>
<td>Refused Services</td>
<td>760</td>
<td>1,447</td>
</tr>
<tr>
<td>Assisted Living Unavailable</td>
<td>82</td>
<td>64</td>
</tr>
<tr>
<td>Waiting List</td>
<td>207</td>
<td>81</td>
</tr>
<tr>
<td>Caregiver Unavailable</td>
<td>186</td>
<td>60</td>
</tr>
<tr>
<td>Other</td>
<td>114</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>12,056</td>
<td>11,287</td>
</tr>
</tbody>
</table>

Source: DOEA CARES CRR Transition Barriers and Diversion Barrier Reports, 07/01/2009 through 06/30/2010 and 07/01/2010 through 06/30/2011.

* Nursing Facilities

Further explanation of specific barrier categories is provided below.

Eligibility Issues:

Although it might not technically be labeled as a ‘barrier,’ the most frequently cited reason an individual cannot go into Medicaid-funded community-based care is because they are not eligible for Medicaid. Many people who apply for services have income or assets that exceed Medicaid eligibility thresholds. A second factor is related to the appropriateness of community services when an individual’s health and/or functioning have declined to a level that makes it unsafe for him or her to remain in or return to the community. For many individuals, home and community based services have the ability to delay nursing facility placement for months or years. When home and community based services are unable to adequately meet an individual’s need for health care, supervision or safety, the individual may require care in a nursing facility setting. CARES professional staff consider the health, safety, and welfare of individuals when making recommendations for community placement.
Medicaid financial eligibility determinations sometimes take more than 30 days in some areas of the state. Modernization of the Department of Children and Families’ eligibility process is reducing many of the time delays. Many of the delays are due to the need for documentation of financial eligibility required to ensure that individuals receiving Medicaid do not have income and assets that could finance their long-term care service needs. This extensive information gathering process can cause some families to favor placement in institutional settings, such as nursing facilities, where Medicare will pay short-term expenses or facilities are willing to provide care until Medicaid eligibility is established and retroactively approved.

**Refusal Issues:**

Another reason individuals do not obtain community-based care is that they choose nursing home care instead. Indeed, although CARES effectively works to divert or transition individuals to the least restrictive settings, individuals frequently exercise their right to choose between nursing home and community-based care. This choice is documented as a refusal to least restrictive placement. Refusals may be due to a client decision that a nursing facility best meets their needs, client inability or reluctance to wait for home and community-based services to be arranged, and client or responsible party/caregiver refusal of community-based options. Families or caregivers are frequently in crisis by the time CARES is contacted and, consequently, may be less receptive to exploring community placements.

**Waiver Funding Issues:**

During the past year the number of individuals requesting home and community-based waiver services increased. Individuals residing in the community who contacted and were assessed by CARES, were placed on waiting lists as needed until waiver vacancies arose due to attrition. The Aged Disabled Adult Waiver Program received a specific increase to its base waiver appropriation in SFY 2010-2011 to serve additional clients, however both the Aged Disabled Adult Waiver and the Nursing Home Diversion Program (NHD) received a slight increase in appropriation to account for the annualization of existing waiver clients who had transitioned from nursing facilities in the prior fiscal year.

In contrast to applicants residing in the community, applicants requesting community-based services who lived in nursing homes were generally able to transition to community-based programs without going on a waiting list. During SFY 2010-2011, the NHD Program, the Aged/Disabled Adult (ADA) Waiver, and the Assisted Living for the Frail Elderly (ALE) Waiver were all open for transition of eligible individuals from nursing facilities to community placement. This was due to the continued nursing home transition funding authorized by the 2010 Florida legislature allowing for the transfer of funding from the nursing home line item to the selected Medicaid Waiver program.

**Unavailability of Assisted Living Facilities:**

Another reason for difficulties locating placement is lack of adult family care homes and assisted living facilities willing to accept Medicaid recipients. Some areas of the state do not have enough assisted living facilities to meet placement demand. This is especially true in rural counties. In addition, Florida has a limited number of licensed adult family-care homes, which also serve as residential alternatives to nursing facilities.
Section V: Statutory Changes

AHCA and DOEA recommend that AHCA continue to have the authority to transfer funding from the Medicaid nursing facility line item to home and community-based waiver programs to support appropriate transition of Medicaid eligible individuals from nursing facilities. In past years, this funding mechanism has enabled CARES staff to transition a significant number of individuals from nursing facilities back to community-based settings. DOE and AHCA are working together to identify ways to ensure that alternative services are accessible and meet both the immediate and long-term care needs of transitioned individuals and their families.
Section VI: Status of 2011 Report Recommendations

The 2011 CARES Report made several recommendations for changes needed to enable more of Florida’s elders to move from nursing homes to less-costly, less-restrictive home and community-based settings or to be diverted from placement in nursing facilities. Each recommendation is presented below, along with a brief report regarding current activities or status of implementation:

1. The CARES Program, along with its partner agencies, should explore options for developing data collection abilities that will allow for the electronic transmission and signature of the medical certification form or AHCA MEDSERV-3008. Currently this form is used to capture complete medical information regarding all Institutional Care Program applicants so that CARES may make a level of care determination. It must be signed and dated by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) per the Florida Administrative Code, Chapter 59G-9.060.

Status: The DOEA and AHCA continue to explore opportunities to both accept electronic signatures on the 3008 and modernize the medical certification process to an electronic, Web-based format that would include electronic signature capability. This includes working with partner agencies and relevant provider associations to identify information technology related funding that can support both the required system development and necessary improvements to data collection and transmission abilities of both CARES and providers.

2. The Agency, DOEA, and DCF should work together to streamline eligibility for Institutional Care Program (ICP) applicants. Specifically, DOEA should work with DCF to evaluate recent changes in the financial and medical eligibility processes. This evaluation should review eligibility determination timeframes when an applicant directly applies for medical and financial eligibility at the same time as well as impact on demand for CARES assessments.

Status: The DOEA, AHCA and DCF continue to meet and work together to resolve eligibility issues for ICP applications including identifying steps to allow for analysis of Medicaid ICP application data and CARES level of care determination data.

3. The CARES Program should work with the AHCA to create a single statewide database that would permit hospital discharge planners, CARES staff and nursing facility staff to determine whether clients had been properly screened for mental illness or mental retardation as required by the PASRR process. By creating a single statewide PASRR database, greater compliance with the Centers for Medicare and Medicaid Services reporting requirement for Medicaid reimbursement would be achieved.

Status: CARES is actively researching system requirements, and the DOEA continues to meet with AHCA to pursue a single statewide database that would permit hospital discharge planners, CARES staff and nursing facility staff to determine whether clients had been properly screened for mental illness or mental retardation as required by the PASRR process. CARES is also identifying the efficiencies and benefits to developing a system to automate this federally mandated process.
4. The Agency and DOEA should work together to transition Nursing Home Diversion enrollments, disenrollments and month-to-month plan changes from the manual process managed by the CARES Program staff and DOEA contract managers to a Medicaid contracted enrollment broker.

Status: The submitted 1915(c) and 1915(b) waiver applications for the new Managed Care Long-Term Care System include provisions that would transfer existing CARES options counseling activities to a contracted enrollment broker starting in 2013.

5. DOEA should evaluate the benefits of the New Admission Reviews to DOEA/CARES and to determine the impact of New Admission Reviews assessments on CARES program resources and DOEA’s ability to place individuals in less-restrictive settings when such individuals desire community-based services.

Status: DOEA/CARES continues to conduct the New Admission Reviews on individuals by providing them with information on alternatives to nursing facility long term care after Medicare coverage for nursing homes ends. This statutory requirement is scheduled to expire on October 1, 2013.
Section VII: Recommendations for SFY 2012

To continue improvements to the CARES Program, the following recommendations are made:

1. AHCA, DOEA and DCF should work together to evaluate fiscal and workload impacts of transitioning the existing Institutional Care Program (ICP) recipient population into the new managed long-term care system. This evaluation should review the medical and financial eligibility process as well as impact on demand for CARES assessments.

2. CARES, along with its partner agencies, should explore options for developing data collection abilities that will allow for the electronic transmission and physician signature of the medical certification form or AHCA MEDSERV-3008. Currently this form is used to capture complete medical information regarding all Institutional Care Program applicants so that CARES may make a level of care determination. In addition to electronic transmission of medical certification information for ICP applicants, modernization of data collection and transfer for the AHCA MEDSERV-3008 should be coordinated with nursing facility and hospital providers to improve data transmission and information sharing during care transitions.

3. DOEA and AHCA should work together to transition all enrollment, disenrollment and month-to-month plan change functions for the Nursing Home Diversion waiver program from the CARES Program to the enrollment broker that will be contracted to handle these functions under the new Statewide Medicaid Managed Care (SMMC) program’s long-term care component. This is essential to replace existing manual and paper driven processes with standard enrollment broker electronic and telephonic capabilities.

4. DOEA should identify existing resources, or submit a legislative budget request, for CARES to procure and implement a single statewide database that would permit hospital discharge planners, CARES staff and nursing facility staff to determine whether clients had been properly screened for mental illness or mental retardation as required by the Preadmission Screening and Resident Review (PASRR) process. A single statewide PASRR database would achieve greater compliance with the Centers for Medicare and Medicaid Services reporting requirement for Medicaid reimbursement. This will also replace current paper driven processes and manual data entry by CARES staff which is essential to ensure an efficient and compliance driven PASRR Program for the State of Florida.
Appendix A:

CARES Planning and Service Areas (PSA) In SFY 2010-2011
CARES
Comprehensive Assessment and Review for Long-Term Care Services

http://elderaffairs.state.fl.us
19 Planning and Service Areas, (PSA’s)

Revised 10/10