Executive Summary

The 2002 Legislature directed the Agency for Health Care Administration (the Agency) to submit annual reports on the Comprehensive Assessment and Review for Long-Term Care Services Program (CARES). CARES is Florida's federally mandated pre-admission screening program for nursing home 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.

This report is required by section 409.912 (15)(d), Florida Statutes (F.S.), which stipulates that by January 1 of each year, the Agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must include:

1. The 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.

As required, this second annual report specifies the rate of diversion to community-based alternatives; describes CARES staffing needs to achieve additional diversions; describes reasons why people cannot always be placed in less restrictive settings; and identifies barriers to the appropriate placement in both the public and private sectors. The report includes policy recommendations for ensuring individuals requiring long-term care are able to receive care in the least restrictive setting.

Data demonstrate that Florida's need for long-term-care services will continue to grow. November 2003 data, reported by the Florida Senate, project that between 2003 and 2025, the age 65 and older population of Florida will increase by 93 percent while the age 85+ population is projected to grow another 77 percent during the same time period. The demand for long-term care options will grow exponentially. The continued emphasis by policymakers on diversions from nursing home settings to home and community-based alternatives has had a demonstrable effect as the diversion rate has risen from 15.3 percent in fiscal year (FY) 1998-99 to 26.4 percent in FY 2002-03. Such increases in the diversion rate are proportional to increases in the CARES budget and staffing as well as increased appropriations for home and community-based services.

Nearly half of CARES determinations continue to be accomplished through desk reviews rather than face-to-face interviews. The Agency raised concern about this workload issue in its 2002 report. Based on the Agency’s recommendations, the Department of Elder Affairs (DOEA) revised its procedures in 2002. All applicants and consumers determined to meet Intermediate II level of care criteria through a desk review now receive a follow-up face-to-face visit to ensure they do, in fact, meet Intermediate II level of care. Intermediate II is currently the lowest acceptable level of care required to meet nursing home eligibility guidelines. The Legislature
has considered eliminating this level of care in the past. The most recent discussions occurred during the 2001 session resulting in proviso specifically permitting the transfer of $3.4 million from the Medical Care Trust Fund to the Assisted Living Waiver. These funds were specified for transitioning Medicaid eligible nursing home residents who met the Intermediate II level of care criteria out of nursing facilities and into the less restrictive, more cost effective Assisted Living Waiver.

According to the Department of Elder Affairs, the performance goal established by the Legislature for FY 2002-03 was exceeded as demonstrated below:

<table>
<thead>
<tr>
<th>Performance Standard</th>
<th>Goal</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of elders the CARES program determined eligible for nursing home placement who are diverted to the community</td>
<td>24.5%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Number of CARES assessments completed</td>
<td>71,555</td>
<td>77,843</td>
</tr>
</tbody>
</table>

Barriers to community placement are documented throughout the report. They include a shortage of assisted living facilities (ALFs) participating in the Assisted Living for the Elderly Medicaid Waiver, particularly in North Florida, and waiting lists statewide for most home and community-based services.

The following recommendations are made to improve CARES operations. Some require statutory changes; others can be implemented through administrative action.

- Assess the feasibility of requiring individuals whose nursing facility stay is expected to exceed twenty days to be assessed by CARES regardless of funding source.
- Consider a pilot project to authorize DOEA to retain a percentage of appropriated service dollars to immediately fund transition services in community settings.
- Continue to co-locate CARES staff with the Department of Children and Families (DCF) Economic Self Sufficiency staff in as many locations as possible.
- Consider amendments to Section 409.912, F.S., to permit CARES to contract CARES functions.
- Consider the elimination of the Intermediate II level of care to tighten the criteria for nursing home and waiver admission. Considerations should include the impact of such a change on qualification for home and community-based services waivers.
- Require all individuals (or designated representatives) applying for Medicaid nursing facility care to indicate in writing that they have been advised of their community care options and indicate acceptance or rejection of community alternatives.
- Improve the reporting capabilities of the CARES data system.
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Section I – Introduction, CARES and Long-Term Care

Florida finances 66 percent of nursing home bed days through the Medicaid program. Medicaid also finances the home and community-based waiver services that exist as alternatives to nursing home care. CARES is an acronym for Comprehensive Assessment and Review for Long-Term Care Services. CARES is Florida’s pre-admission screening program for nursing facilities as federally mandated by 42 Code of Federal Regulations (CFR) 456.372 for any person seeking financial assistance through Medicaid for nursing home care. The Agency for Health Care Administration (the Agency) has regulatory oversight for CARES and has delegated operational responsibility for CARES to the Department of Elder Affairs (DOEA).

CARES performs the medical review determination for nursing home care (the Medicaid Institutional Care Program) through assessments of consumers who apply for Medicaid reimbursement for their nursing home care. Assessments must comply with the 1987 Federal Nursing Home Reform Act, which requires additional screening for applicants with certain mental illness or mental retardation diagnoses. CARES is responsible under 42 CFR 441.391 (3)(b)(1)(ii) for determining whether applicants meet eligibility criteria for most of Florida’s home and community based waiver programs. Section 409.912 (13)(a), F.S., requires the Agency, in conjunction with CARES, to:

“Ensure that Medicaid payment for nursing home care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall ensure that individuals participating in Medicaid home and community-based waiver programs meet the criteria for those programs, consistent with approved federal waivers.”

Section 409.912, F.S., further requires the Agency to submit an annual report to the Legislature and the Office of Long-Term Care Policy by January 1 of each year describing the operation of the CARES program.

Based on statutory requirements, this report provides data and information regarding:

1. The rate of diversion to community alternative programs;
2. CARES program staffing needs to achieve additional diversions;
3. Reasons the CARES program is unable to place individuals in less restrictive settings when a less restrictive setting is desired by the individual and the individual is assessed as able to succeed in a community setting;
4. Barriers to appropriate placement, including barriers due to policies or operating procedures of other agencies or state-funded programs; and
5. Statutory changes necessary to ensure that individuals in need of long-term care services are able to receive that care in the least restrictive environment possible.
Section II – Background and History

Growth Projections and Implications for Long-Term Care Assessments

Florida continues to be home to the oldest population, and leads the country in the demographic transition toward an even older population. Florida is home to the largest percentage of individuals age 65 and older. This age 65+ population is expected to continue to increase at a rapid rate, along with the proportion of persons over age 85. The Florida Senate in November 2003 estimated that between 2003 and 2025, the age 65 and older population in Florida will increase by 93 percent. Individuals age 85 and older are the frailest population with the greatest need for long-term care. That population is expected to increase by approximately 77 percent in the next twenty years. The growth rate of this population will increase the demand on the long term care assessment and service delivery system. Assessment demands will grow in line with the increase in the elder population due to federal regulations that require every applicant for Medicaid-financed nursing home or home and community-based waiver care to participate in pre-admission screening, which is the responsibility of CARES.

Figure 2.1, Age Distribution of State Population

Source: Pepper Institute on Aging and Public Policy, Florida’s Aging Population, 2002.

Medicaid long-term care spending has doubled in the last 10 years and is on track to dramatically rise over the next 20 years. In FY 2003-04, 17.45 percent of the Medicaid budget was appropriated for nursing facility care compared to 6.18 percent for Medicaid home and community-based care. The following tables provide data that support the need for increased and/or more efficient staffing (a higher staff-to-assessment ratio) for CARES pre-admission screenings. From a cost containment perspective, data on Florida’s increasing aging population also support the demand for increased diversions to home and community-based care. Growth in waiver spending (home and community-based services) was 32.37 percent in FY 1992-93, and while waiver spending has continued to grow annually, it has not again achieved as high a growth rate as FY 1992-93. Growth in waiver spending was recorded at 17.04 percent for FY 2001-02 compared to the previous year.
A continued emphasis by policymakers on diversions from nursing homes to home and community based alternatives will assist Florida in complying with federal directives related to the Americans with Disabilities Act. An increased emphasis is also imperative to contain long-term care costs over the next twenty years. As demonstrated by growth projections, demand for Medicaid funding and an array of consumer-friendly, non-institutional long-term care options will increase. Enhanced emphasis on less expensive and consumer-preferred home and community based alternatives in the immediate future is an opportunity to establish an improved pre-admission screening program.

### Table 2.1 Growth in Waiver Spending (Elder-Related Waivers)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Growth Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1992-93</td>
<td>32.37%</td>
</tr>
<tr>
<td>FY 1993-94</td>
<td>-2.38%</td>
</tr>
<tr>
<td>FY 1994-95</td>
<td>27.83%</td>
</tr>
<tr>
<td>FY 1995-96</td>
<td>17.42%</td>
</tr>
<tr>
<td>FY 1996-97</td>
<td>30.89%</td>
</tr>
<tr>
<td>FY 1997-98</td>
<td>22.49%</td>
</tr>
<tr>
<td>FY 1998-99</td>
<td>24.13%</td>
</tr>
<tr>
<td>FY 1999-00</td>
<td>20.56%</td>
</tr>
<tr>
<td>FY 2000-01</td>
<td>32.00%</td>
</tr>
<tr>
<td>FY 2001-02</td>
<td>17.04%</td>
</tr>
</tbody>
</table>

Source: Florida Medicaid, January 15, 2003

<table>
<thead>
<tr>
<th>Total Elderly Population 65+</th>
<th>Elderly 65+ as % of Total Population</th>
<th>Elderly 65+ Medicaid Beneficiaries</th>
<th>Percent of Elderly Beneficiaries 65+</th>
<th>Elderly 65+ Beneficiaries as % Of Total Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>34,896,316</td>
<td>12.4%</td>
<td>3,900,000</td>
<td>11%</td>
</tr>
<tr>
<td>Florida</td>
<td>2,812,898</td>
<td>17.6%</td>
<td>271,830</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

Sources: U.S. Census Bureau 2000 Data and Centers for Medicare and Medicaid Services 2000 Medicaid Chart Book
CARES History, 1980-2003

In 1980, the Florida Legislature authorized the CARES program to help control the rising cost of Medicaid-financed nursing home care. The intent was to verify that those applying for Medicaid nursing home assistance actually required nursing home care. Prior to CARES, Medicaid employed nurses to perform desk reviews of applicant records to determine if level of care criteria were met.

The first CARES program was a pilot begun in March 1982 in the Jacksonville, St. Petersburg and Miami areas. Organizationally, the program was assigned to Medicaid within what was then the Department of Health and Rehabilitative Services (HRS). For the first time, multi-disciplinary assessment teams were formed, each comprised of a registered nurse and a social worker, with consultation from physicians on level of care determinations.

By 1986, the Legislature determined that CARES had demonstrated its cost effectiveness and approved its expansion statewide. Two years later, as part of Governor Bob Martinez’s Better Living for Seniors initiative, CARES was transferred within HRS from Medicaid to the Aging and Adult Services Program Office, which administered general revenue programs for Florida’s elderly and disabled adults.

In January 1989, implementation of the federal Nursing Home Reform Act (OBRA 1987) expanded pre-admission screening. OBRA required states to pre-screen all nursing facility residents to determine whether a diagnosis of mental illness or mental retardation was present and to determine the need for specialized services. To comply, CARES expanded its operations and now performs assessments for all adult applicants for the Medicaid Institutional Care Program. Simultaneously, CARES was given additional responsibilities to conduct pre-admission screenings in conjunction with the expansion of home and community-based waivers.

In 1995, the Legislature transferred CARES to the Department of Elder Affairs (DOEA). Since the transfer of CARES to DOEA, Florida has significantly expanded the CARES program beyond the certification of need for nursing facility services. Expanded functions included a pilot CARES program in Orlando and West Palm Beach in 1996 to out-post CARES staff in hospitals that had provided a significant portion of nursing home admissions in the prior year.

In July 1999, the U.S. Supreme Court issued the Olmstead v. L.C. decision, which interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation to require states to administer services, programs and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” The Supreme Court observed that the “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons isolated are incapable or unworthy of participating in community life.” The Supreme Court also observed that “confine ment 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.”

CARES staff perform functions vital to assisting the state not only in controlling the publicly supported costs of nursing home placements but also with compliance and adherence to federal regulations and Supreme Court findings. The ADA and the Olmstead decision reinforce that people residing in nursing homes, state facilities and other institutional settings must have opportunities to live in the most integrated settings appropriate to their needs. The CARES...
program is Florida’s primary vehicle for ensuring the appropriate placement of individuals requiring long term care in community settings.

As the number of nursing home placements has increased through the years, the CARES workload has increased. CARES plays a significant role in the federally mandated assessment process designed to prevent inappropriate nursing facility admissions and retention of individuals with mental illness (MI) and mental retardation (MR) in nursing facilities. Pre Admission Screening and Resident Review (PASRR) was enacted as part of the Nursing Home Reform Act under the Omnibus Budget Reconciliation Act of 1987 and amended in 1990 and 1996. The state mental health and mental retardation authorities must make two determinations based upon the person’s total needs: whether the person needs specialized services for his/her MI/MR and whether the person needs nursing facility services. If the person is determined to need such services, he/she can be admitted and if the person needs specialized services, the state must provide them while the person resides in the nursing facility. In Florida, PASRR is initiated by CARES simultaneously with the level of care determination. CARES staff are responsible for the required Level I screening that identifies the possible presence of MI/MR. If the pre-admission screening reveals the possibility of MI/MR, a referral must then be made for further assessment known as the Level II evaluation.

In June 2002, representatives from the Atlanta Regional Office of the Centers for Medicare and Medicaid Services (CMS), completed a review of the Florida PASRR Program. A final report from CMS was issued in January 2003. Findings affecting CARES operations had to do with misinterpretations of advance determinations by category that states are permitted to make regarding nursing home eligibility and placement. CMS found that advance determinations were misunderstood to be “exemptions.” These exemptions from Pre-Admission Screening and Resident Review requirements were being made on certain individuals for whom it is required and allowed open-ended NF admissions without individualized evaluations for persons with delirium and for persons who require convalescent care after hospitalization. All three of these provisions permitted individuals with MI or MR to be admitted to a NF without receiving the required evaluations and determinations. The Agency and CARES conducted training statewide in November 2003 to correct this misinterpretation. Further training is planned for January 2004.

Section III – CARES Oversight, Performance Measures and the Rate of Diversion

Oversight-Interagency Agreement

The Agency for Health Care Administration (Agency) administers CARES through an interagency agreement with DOEA. The agreement must conform to the provisions of Section 409.912, F.S., related to cost-effective purchasing of health care, and incorporates additional Agency oversight of CARES. The agreement has been revised to specify the duties/responsibilities of both the Department of Elder Affairs and the Agency for Health Care Administration with respect to CARES. The Agency must oversee activities statewide through programmatic and administrative reviews and participate in quarterly meetings with CARES staff. CARES and DOEA must achieve specified measures of program performance and submit regular reports on operations to the Agency. The current agreement was executed on December 4, 2003. A copy of the agreement is attached to this report (Appendix A).
Performance Measures and CARES Rate of Diversion

Florida has been utilizing a performance-based program budgeting (PB²) system since 1994. Under this system, agencies include outcome and output measures in their legislative budget requests, and the Legislature sets standards for these measures in the Appropriations Act. The FY 2002-03 performance measures for DOEA included a goal of achieving a 24.5 percent rate of diversion from nursing facilities to the community and the completion of 71,555 CARES assessments. According to the Department, the goal for FY 2002-03 was exceeded. A total of 78,167 assessments were performed while a 26.4 percent diversion rate was achieved.

Like many states, Florida is looking at nursing home diversion alternatives as a way to control Medicaid expenditures. CARES defines a “diversion” as a person determined by CARES assessors to meet nursing home level of care criteria but placed successfully in a community-based setting through CARES staff intervention. According to CARES administrators, “staff intervention” means that once a community placement recommendation is made, CARES makes referrals to appropriate community service agencies on behalf of the individual. CARES staff follows up thirty days later to determine if the person is still “in the community.” If so, CARES counts this as a “diversion.” However, whether or not the individual is receiving needed services is not taken into account.

Barriers to diversions will be discussed in a subsequent section of this report. CARES representatives specifically cite a shortage of home and community-based service funds and providers, which creates waiting lists for some home and community based service programs, as the greatest barrier to meeting its performance goal. As indicated in Table 3.1, the percentage of diversions from nursing home placements has increased significantly from 15.3 percent to 26.4 percent since FY 1998-99.

Table 3.1: CARES Appropriation, Consumers Assessed, and Rate of Diversion from Nursing Homes Increases Annually

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Funding</th>
<th>Consumers Assessed</th>
<th>Cost Per Assessment</th>
<th>% Diverted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-1999</td>
<td>$8,448,930</td>
<td>54,926</td>
<td>$153.82</td>
<td>15.3%</td>
</tr>
<tr>
<td>1999-2000</td>
<td>$9,361,546</td>
<td>62,341</td>
<td>$150.17</td>
<td>17.8%</td>
</tr>
<tr>
<td>2000-2001</td>
<td>$10,971,736</td>
<td>69,482</td>
<td>$157.90</td>
<td>22.7%</td>
</tr>
<tr>
<td>2001-2002</td>
<td>$11,095,299</td>
<td>77,559*</td>
<td>$143.05</td>
<td>24.3%</td>
</tr>
<tr>
<td>2002-2003</td>
<td>$11,297,587</td>
<td>78,167</td>
<td>$144.53</td>
<td>26.4%</td>
</tr>
</tbody>
</table>

Source: DOEA  *According to the Department of Elder Affairs, the figure provided for number of consumers assessed in last year’s report was incorrectly based on the Summary of Cases by Assessment Site and should have been based on the Alternative Placements (Diversion) Report.

In FY 2002-03, the CARES budget was $11,297,587. With 78,167 assessments, the cost per assessment was $144.53. Since FY 1998-99, CARES has become more efficient, represented by the decrease in the cost per assessment from $153.82 in 1998 to the current $144.53 per assessment cost.

According to information provided by DOE,A, in FY 2003-03 32 percent of CARES assessments were completed in the facility following admission. Such individuals may have privately paid for
care for a period of time and utilized all resources before seeking certification of level of care in order to obtain Medicaid payment. Others may have transferred from the hospital for a period of rehabilitation covered by Medicare but did not progress to the point of discharge and subsequently seek the required certification of level of care for Medicaid enrollment. These assessments are completed at the nursing facility and include a review of the medical record and a face-to-face interview with the resident.

The next most common type of assessment completed by CARES staff (25 percent of workload) is a review of records submitted by case managers seeking verification of eligibility for home and community-based services provided through various Medicaid waiver programs. Case managers submit assessments and medical records to CARES for review and determination that the individual meets the criteria specified within each federally approved waiver. As the number of approved waivers increases, the workload for CARES staff will increase substantially.

Table 3.2 contains specific information provided by CARES regarding workload for FY 2002-2003.

<table>
<thead>
<tr>
<th>Assessment Site</th>
<th>Assessments Completed</th>
<th>Percentage of Workload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility – Initial Application</td>
<td>25,067</td>
<td>32%</td>
</tr>
<tr>
<td>Office/Medicaid Waiver Reviews</td>
<td>19,527</td>
<td>25%</td>
</tr>
<tr>
<td>Office/Medical Case Reviews</td>
<td>14,938</td>
<td>19%</td>
</tr>
<tr>
<td>Nursing Facility Continued Residency Reviews (CRR’s)</td>
<td>7,540</td>
<td>10%</td>
</tr>
<tr>
<td>Individual’s Home – Initial Application</td>
<td>5,959</td>
<td>8%</td>
</tr>
<tr>
<td>Hospital</td>
<td>2,835</td>
<td>4%</td>
</tr>
<tr>
<td>Other*</td>
<td>2,401</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>78,267</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: DOEA *ALFs, psychiatric hospitals, meal sites, etc.

In its first annual CARES report to the Legislature, the Agency specifically expressed concern regarding the high number of desk reviews completed by CARES. In response to this concern, the Department of Elder Affairs has changed its procedures to include a face-to-face visit for all consumers determined to meet the Intermediate II level of care. However, the Agency is still concerned that 44 percent of CARES assessments are completed through desk reviews and critical decisions are being made without the benefit of a face-to-face visit. DOEA reports that a substantial but undetermined percentage of office based medical case reviews are appropriate due to death, the physical condition of the patient and requests for retroactive Medicaid payment for discharged patients.
Section IV - Barriers to Community Placements

There are a number of barriers that prevent 1) placement of individuals in the community instead of in a nursing facility and 2) transition of nursing home residents from nursing facilities to the community. Barriers cited by the DOEA in the CARES 2002 report included:

- Waiting lists for home and community-based services;
- Weary and unwilling caregivers;
- Physician preference for nursing facility placement over community placement;
- Length of time for completion of a financial eligibility determination; and
- Lack of community resources (Assisted Living Facilities)

Waiting lists and the length of time to complete a financial eligibility determination present systemic barriers to diversions to the community. Waiting lists for home and community-based services are maintained by each agency responsible for operations of these programs. It must be noted that as the number of waiver programs increases, the CARES workload is directly affected.

As reported in the 2002 report to the Legislature, it is not uncommon for some financial eligibility determinations to take three to six months in some areas of the state. This lengthy process biases some families toward placement of family members in an acute care setting, where Medicare will pay expenses for the short term. To compound this concern, families or caregivers are frequently “burned out” by the time CARES is contacted and are consequently less receptive to exploring community placements. Additionally, physicians are often undereducated about community alternatives. Consequently, physicians often recommend nursing facility placement over home and community based alternatives. Families, who are often in crisis at the time alternatives are presented, are also ill informed about home and community based alternatives. The state should increase its educational campaigns to educate both health care providers and the public about the availability and benefits of home and community based alternatives. Some other states have prioritized changing these public and provider perceptions as a means to contain costs.

The state’s long term care policies should also encourage the increased availability of secure, specialized assisted living facilities (ALFs). As reported in the 2002 report, some areas of the state, especially North Florida, do not have enough ALFs to meet placement needs. The availability of facilities with a secure Alzheimer’s unit is limited, as is the availability of ALFs enrolled as Assisted Living Waiver providers. Lack of specialized and secure facilities results in limited placement opportunities outside of a nursing facility. Additionally, Florida has a limited number of licensed adult family care homes, which also serve as residential alternatives to nursing facilities.

The following chart graphs the barriers to diversion from January 2002 through June 2003. The left bar represents general diversion barriers. A general diversion barrier is defined as a circumstance that prevents an individual’s placement in the most appropriate, least restrictive environment. Such barriers result in the individual’s placement in a nursing facility. The right bar represents a transition barrier. A transition barrier is a circumstance that prevents an individual with “community placement potential” from leaving a nursing facility and returning to a less restrictive community setting. General diversion barriers and transition barriers include the limited availability of home and community based services, the limited availability of appropriate
assisted living facilities (ALF), caregiver-related barriers, barriers related to the individual's decline in health, refusal-related barriers, and barriers caused by program-specific ineligibility.

**Figure 4.1 Barriers to Diversions and To Transitions - January 2002 – June 2003**

<table>
<thead>
<tr>
<th>Barriers As Reported By CARES</th>
<th>Individuals Not Diverted (Left Bar) or Transitioned (Right Bar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALF Unavailable</td>
<td>339</td>
</tr>
<tr>
<td>Caregiver Unavailable</td>
<td>52</td>
</tr>
<tr>
<td>Family Refused</td>
<td>9</td>
</tr>
<tr>
<td>Eligibility Issues</td>
<td>142</td>
</tr>
<tr>
<td>Health Declined</td>
<td>1462</td>
</tr>
<tr>
<td>HCBS Unavailable</td>
<td>194</td>
</tr>
<tr>
<td></td>
<td>242</td>
</tr>
<tr>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

Source: Department of Elder Affairs
Section V - Staffing to Accomplish CARES Functions

The Legislature requires reporting on “CARES program staffing needs to achieve additional diversions.” The Agency and DOEA consider the level of CARES staffing to be a key variable in enabling CARES to carry out its mission to accomplish additional diversions and operate efficiently and cost-effectively. The following is an overview of CARES staffing patterns and operations related to level of care determinations.

Staffing Patterns/History

For many years, CARES operated with 115 full-time equivalent (FTE) positions; however, staffing has increased substantially since 1995. In 1995, an additional 31 registered nurse positions were authorized to increase the number of site visits and decrease the number of desk reviews. In 1998, additional positions were authorized, allowing CARES staff to be more responsive to individuals being discharged from hospitals and to better serve the increased number of consumers diverted from institutional settings to their local communities.

Presently DOEA employs 197 FTE’s and 34 Other Personal Service (OPS) positions to perform CARES functions, which comprise 53 percent of the total positions assigned to DOEA. In addition, the CARES seven-member headquarters management team is part of the DOEA Division of Statewide Community Based Services and is responsible for policy and budget development, training and supervision of field staff, data collection, and quality assurance. CARES’ staff turnover rate for FY 2002-03 was 5.12 percent, which is slightly less than the previous year’s rate of 5.5 percent. This compares favorably with the Department’s overall turnover rate of 8.96 percent and that of all state employees which was 8.11 percent.

CARES field staff account for 231 positions housed in 17 offices across the state. Locations generally correspond with DOEA planning and service areas, with larger areas being served by two office locations. Each CARES office employs a supervisor responsible for daily local office operations. Table 5.1 details staffing in each CARES location.
### Table 5.1 Total CARES Staff by Position and PSA

<table>
<thead>
<tr>
<th>PSA</th>
<th>HSPS Supervisor II</th>
<th>Clerical/ Admin.</th>
<th>Senior CARES Assessors</th>
<th>CARES Assessors</th>
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<td>21</td>
<td>69</td>
<td>59</td>
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Source: Department of Elder Affairs  **All MDs are OPS

NOTE: Totals do not include DOEA Headquarters Staff

The increased demand for CARES assessments has not kept pace with the number of CARES staff that conduct assessments. This has placed pressure on CARES staff and has created actual or perceived delays in level of care determinations. The Agency recommends that DOEA, in conjunction with AHCA, conduct a staffing study of CARES personnel in each of the seventeen CARES field offices to determine whether there are sufficient staff to complete timely assessments and level of care determinations. The staffing study will be reviewed by the Agency and should be utilized to develop legislative budget requests.

CARES staffing demands may increase significantly in the future. The Americans with Disabilities Act and Florida’s response to federal directives to transition individuals from institutional to community settings have increased demands on the CARES staff and operations. The Nursing Home Diversion Waiver expansion and expansions in other home and community-based programs have all taxed the CARES assessment staff and will continue to increase demands on staff.

**Assessment and Determination of Level of Care**

In addition to the Agency’s concerns about CARES staffing, the Agency is also concerned with the pre-admission screening and assessment methodology. The present eligibility and assessment methods are outlined in the following section, along with recommendations and considerations for improvements.
An individual seeking Medicaid coverage for nursing home care must meet both financial and medical eligibility criteria. CARES staff make the Medicaid medical eligibility determinations. The Office of Economic Self-Sufficiency staff in the Department of Children and Families (DCF) conduct the financial eligibility determinations in a separate process. Since CARES medical eligibility determination staff work closely with the DCF personnel determining financial eligibility, efforts to co-locate CARES and DCF eligibility functions should continue.

To make the medical eligibility determinations, a CARES social worker or a registered nurse assesses an applicant’s physical and mental capabilities and limitations, health care needs, and social support systems. A consulting physician then reviews the assessment with CARES staff and makes the final decision (called a "level of care determination") about the applicant’s medical eligibility for Medicaid long term care. During this consultation, the team also makes a recommendation for the least restrictive placement that will meet the applicant’s service needs. The placement recommendation may be a permanent placement in a nursing home; temporary placement in a nursing home; placement in an assisted living facility or an adult family care home; or maintaining residency in the applicant’s home or the home of a caregiver with supportive care.

Medicaid waiver programs, also known as home and community-based services, may supplement placement in a community setting. In addition to the level of care requirement, most of the home and community-based waiver programs specify additional targeting criteria such as a specific diagnosis or disability that must be met. CARES determinations must be made for the Medicaid waivers and programs listed below:

- Adult Day Health Waiver (January 2004)
- Aged/Disabled Adult Waiver
- Assisted Living for the Elderly Waiver
- Assistive Care Services
- Channeling Waiver
- Frail Elder Program
- Project AIDS Care Waiver
- Nursing Home Diversion Waiver
- Traumatic Brain/Spinal Cord Injury Waiver
- Adult Cystic Fibrosis Waiver (January 2004)
- Program of All Inclusive Care for the Elderly (PACE)

CARES staff determine whether an applicant for the Medicaid Institutional Care Program (nursing home care) and the various Medicaid home and community based waivers meets the level of care criteria specified in administrative rule. A skilled level of care is defined in Florida Administrative Code (FAC) 59G-4.290 as the continuous need for 24-hour nursing services provided under the direct supervision of professional and licensed personnel. Examples of services that qualify as skilled nursing services include but are not limited to:

- Intravenous medication or fluids;
- Intramuscular or subcutaneous injection when administered and monitored at least five times weekly;
- Medication management;
Levin tube and gastrostomy feedings;
Insertion, replacement, and sterile irrigation of catheters;
Early post-operative colostomy and ileostomy care; and
Treatment of widespread infected or draining skin disorders.

FAC 59G-4.180 stipulates the requirements for an intermediate care services level of care, Level I or Level II in the community or in a nursing facility as specified below:

- Services must be ordered by and remain under the supervision of a physician;
- Services must be medically necessary and provided to a person whose health status and medical needs are of sufficient seriousness as to require management, periodic assessment, planning or intervention by licensed nursing or other health professionals; and
- Necessary to achieve the medically desired results and ensure the comfort and safety of the applicant or recipient.

Level I Intermediate Care is specified as extensive health-related care and service required by an individual who is incapacitated mentally or physically. Examples of qualifying Level I services include but are not limited to:

- Administration of routine or stabilized dosages of oral medications, eye drops, or ointments;
- Routine administration of injections and observation of the individual's response and side effects;
- Administration and adjustment of pain medication and monitoring for results and side effects;
- Routine oral suctioning;
- Tracheotomy care when an individual's condition is stable but he/she is unable to perform self-care for medical, physical, or mental reasons;
- Routine care of a suba-pubic catheter and routine care of in-dwelling bladder catheters;
- Prophylactic and palliative skin care including bathing and application of creams;
- Bowel and bladder control training;
- Care of decubitus ulcers that are superficial and non-infected;
- Administration of oxygen on an emergency or short-term basis; and
- Rehabilitative restorative care and passive range of motion exercises.

Level II of Intermediate Care is limited health-related care and services required by an individual who is mildly incapacitated or ill to a degree requiring medical supervision. Individuals requiring this level of care shall:

- Be ambulatory, with or without devices;
- Demonstrate independence in activities of daily living; and
- Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive behavior requiring 24-hour nursing supervision.

Examples of services, in addition to medical supervision, qualifying as Intermediate Level II include but are not limited to:

- Routine administration of oral medication;
Comprehensive Assessment and Review for Long Term Care Services (CARES)

- Assistance with mobilization, i.e., transferring from a bed to chair or manipulating a wheelchair in difficult places;
- Assistance with bathing, dressing, and grooming;
- Assistance with meals, i.e., cutting food and pouring a beverage;
- Application of medically prescribed elastic stockings if the recipient cannot manage independently;
- Provision of social and leisure activities designed to reduce isolation and enhance communication and social skills; and
- Ongoing medical and social evaluations to determine the point when a recipient’s progress has reached a point where medical and related needs can be met appropriately outside the facility through alternative placement/services.

The eligibility determination process is identical whether someone is seeking nursing home placement or participation in a waiver program. Upon request, CARES also provides an assessment for private pay individuals.

Table 5.2 shows the percentages of individuals assessed and determined to meet each of the aforementioned levels of care during FY 2002-03. Please note that this total differs from the total number of assessments completed because it does not include the resident reviews done in the nursing facilities.

**Table 5.2 CARES Level of Care Determination - FY 2002-2003**

<table>
<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Number of Persons Assessed</th>
<th>Percent of Total Assessments</th>
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<tr>
<td>Skilled</td>
<td>23,606</td>
<td>33%</td>
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<td>Meets Waiver Criteria</td>
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<tr>
<td>Intermediate I</td>
<td>17,071</td>
<td>25%</td>
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<tr>
<td>Risk of Hospitalization*</td>
<td>5,288</td>
<td>8%</td>
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<tr>
<td>Intermediate II</td>
<td>2,915</td>
<td>4%</td>
</tr>
<tr>
<td>Does Not Meet LOC</td>
<td>1,017</td>
<td>1%</td>
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<td>Withhold LOC**</td>
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<tr>
<td>Fails to Meet Specific Waiver Criteria***</td>
<td>624</td>
<td>.08%</td>
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<tr>
<td>Other</td>
<td>16</td>
<td>.02%</td>
</tr>
<tr>
<td>Total</td>
<td>70,579</td>
<td>100%</td>
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Source: DOEA  * Project AIDS Care waiver program criteria **Term applies to applicants waiting for completion of a PASRR Level II evaluation or when the Level II evaluation indicates need for services that cannot be provided in a nursing facility; or when person is a danger to self or others and nursing facility placement is not appropriate. ***Certain waiver programs have additional targeting criteria.

Based upon the need to limit Medicaid expenditures, the Agency has held discussions regarding an amendment to FAC 59G. This amendment would eliminate Intermediate II level of care and thus reserve Medicaid nursing facility funding for those with the greatest medical and functional deficits.

**Continued Residency Reviews and Options for Transition**

As previously described, part of the CARES mission is to ensure that individuals residing in nursing facilities continue to require the level of care provided in the facilities, or be transitioned to a less restrictive, home and community-based setting. CARES accomplishes this level of care determination through Continued Residency Reviews (CRRs). Currently, CARES staff
conduct CRRs on a minimum of twenty percent of Medicaid recipients in each nursing facility annually to determine whether there is a need for continued nursing home care. Resident case records to be reviewed are randomly selected from the facility’s most recent Medicaid census. If a resident no longer meets the criteria for nursing facility care, an alternative placement must be made. Options include assisted living or home and community-based care. In 2002, the Agency, in concert with DOEA, recommended that CARES staff review a larger sample of nursing home residents. However, DOEA indicates that a lack of staffing prevents a review of a sample greater than 20 percent annually. Any expansion of the assessment of nursing home residents for possible transition may require operational changes to CARES, increased funding for CARES staff, as well as increased funding for home and community based services.

To address the expansion of long term care assessment capabilities, the Florida Senate Interim Project Report 2004-144 describes three approaches for consideration. The Florida Senate suggests one approach could entail a “Transition Unit” that would travel around the state and perform random sample assessments. The example described by the Senate suggests, “two RNs could handle the on-site review at the nursing home and once they found possible transition candidates, they could contact the local CARES offices which could then work with the individuals to see if transitioning was an option.” The Agency has begun the procurement process to contract with an organization to create transition teams and propose assessment methodologies. These activities are a part of the Florida Nursing Home Transition Initiative, which will assess at least 1,400 persons and transition individuals from nursing facilities to the community for FY 2003-04 and FY 2004-05.

A second approach contained in the Senate Report includes the appropriation of additional funds for the CARES program at a level sufficient to allow CARES staff to assess all nursing home admissions. This would expand the assessment population from Medicaid enrollees to include private pay individuals. The Agency made this particular recommendation in its 2002 CARES report. Under this model, CARES staff would conduct an assessment prior to Medicaid payment being authorized. In addition to assessing Medicare-financed nursing home residents, CARES staff would be in a position to present a plan to transition a nursing facility resident based upon the resident’s willingness to return to a community-based setting. As the Senate Report suggests, the presentation of alternatives and choices to residents, family members, and nursing home staff either prior to or at the time of admission could make residents and their families more inclined to consider discharge at a future date.

A third assessment option presented in the Senate Report is to support transition planning under the Medicaid State Plan as a targeted case management service. Reimbursement options for this service include either a “cost-based” approach that would pay providers for the amount of time devoted to transitional planning, or a “capitated” approach that would pay providers a fixed amount for each person transitioned, or for each person who was at least identified as a candidate for transition.
Section VI – Summary and Recommendations

The Agency offers the following recommendations in two categories, statutory and administrative, in the belief that they will help the state divert more people from nursing homes to less costly, more desirable home and community-based settings.

Statutory Changes

1. The Legislature should assess the feasibility of amending section 409.912, F.S. – cost-effective purchasing of health care - to require that all individuals whose nursing home stay is expected to exceed twenty days be assessed by CARES regardless of the initial funding source. Ninety-seven percent of all nursing home admissions are from hospitals. Initially, Medicare pays for nursing facility care and therapy, and the goal is to discharge Medicare residents to the community within the Medicare coverage period. According to the Centers for Medicare and Medicaid Services, the average time covered by Medicare is 17 – 28 days after which the resident is either discharged or it is determined that the person cannot return home without support. In a high percentage of cases that also triggers the beginning of the application process for Medicaid coverage.

According to the Agency’s State Center for Health Statistics, most Medicaid conversions happen within the first year of a nursing home stay. If CARES staff were to initiate pre-screening and diversion assistance immediately, more families would become aware of alternative resources and potentially choose a more cost effective setting.

2. Amend section 409.912, F.S., to require all individuals or designated representatives applying for Medicaid nursing facility care to indicate in writing that they have been advised of their community care options and indicate acceptance or rejection of community alternatives. This requirement would ensure that Medicaid applicants and their families have been made aware of the available options.

3. Consider amendments to Section 409.912, F.S., to permit AHCA/DOEA to contract some CARES functions. This would require an amendment to section 409.912, F.S. Other states successfully determine medical eligibility and conduct pre-admission screening through contracted entities such as Area Agencies on Aging or other entities.

4. Consider the implementation of a pilot project (within the parameters of similar initiatives described in Chapter 2002-223, Laws of Florida) allowing the Department of Elder Affairs to retain a percentage of service dollars for providing immediate assistance for individuals being discharged from a hospital who are at imminent risk of a nursing facility placement. This would allow for services such as home delivered meals, respite care and consumable medical supplies while long-term care planning is completed.

Administrative Changes

1. Assess the feasibility of eliminating the Intermediate II level of care, requiring that more restrictive levels of care be met for nursing home and waiver coverage. As demonstrated in this report, 4 percent of eligibility determinations made by CARES were assigned an Intermediate II level of care. This raises questions whether individuals needing the care ascribed to this level should be utilizing limited long term care resources.
2. Continue efforts to co-locate CARES and Department of Children and Families’ Economic Self Sufficiency offices to permit consumers easier access to the principal entities involved in the eligibility and level-of-care determinations. Over 90 percent of Institutional Care Program applications originate in one of these offices. Operating in separate locations is time consuming and confusing for applicants.

3. Modernize the CARES database in order to produce reliable and timely data. The Department is currently developing an Internet-based CARES Management Systems and Client Information and Referral Tracking System application to link existing CARES and providers’ databases. The Agency needs reliable data consistently available regarding numbers of level of care determinations and the timeliness of these determinations.

**Staffing Recommendations**

1. Assess CARES Staffing Requirements

The Agency requested input from the Department of Elder Affairs regarding specific staffing needs. The Department provided the following:

“CARES is requesting an increase in its administrative and field level staff for the reason that CARES is the single point of entry for the diversion waiver cases. The assessments of potential enrollees are more labor intensive than regular long term care nursing home applications and the CARES staff is heavily involved in choice counseling and onsite visits as well. This year the diversion program expanded from two PSAs to ten PSAs. To date, there has been no additional allocation in either the administrative staff or the field level staff to handle the additional workload of enrolling approximately 1,800 people. Additionally, certain CARES units have shown an increased number of field level staff either retiring or moving to other jobs because they can no longer handle the pressure of their job since the implementation of the diversion program.

Beginning in January 2004, CARES personnel will be training nursing facilities on PASRR policy and procedures. Additionally, CARES will also be coordinating a yet to be determined number of private pay psychiatric evaluations. If the number of private pay psychiatric evaluations equal the number of Medicaid psychiatric evaluations, there may be an increase of over 4,000 cases.

During SFY 2002-2003, CARES total assessments were 78,267 with a diversion rate of 26.8 percent. During the same period of time, CARES had less than 100 clients request a fair hearing, thus, showing that CARES has an error rate of less than one (1) percent.”

As noted in this report, CARES staff turnover did not increase significantly in the reporting period. The Agency was not able to obtain from the Department the specific data to substantiate the need for additional staff. However, the Agency recommends that a comprehensive staffing study be done to develop staffing formulae for the program.

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1 CARES volunteered to coordinate with nursing facility administrators on referrals for psychiatric evaluations required by non-Medicaid residents in need of a PASRR level II evaluation.
Co-location of medical and financial eligibility functions continues to be a recommendation for improving staffing and efficiency. Co-location has been recommended repeatedly by the Agency, DOEA, related task forces, and most recently the Senate in its November 2003 Interim Project Report 2004-144. DOEA reports that affecting the co-location of functions is a slow process due to leasing and other issues related to co-locating functions. The removal of barriers to co-location is recommended.

2. Add 1 FTE at the Agency to Oversee CARES Operations

To effectively oversee the operations of CARES, the Agency needs a full time equivalent position devoted exclusively to its monitoring responsibilities. A legislative budget request was submitted to meet this need. The duties and responsibilities of this opposition would include the following:

- Provide oversight of the CARES budget for compliance with federal regulations;
- Provide oversight of the DOEA/AHCA Interagency Agreement;
- Monitor CARES field staff for compliance with program standards;
- Assist CARES field staff with development of appropriate corrective action plans based on monitoring findings;
- Receive and analyze data and reports submitted by CARES;
- Analyze Medicaid data and compare with CARES reports;
- Make recommendations to management based on analysis and monitoring;
- Identify and make recommendations on CARES operational and policy issues; and
- By January 1 of each year, prepare and submit to the Florida Legislature the required annual report describing the operations of the CARES program for the previous fiscal year.

Conclusion

As Florida’s population continues to age, the need for long-term care services, both institutional and in-home options, will continue to grow exponentially as well as the pre-admission screening and eligibility requirements. In order to meet the needs of frail elders, the Agency will seek and propose innovative strategies from both the public and private sectors.
Appendix
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