

SECTION D

Medicaid Programs

The Department supports and operates Medicaid programs in partnership with the Agency for Health Care Administration (AHCA), Florida's designated Medicaid agency. Medicaid programs provide alternative, less restrictive, long-term care options for elders who qualify for skilled nursing home care. These options include care in the home or in a community setting, such as an assisted living facility or adult day care center, or in an institutional setting, such as a nursing facility. Medicaid programs provide eligible elders with a choice of care settings that promotes increased independence.

Medicaid Programs

Comprehensive Assessment and Review for Long-Term Care Services (CARES)

Description

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) program is Florida's federally mandated pre-admission screening program for nursing home applicants. A registered nurse or assessor performs face-to-face client assessments. A physician or registered nurse reviews each application to determine the medical level of care for the applicant. By identifying long-term care needs and establishing appropriate levels of care, the program makes it possible for individuals to remain safely in their homes using home and community-based services or in alternative community settings such as assisted living facilities.

Federal law mandates that the CARES program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement or home and community-based services. A pre-admission screening is also mandatory for all applicants (including private-pay) prior to admission to a Medicaid-certified nursing facility to screen for intellectual disabilities or serious mental illness. Any person or family member can initiate a CARES assessment by applying for the Medicaid Institutional Care Program (ICP). Assessments are completed at no cost to the clients.

Services and Activities

- Determine medical eligibility for the Medicaid ICP;
- Determine medical eligibility for Medicaid programs that provide home and community-based services;
- Conduct screenings for serious mental illness and intellectual disability for individuals prior to nursing facility admittance to determine if further evaluation is needed; and
- Conduct medical assessments for residents in nursing facilities entering court-ordered receivership.

Administration

The Department of Elder Affairs administers CARES in partnership with the Agency for Health Care Administration. There are 17 CARES field offices located throughout the state. CARES personnel include physicians, registered nurses, assessors, administrative support staff, office supervisors, and regional program supervisors. CARES management structure also includes central office staff responsible for program and policy development.

Eligibility

Florida residents seeking Medicaid assistance for nursing facilities or community-based long-term care services must meet both medical and financial eligibility requirements. CARES is responsible for performing face-to-face comprehensive assessments of all Medicaid long-term care applicants to determine if individuals meet the State's medical level of care eligibility requirements. Financial eligibility is determined by the Florida Department of Children and Families or the Social Security Administration (SSA).

Statutory Authority

Title XIX of the Social Security Act of 1965; 42 Code of Federal Regulations 456; 42 Code of Federal Regulations 483.100-483.138 (Subpart C); sections 409.985, Florida Statutes; Chapter 59G-1.040, 59G-4.180, and 59G-4.290, Florida Administrative Code.

Funding Source and Allocation Methodologies

The Department of Elder Affairs allocates CARES spending authority to each of the 17 CARES field offices, located in 11 Planning and Service Areas around the state, based on the number of client applications and assessments and the number of CARES personnel in each office.

Program Highlight

The responsibilities of CARES employees don't stop with completing medical eligibility assessments for nursing home and Medicaid Waivers. When the Governor declares a state of emergency, CARES team members are called on to work in Special Needs Shelters. Special Needs Shelters provide medical oversight to evacuated individuals with significant medical conditions and/or disabilities until they can return to their homes or alternative living arrangements. If individuals cannot return to their homes, CARES employees provide assistance with locating alternative housing. CARES also works with other state agencies, county partners, and charity organizations in Disaster Recovery Centers and Disaster Assistance Centers. These centers provide help with registering for FEMA assistance, crisis counseling, Supplemental Nutrition Assistance Program (SNAP) information, employment information and training services, medical attention and health concerns, and food and water.

After Hurricane Irma, CARES employees working in a St. Lucie County Special Needs Shelter assisted with placing two evacuated individuals from another state in an assisted living facility. After the placement, CARES received a follow-up call from the assisted living facility staff regarding prescription medications for the individuals. Both individuals needed prescription refills within several days. These medications were expensive and neither individual had Florida health insurance. The CARES staff worked diligently to find a solution. Subsequently, the Department of Health's pharmacy assisted the individuals with the prescription refills.



CARES Appropriation History and Numbers Served

State Fiscal Year	Federal Funding = 75% State Funding = 25%	Total Number of Assessments	Percent Diverted*
2008-2009	\$16,269,207	97,643	36.3%
2009-2010	\$16,135,481	105,217	34.3%
2010-2011	\$17,815,669	108,119	39.2%
2011-2012	\$17,643,458	120,603	38.7%
2012-2013	\$17,183,815	122,894	36.1%
2013-2014	\$17,300,580	**80,706	20.9%
2014-2015	\$18,358,055	88,075	n/a
2015-2016	\$18,316,195	93,790	n/a
2016-2017	\$18,332,574	100,304	n/a
2017-2018	\$17,983,094	#109,680	n/a

*Percent Diverted is the percentage of initial CARES assessments where the person continues to reside in the community for 30 days or more after assessment. Percent Diverted is not based on the total number of assessments. After implementation of the Statewide Medicaid Managed Care Program in 2014, CARES was no longer responsible for diversion to community alternative programs.

**The reduction in the number of assessments is due to CARES no longer performing annual face-to-face assessments of Medicaid waiver program participants beginning March 1, 2014.

#Projection

Source for assessments: CIRTS

Medicaid Programs

Program of All-Inclusive Care For the Elderly (PACE)

Description

The Program of All-Inclusive Care For the Elderly (PACE) model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides a comprehensive array of home and community-based services at a cost less than nursing home care. Individuals who choose to enroll in PACE have both their medical and long-term care needs managed through a single provider.

Services and Activities

In addition to services covered under Medicaid, PACE includes all services covered by Medicare. PACE is unique in several respects. PACE providers receive both Medicare and Medicaid capitated payments and are responsible for providing the full continuum of medical and long-term care services. In addition, PACE organizations receive an enhanced capitation payment from Medicare beyond that of a traditional Medicare health maintenance organization. PACE also has a unique service delivery system, with many services being delivered through adult day care centers and case management provided by interdisciplinary teams.

Administration

PACE is administered by the Department of Elder Affairs in partnership with the Agency for Health Care Administration and the federal Centers for Medicare & Medicaid Services (CMS).

Eligibility

To be eligible for PACE, an individual must be age 55 or older, be eligible for Medicare or Medicaid with income and assets up to the Institutional Care Program (ICP) level, meet medical eligibility, and live in proximity to a PACE Center.

Statutory Authority

42 Code of Federal Regulations 460; Balanced Budget Act of 1997; and Chapters 409 and 430, Florida Statutes.

Funding Source and Allocation Methodologies

Funds come from the federal Medicaid Trust Fund and state General Revenue.

PACE Centers	Counties Funded	Funded Slots
Florida PACE	Broward	125
Florida PACE	Miami-Dade	709
Hope Select Care PACE	Lee, Charlotte, and Collier	440
Palm Beach PACE	Palm Beach	656
Suncoast PACE	Pinellas	325
PROGRAM TOTAL		2,255

NOTE: Each state and federally approved site has a maximum number of individuals that may receive services through PACE.

PACE Appropriation History and Numbers Served

State Fiscal Year	Combined Federal and State Funding	Clients Served
2008-2009	\$10,278,683	550
2009-2010	\$10,278,683	550
2010-2011	\$9,960,079	900
2011-2012	\$14,269,333	795
2012-2013	\$25,207,786	1,018
2013-2014	\$28,330,951	1,100
2014-2015	\$36,526,016	1,108
2015-2016	\$39,550,155	1,539
2016-2017	\$50,282,883	1,866
2017-2018	\$47,718,123	#1,894

#Projection

Source for clients served: Monthly enrollment reports from PACE Organizations

Program Highlight

A PACE enrollee had a long-standing history of multiple psychiatric issues and was at high risk of being permanently placed in an institution. She was a danger to herself as she often left her home in the middle of the night and needed daily monitoring and redirection. Since enrollment in the program, PACE staff has monitored her medical issues closely and adjusted her medication. Additionally, she sees a psychiatrist on a regular basis and has not exhibited any of her past behaviors. The daughter credits her mother's improvement to her attendance at the PACE Center four days a week. She has also said that her mother's socialization skills have progressed with peers, family, and staff, and she feels that the services provided have not only enhanced the quality of her mother's life but her own as well.



Medicaid Programs

Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC)

Description

The Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC) was authorized by the 2011 Florida Legislature through House Bill 7107, which created Part IV of Chapter 409, Florida Statutes, to establish the Florida Medicaid program as an integrated Statewide Managed Care Program for all covered services, including long-term care services.

Medicaid recipients who qualify and become enrolled in SMMC LTC receive long-term care services from a managed care plan. The program uses a managed care delivery system to provide long-term care services and acute care services, including case management and coordination, to individuals who are dually eligible for Medicare and Medicaid or to Medicaid-eligible adults with a disability.

The state Medicaid program, through a monthly capitated rate, funds all home and community-based services and nursing home care. Clients are able to receive an array of acute and long-term services, such as home-delivered meals, coordination of health services, and intensive case management. These services are delivered through enrollment in managed care plans.

Services and Activities

SMMC LTC enrollees receive long-term care and acute services. Long-term care services provided include homemaker, companionship, assisted living services, case management, adult

day care, home accessibility adaptation, escort, hospice, assistive care, assisted living facility services, behavioral management, personal care, personal emergency response systems, medical equipment and supplies, intermittent and skilled nursing, medication administration and management, caregiver training, home-delivered meals, respiratory therapy, respite care, occupational therapy, physical therapy, speech therapy, nursing facility services, and non-emergency transportation. Acute care services are covered by the enrollment in a Statewide Medicaid Managed Care Managed Medical Assistance (MMA) program and through Medicare enrollment.

Administration

The Agency for Health Care Administration (AHCA) administers this program. The Department of Elder Affairs monitors the health plans in coordination with AHCA and administers the Independent Consumer Support Program (ICSP) to ensure that SMMC LTC consumers have multiple access points for information, complaints, grievances, appeals, and questions.

Eligibility

SMMC LTC enrollees must be age 18 or older and determined disabled by the Social Security Administration or be age 65 or older and enrolled in Medicare Parts A and B, be eligible for Medicaid up to the Institutional Care Program (ICP) income and asset levels, and be determined by CARES to be medically eligible by requiring nursing home level of care.

Statutory Authority

Section 1915(c)(1) of the Social Security Act; and section 409, Florida Statutes.

Funding Source and Allocation Methodologies

Funds are allocated from the federal Medicaid Trust Fund and General Revenue to the Agency for Health Care Administration.

Numbers Served

State Fiscal Year	Clients Enrolled
2013-2014*	97,364
2014-2015	110,241
2015-2016	116,745
2016-2017	122,068
2017-2018	#122,068

*August 2013 - June 2014

#Projection

Source: Agency for Health Care Administration

Program Highlight

The Department of Elder Affairs has continued the Person-Centered Monitoring (PCM) program, implemented in 2015, for all Statewide Medicaid Managed Care Long-term Care (SMMC LTC) enrollees. PCM is a national initiative led by the Centers for Medicare and Medicaid Services (CMS) geared towards improving quality of care and, ultimately, resulting in better outcomes for SMMC LTC enrollees.

The PCM program consists of two main elements: case file reviews and face-to-face visits. A statistically significant random sample of case files are requested quarterly from each SMMC LTC managed care plan and are reviewed by DOEA staff to ensure that all case management requirements are met. Elements reviewed include timeliness and appropriateness of monthly contacts, involvement of the enrollee and/or their representative in the decision-making process, and whether authorized services meet the assessed need of the enrollee, among many others.

Face-to-face visits are conducted monthly with enrollees and/or their representative to determine enrollee satisfaction and ensure that quality care is being provided by the managed care plans. Visiting enrollees in their communities allows DOEA staff to interact with enrollees on a more personal level and provides the enrollees a valuable outlet to voice their opinion on the program and their provider. PCM allows DOEA to more adequately evaluate the SMMC LTC program through the eyes of the elders we serve and ensure that they are receiving the quality of care expected.

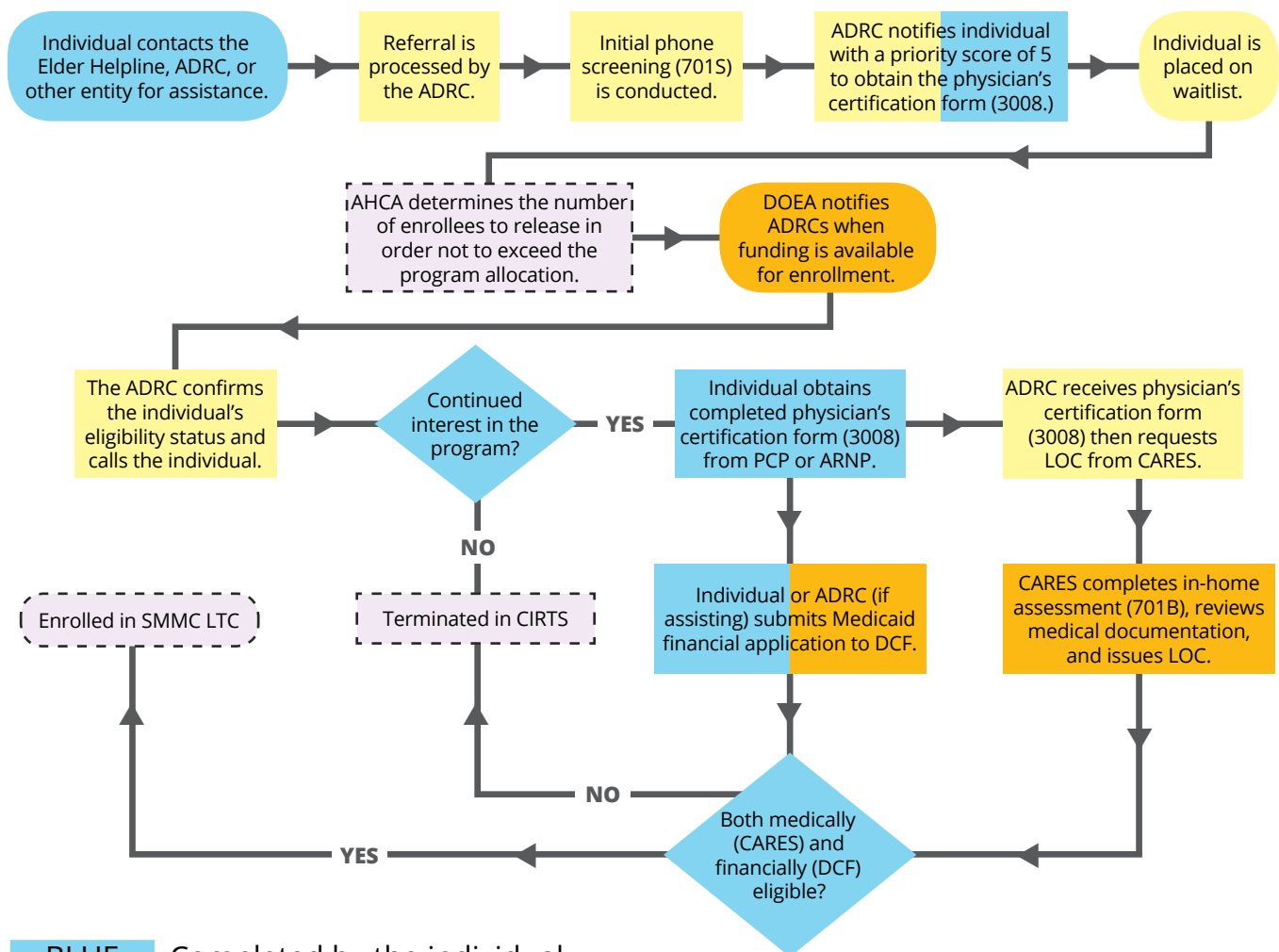
Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC) Waitlist Process Map

The Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC) Waitlist Process Map provides an overview of the process for an individual to be enrolled in SMMC LTC. The process map demonstrates the interaction between an individual and DOEA from the beginning of the process to enrollment (end of process).

The length of time to complete the enrollment process depends upon several factors including funding and proper documentation being submitted.

ACRONYMS USED IN WAITLIST PROCESS MAP

- ADRC:** Aging and Disability Resource Center
- AHCA:** Agency for Health Care Administration
- ARNP:** Advanced Registered Nurse Practitioner
- CARES:** Comprehensive Assessment and Review for Long-Term Care Services Program
- CIRTS:** Client Information and Registration Tracking System
- DCF:** Department of Children and Families
- DOEA:** Department of Elder Affairs
- LOC:** Level of Care
- PCP:** Primary Care Physician
- SMMC LTC:** Statewide Medicaid Managed Care Long-term Care Program



- BLUE** Completed by the individual
- YELLOW** Completed by the ADRC
- ORANGE** DOEA/CARES action