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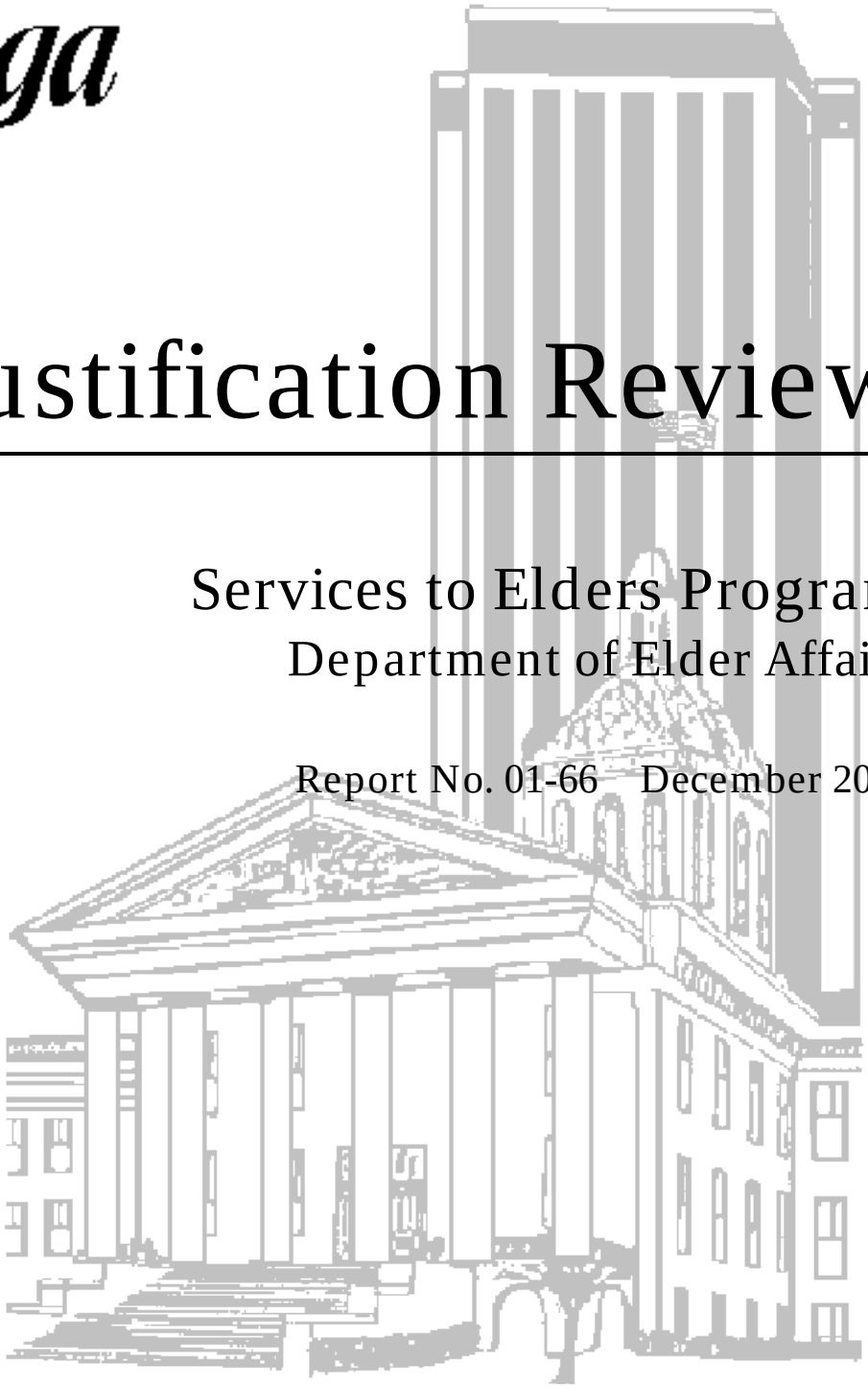

Justification Review

Services to Elders Program
Department of Elder Affairs

Report No. 01-66 December 2001

Office of Program Policy Analysis and Government Accountability

an office of the Florida Legislature

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Project supervised by Frank Alvarez
Project conducted by Nancy Dufoe, Cleo Johnson, Claire Mazur, and Scott Stake (488-0021)
John W. Turcotte, OPPAGA Director

The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

John W. Turcotte, Director

December 2001

The President of the Senate,
the Speaker of the House of Representatives,
and the Joint Legislative Auditing Committee

I directed our office to examine the Services to Elders Program administered by the Department of Elder Affairs. OPPAGA reports findings and recommendations required by the Government Performance and Accountability Act of 1994. Nancy Dufoe, Cleo Johnson, Claire Mazur, and Scott Stake conducted the examination under the supervision of Frank Alvarez.

We wish to express our appreciation to the staff of the Department of Elder Affairs for its cooperation and the many courtesies shown us during the course of the examination.

Sincerely,

John W. Turcotte
Director

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Executive Summary

Justification Review of the Services to Elders Program

Purpose

This report presents the results of OPPAGA's program evaluation and justification review of the Department of Elder Affairs' Services to Elders Program. State law directs OPPAGA to complete a justification review of each state agency that is operating under a performance-based program budget. The Department of Elder Affairs, which organizes all of its services under the Services to Elders Program, began operating under a performance-based program budget in Fiscal Year 1999-00. Thus, OPPAGA conducted this review to assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

Background

The purpose of the Services to Elders Program is to administer services and long-term care programs to the elderly. The program's major goal is to help elders remain in their own communities in the least restrictive, most appropriate, and safest setting to prevent unnecessary or premature nursing home placement. Another goal is to promote and advocate for services for the state's elderly population. The Services to Elders Program fulfills these goals by providing Florida's citizens over the age of 60 with a variety of services in five major areas: Self-Care and Community Volunteer Services, Statewide Home and Community-Based Services, the Nursing Home Pre-Admission Screening Program, Consumer Advocate Services, and Long-Term Care Pilot Programs.

The Services to Elders Program operates under the organizational mandates of the Older Americans Act of 1965. [1] The original act and subsequent amendments establish a network of federal, state, and local agencies to plan and provide a variety of programs to meet the needs of older persons in the community. As Florida's state unit on aging, the Department of Elder Affairs is responsible for planning, coordinating,

[1] *U.S. Code*, Title 42, Ch. 35.

funding, administering, and evaluating programs and services for the state's elders. It monitors 11 Area Agencies on Aging (AAAs), which are public or non-profit organizations responsible for planning and coordinating programs and services for individuals in regional planning and service areas. Currently, 53 lead agencies are contracted by AAAs to provide case management and other services, such as homemaking, home health, respite, and personal care, either directly or through subcontracts with over 1,100 local service providers.

In Fiscal Year 2000-01, the department's largest budget entity, Home and Community-Based Services, provided services to 162,661 clients. [2] The Legislature appropriated $306,843,280 to the program for Fiscal Year 2001-02, with state general revenues accounting for 37% ($112,251,990) of the total appropriations, and the remaining 63% ($194,591,290) coming from various state and federal trust funds. Over the past five years, the Legislature has increased funding by 51%.

Program Benefit, Placement, Privatization, and Performance

The program benefits elders and should be continued

The Services to Elders Program benefits Florida's elders and should be continued. The program plans, develops, coordinates, and administers services critical for assisting the state's elder citizens to age with dignity and to remain independent as long as possible. This is especially important to Florida, since the state has the largest percentage (17.6%) and second highest number of elders over the age of 65 (2,807,597) in the nation. Support services are cost-effective because they can help delay or prevent nursing home placement.

The program is appropriately placed within the Department of Elder Affairs

We found no compelling reason to transfer the Services to Elders Program from the Department of Elder Affairs to another state agency. Such a move in effect would dismantle the department, which Florida voters created by constitutional amendment in 1991 to focus exclusively on the needs of elders. In addition, the move would possibly achieve no cost savings because the state still would have to provide the same level of services to the same number of clients.

The program is substantially privatized

With the exception of its administrative and oversight functions and pre-admission screening activities, the program is essentially (94%) privatized.

[2] This Fiscal Year 2000-01 client count does not include clients served in the CARES, Long-Term Care Ombudsman, and Public Guardianship Programs because program staff was unable to provide an unduplicated count. Furthermore, due to a change in methodology program staff reported a lower client count in their Fiscal Year 2001-02 Long Range Program Plan.

Although it is possible to privatize certain functions, such as nursing home pre-admission screening, we did not identify a compelling reason to privatize this function.

The program generally meets goals, but could serve more high-risk clients and measure the results of some services

Using data from Fiscal Years 1999-00 and 2000-01 performance-based program budgeting (PB^2) measures and other relevant performance information, we determined that the program has met some but not all of its legislative performance goals. The program exceeded its legislative goals to divert elders from nursing home care and to limit the percentage of clients who are probably eligible for Medicaid funding from being served in state funded programs. The program also provided effective nutritional and caregiver services, though it should do a better job of measuring the impact of these services. In addition, the program fell short of meeting its goal to serve the highest priority client groups (i.e., abused and neglected clients and clients at imminent risk of nursing home placement) and has not established performance measures to evaluate the effectiveness of the services provided by the Alzheimer's Disease Initiative.

Options for Improvement

Laptop computers, co-location with service providers, and better information flow should increase CARES program efficiency

The Services to Elders Program is generally meeting legislative goals, but improvements are needed to enhance program performance. To improve the efficiency of CARES staff assessments and increase client diversions from nursing homes, the program should make it a priority to fully implement the laptop computer pilot project so that assessment information from the laptops can be downloaded to the main computer system. In addition, CARES staff should continue to co-locate with service providers whenever possible in order to collaborate more closely with service providers and Department of Children and Families financial eligibility staff.

To ensure that accurate data is reported to the Legislature and other policymakers, the program should continue to improve and monitor the accuracy of the data on abused and neglected clients. Also, the program should routinely reconcile data between CARES and service providers to make certain that accurate information about imminent risk clients is available and closely monitor local providers' compliance with contract requirements, so that all imminent risk clients are served.

To maximize the number of Medicaid-eligible clients that are transferred from the Community Care for the Elderly program to the waiver, the program should improve efforts to inform clients about the Medicaid waiver program, work with the Department of Children and Families to improve the timeliness of the financial eligibility process, and monitor the provider agencies' adherence to the contractual requirements for

transferring clients more closely and sanction providers that do not comply.

To better assess clients' nutritional status, the program should design a supplemental nutritional assessment that better measures a client's improvement over time by Fiscal Year 2002-03. It should also continue to work on the federal Administration on Aging pilot project, which tests an assessment that asks questions about nutritional changes.

To better measure the likelihood of a caregiver continuing to provide care, the program should change its performance measure. One option is to incorporate the case manager's assessment about the likelihood of the caregiver continuing to provide care. Another option is to measure the quality of caregiver support services. This measure should reflect how many caregivers who self-report that they are very likely to provide care are still providing care a year later.

To ensure that the Alzheimer's Disease Initiative is providing beneficial services, the program should track information that measures the impact of caregiver support services. The information should include the degree to which caregivers are satisfied with the services they receive and to what extent Alzheimer's patients are being kept out of nursing homes.

The program needs to improve oversight of providers

Although the program generally delivers effective services to Florida's elder population through the aging network system, which includes the area agencies on aging, lead agencies, and service providers, we found several deficiencies with the current management system that diminish the program's overall efficiency and effectiveness. To improve the current program management and oversight systems, the program should take the actions discussed below.

- By the end of Fiscal Year 2001-02, program officials should establish target dates for updating all sections of the client services manual. Once the manual has been updated, they should submit the manual to the proper rule-making authorities, so that it becomes a legally binding document.
- Program officials should enhance written instructions to provide clear and comprehensive guidelines for all policies and procedures as the client services manual is updated. Also, by the end of Fiscal Year 2001-02, they should provide training and technical assistance to AAAs and lead agencies to address at least two unclear policies: the termination of CCE clients who refuse to transfer to services under the Medicaid waiver and the application of cost allocation and unit cost methodologies.
- By the end of Fiscal Year 2001-02, program officials should standardize definitions for program service units to the extent possible, so that a state rate for each service can be established, and enhance procedures for identifying, allocating, and reporting administrative costs. Once clear definitions and procedures have been established, these officials

should institute an absolute unit rate limit for each type of service based upon a market analysis and set a reasonable standard for administrative costs by the end of Fiscal Year 2002-03.

- Program officials should establish minimum standards for AAA monitoring procedures and instruments by the end of Fiscal Year 2001-02.
- Program headquarters should take corrective actions upon all AAAs that fail to comply with contract agreements within a reasonable time as specified by headquarters and enforce AAAs to correct incompliant providers as needed.

Long-term care pilot projects have potential for delaying nursing home placement, but improvements are needed

Managed long-term care is a new and complex business for the health management organization industry. Although the program experienced problems implementing the Long-Term Care Community Diversion Pilot Project, it is moving along with implementation plans for two additional pilot projects, Program for All-Inclusive Care for the Elderly and Social Health Maintenance Organization. Accordingly, we recommend that the program

- petition the Centers for Medicaid and Medicare Services (formerly the Health Care Finance Administration, or HCFA) to pursue waivers that achieve the integration of Medicare and Medicaid services under one provider.

As required by s. 430.709, *Florida Statutes*, the program contracted for an independent evaluation of the Long-Term Care Community Diversion project. However, the preliminary evaluation did not report on the cost of services, as required by law, nor did it assess client outcomes. Therefore, we recommend that the Legislature

- require the department to closely monitor contract providers to ensure that the elder enrollees are receiving the adequate care they need to delay or avoid nursing home placement and properly sanction contractors that do not meet this desired outcome.

We also recommend that the program

- contractually require providers to report cost information and
- contract for a comprehensive evaluation for the Long-Term Care Community Diversion project that addresses the areas required by law. At a minimum, the evaluation should include
  - a cost comparison of pilot participants with Medicaid waiver and nursing home clients;
  - client-specific outcomes, such as whether clients' desires are being met in terms of choice of services and providers and their right to privacy;
  - continuity of security, and whether the client is getting the necessary support from MCO case management to meet desired outcomes;

- a comparison between the pilot's frequency of incidents of preventable hospitalization and the national average; and
- an actuarial analysis of the capitation rate of the pilot program.

Agency Response

The Secretary of the Department of Elder Affairs provided a written response to our preliminary and tentative findings and recommendations. (See Appendix D, page 48, for his response.)

Chapter 1

Introduction

Purpose

This report presents the results of OPPAGA's program evaluation and justification review of the Department of Elder Affairs' Services to Elders Program. State law directs OPPAGA to complete a justification review of each state agency that is operating under a performance-based program budget. Program evaluation and justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

The Department of Elder Affairs, which began operating under a performance-based program budget in Fiscal Year 1999-00, organizes all of its services under one program, the Services to Elders Program. This report assesses these services and identifies alternatives to improve the efficiency and effectiveness of program operations. Appendix A summarizes our conclusions regarding each of the nine areas the law directs OPPAGA to consider in a program evaluation and justification review.

Background

The Services to Elders Program provides services to avoid or delay nursing home placement

The purpose of the Services to Elders Program is to administer services and long-term care programs to the elderly. The program's major goal is to help elders remain in their own communities in the least restrictive, most appropriate, and safest setting to prevent unnecessary or premature nursing home placement. The program also promotes and advocates for services for the state's elderly population.

The Services to Elders Program provides Florida's citizens over the age of 60 with a variety of services in five major areas.

Self-Care and Community Volunteer Services offer information and referral and wellness programs to aid the elderly and their caregivers in making informed choices about their health. In addition, these services provide information, training, and technical support to agencies and individuals interested in volunteering, utilizing volunteers, or needing the services of volunteers.

Statewide Home and Community-Based Services support and maintain elders' independence and quality of life through the programs described below.

- ***Older Americans Act Programs***. Federally funded Older Americans Act programs provide a variety of home and community-based services, such as congregate meals and nutrition education, home-delivered meals, homemaker services, chore services, home health aides, adult day care, transportation, and information and referral.
- ***Alzheimer's Disease Initiative.*** This initiative provides a continuum of services to meet the needs of individuals with Alzheimer's disease and other memory-related disorders and their caregivers. Services include caregiver respite, day care, and memory disorder clinics. The initiative also funds research on topics, such as diagnostic techniques, therapeutic interventions, and supportive services.
- ***Home Care for the Elderly.*** This program gives relatives or other caregivers a monthly subsidy to assist them in keeping frail elders in their own homes or the homes of caregivers. The program may also provide special subsidies to purchase additional services or supplies, such as respite care and medical supplies.
- ***Community Care for the Elderly.*** This program offers services and case management to frail elders, making it possible for them to live independently. Services include homemaker services, personal care, and respite care. Depending on the availability of funding, elders may also receive adult day care, home health aides, counseling, home repair, medical therapeutic care, and emergency alert response services.
- ***Medicaid Assisted Living for the Elderly Waiver.*** This federal waiver program allows Florida to use Medicaid Waiver funds to pay for additional services to individuals in assisted living facilities. The assisted living facilities provide housing, meals, and some supportive services. To maintain a client in these facilities and prevent or delay nursing home placement, the waiver program funds other needed services, such as personal care, physical therapy, and intermittent nursing services.
- ***Medicaid Aged/ Disabled Adult Waiver.*** This federal waiver program utilizes Medicaid funds to provide services to frail, severely impaired elders and disabled adults who are unable to care for themselves and are eligible for nursing home placement. The program makes available various services, such as homemaker services, personal care, medical supplies, and adult day care, which allow clients to remain in their homes instead of in nursing homes.

The Nursing Home Pre-Admission Screening Program, or Comprehensive Assessment and Review for Long-Term Care Services (CARES), conducts pre-admission screenings for nursing home applicants. The program is federally mandated to determine clients' level of need for long-term care and their medical eligibility to receive Medicaid funded long-term care

services. Based on the assessment, CARES staff recommends the least restrictive and most appropriate placement.

Consumer Advocate Services, which include the Long-Term Care Ombudsman and the Public Guardianship programs, provide investigative and protective service to elderly clients. The Long-Term Care Ombudsman Program receives, investigates, and resolves complaints of residents living in long-term care facilities, such as nursing homes and assisted living facilities. The Public Guardianship Program supplies guardians to protect the property and personal rights of incapacitated individuals. Both of these programs are administratively housed in the Department of Elder Affairs, but are independent of the program's control.

Long-Term Care Pilot Programs test innovative ways to provide long-term care services. The Long-Term Care Community Diversion Pilot Project uses a managed care delivery system to offer home and community-based long-term care as an alternative to nursing home care and integrates the delivery of acute and long-term care. [3] The program is also currently planning two other pilot projects: the Program for All Inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (SHMO). PACE is designed to provide acute services, such as physician care and inpatient hospital visits, and long-term care services, paid for with integrated and capitated Medicaid and Medicare funds. The target implementation date for the PACE pilot is June 2002. SHMO will build upon the experiences and successes of the Community Diversion and PACE pilots to deliver a comprehensive package of preventive, acute, and long-term care services. Program staff has not identified an implementation date.

Program Organization

Many agencies provide services to the elderly

The Services to Elders Program operates under the organizational mandates of the Older Americans Act of 1965. [4] The original act and subsequent amendments establish a network of federal, state, and local agencies to plan and provide a variety of programs to meet the needs of older persons in the community. As reflected in Exhibit 1, Florida's aging network includes the Department of Elder Affairs, Area Agencies on Aging, lead agencies, and local service providers. [5]

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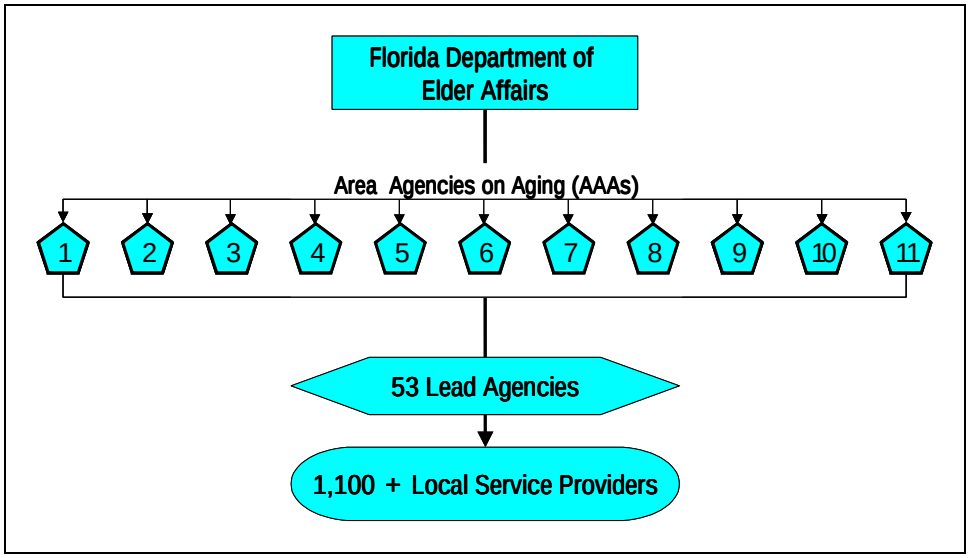
[3] Currently, the Long-Term Care Community Diversion Pilot Project is in Orange, Osceola, Palm Beach, and Seminole counties.

[4] *U.S. Code*, Title 42, Ch. 35.

[5] The Administration on Aging, located in the federal Department of Health and Human Services, is the principal federal agency responsible for elder programs. It provides funding and assistance to states to develop community-based systems of services for elders.

Exhibit 1
The Florida Aging Network Has Many Layers

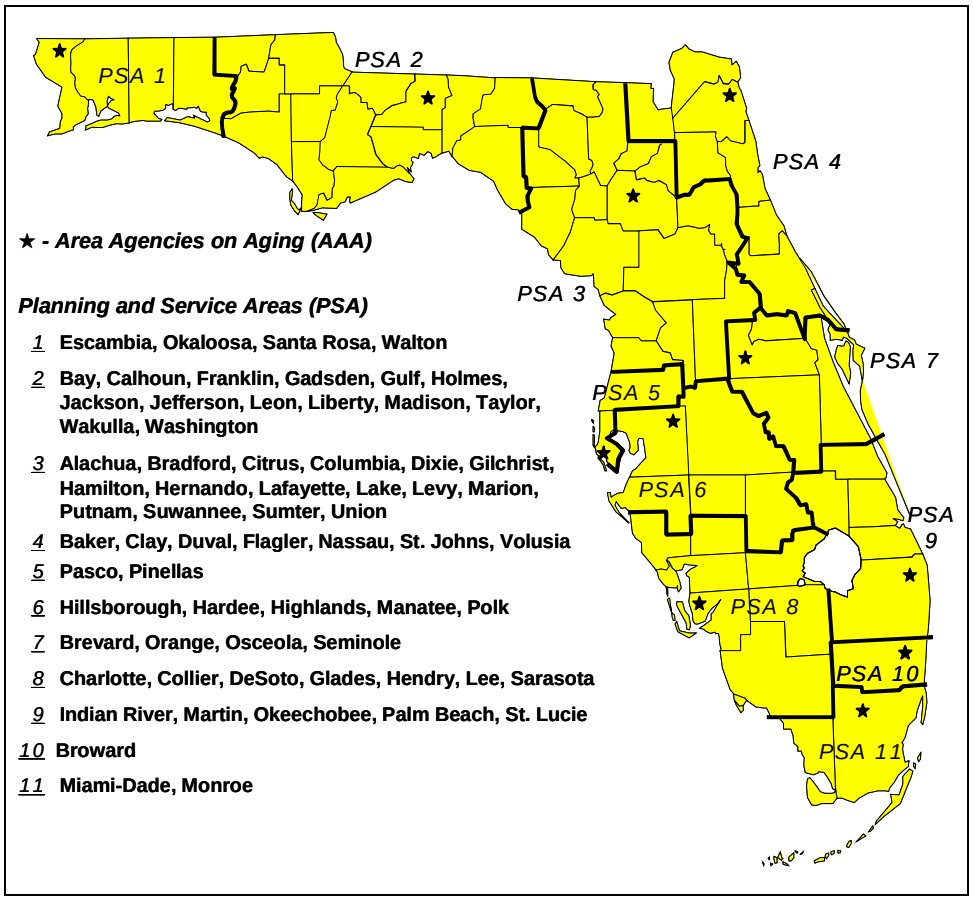


Source: Florida Department of Elder Affairs.

The Department of Elder Affairs serves as Florida's state unit on aging. The Older Americans Act requires that each state designate one agency to be the focal point for programs and issues related to the elderly. As Florida's state unit on aging, the Department of Elder Affairs is responsible for planning, coordinating, funding, administering, and evaluating programs and services for the state's elders.

Area Agencies on Aging (AAAs) provide regional management. The Older Americans Act also requires that states establish Area Agencies on Aging (AAAs) to coordinate elder services in regional planning and service areas. These geographic areas are designated based on factors that include the distribution of elders, the need for services with emphasis on the needs of low-income minorities, and existing boundary areas for the delivery of social services. AAAs are public or non-profit organizations responsible for planning and coordinating programs and services for individuals at the local level. Each AAA administers federal, state, local, and private funds through contracts with lead agencies and other local providers that deliver direct services. Exhibit 2 shows the boundaries of Florida's 11 planning and service areas and the location of the AAAs.

Exhibit 2
Eleven Planning and Service Areas and Area Agencies on Aging Serve Florida's Elderly



Source: Department of Elder Affairs.

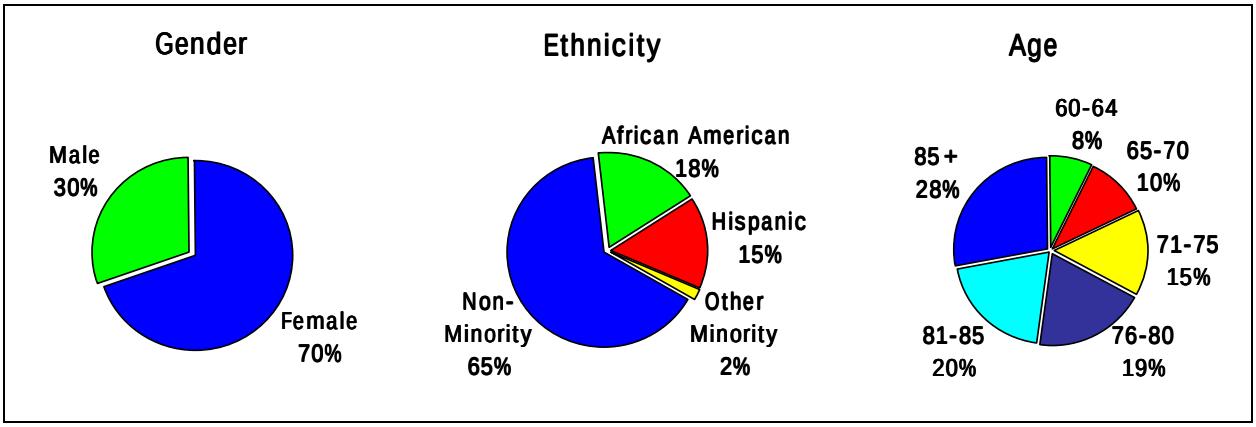
AAAs contract with lead agencies to provide Community Care for the Elderly case management, as well as other services. Currently, 53 lead agencies offer services, such as homemaker services, home health aides, respite care, and personal care, either directly or through subcontracts with providers. Of the 53 lead agencies, 9 are county governments and the remaining 44 are not-for-profit agencies.

Local agencies provide most of the state's direct services to elders. Local service providers are contracted by lead agencies to deliver services, such as transportation, home health aides, meals, counseling, and day care. As of June 2001, over 1,100 local service providers had contracts with lead agencies to meet the needs of the elders in their communities.

Clients served

In Fiscal Year 2000-01, the Department's largest budget entity, Home and Community-Based Services, provided services to 162,661 clients.[6] As shown in Exhibit 3, clients who received services were generally non-minority females over the age of 75.

Exhibit 3
The Majority of Program Clients Are Female, Non-Minority, and Over the Age of 75



Source: Florida Department of Elder Affairs.

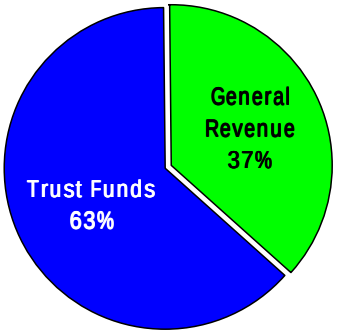
Program resources

The majority of the program's appropriations come from trust funds

Florida's Legislature appropriated $306,843,280 to the Services to Elders Program for Fiscal Year 2001-02. As shown in Exhibit 4, revenues come from several sources, with general revenue accounting for more than one-third ($112,251,990 or 37%) of the total appropriations. The remaining appropriations ($194,591,290 or 63%) are from various state and federal trust funds.

[6] This Fiscal Year 2000-01 client count does not include clients served in the CARES, Long-Term Care Ombudsman, and Public Guardianship Programs because program staff was unable to provide an unduplicated count. Furthermore, due to a change in methodology program staff reported a lower client count in their Fiscal Year 2001-02 Long Range Program Plan.

Exhibit 4
The Program Is Funded with State General Revenue and Trust Funds

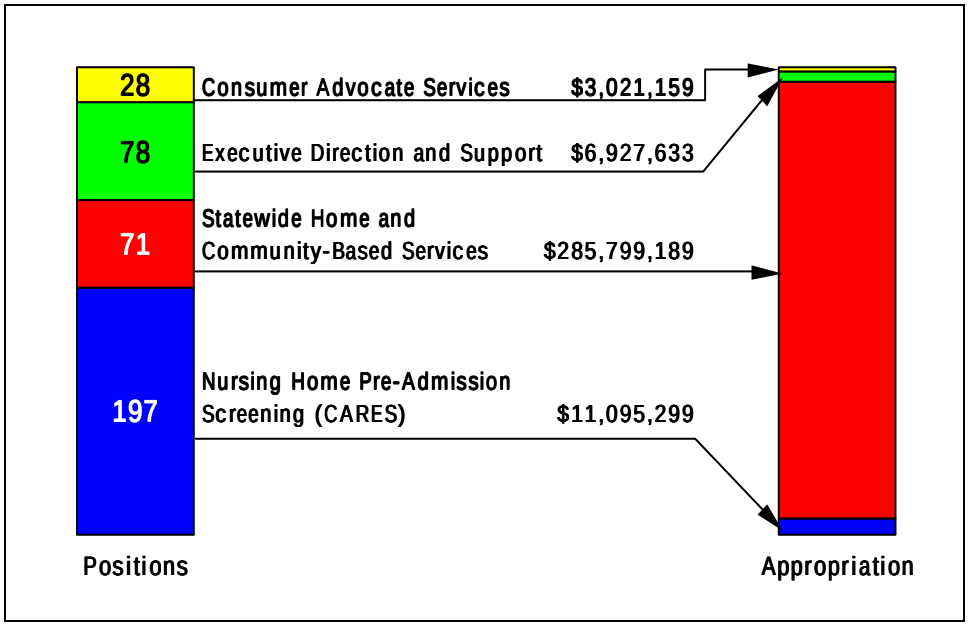


Revenue Source	Fiscal Year 2001-02 Appropriations
Trust Funds	
Grants and Donations Trust Fund	$ 562,880
Administrative Trust Fund	834,411
Tobacco Settlement Trust Fund	25,136,409
Operations and Maintenance Trust Fund	71,025,485
Federal Grants Trust Fund	97,032,105
Trust Funds Total	***$194,591,290***
State General Revenue	***112,251,990***
Total	**$306,843,280**

Source: Ch. 2001-253, *Laws of Florida.*

For Fiscal Year 2001-02, the Legislature appropriated 374 full-time equivalent (FTE) positions to administer the Services to Elders Program. Over half of the positions, 197 (53%), were assigned to the Nursing Home Pre-Admission Screening (CARES) program. Exhibit 5 shows the program's position and appropriation allocations.

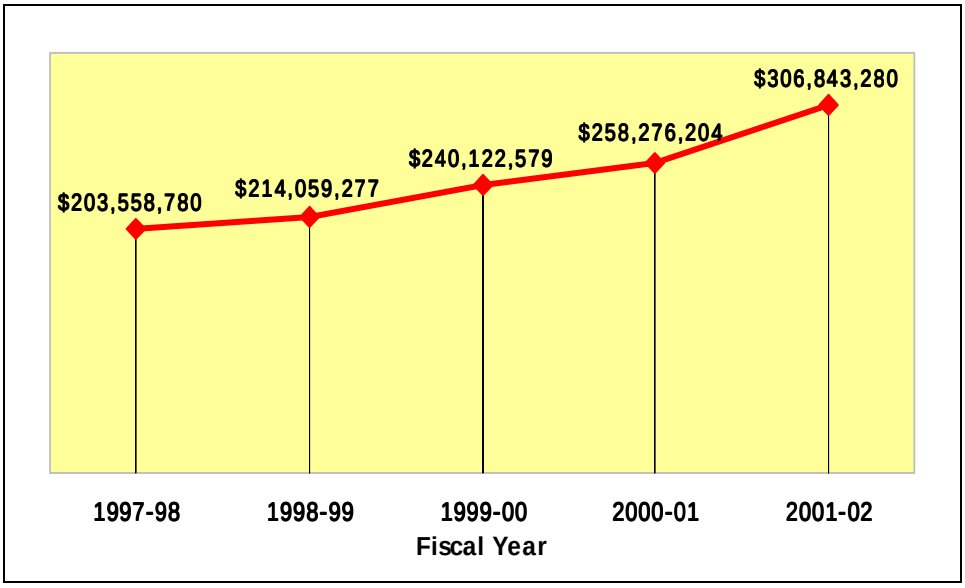
Exhibit 5
The Majority of Positions Are in the CARES Program, But Funding Is Concentrated in Home and Community-Based Services



Source: Ch. 2001-253, *Laws of Florida.*

Over the past five years, the program's funding increased by 51%, from $203,558,780 in Fiscal Year 1997-98 to $306,843,280 in Fiscal Year 2001-02 (see Exhibit 6). During the same period, FTE positions increased by 16%, from 322 to 374, and the number of clients increased by 41%, from 114,980 to 162,661.

Exhibit 6
Program Appropriations Increased 51% from Fiscal Year 1997-98 to Fiscal Year 2001-02



Source: Laws of Florida, General Appropriations Act, Fiscal Year 1997-98 to Fiscal Year 2001-02.

Chapter 2

Program Benefits, Placement, and Privatization

Introduction

The Department of Elder Affairs' Services to Elders Program began operating under performance-based budgeting in Fiscal Year 1999-00. The program serves Florida's elderly citizens by providing services that allow them to live in the community as long as possible and to avoid unnecessary or premature institutionalization. Program services focus on helping elders to age in the most comfortable and appropriate elder-friendly environment with security, purpose, and dignity.

Services benefit elders and the state and should be continued

The program provides services that assist elder citizens to age with dignity and remain independent

The Services to Elders Program benefits Florida's elders and should be continued. The program plans, develops, coordinates, and administers services critical for assisting the state's elder citizens to age with dignity and to remain independent as long as possible. Many elders are frail, have difficulty caring for themselves, and are economically disadvantaged, increasing their risk of nursing home placement. As of January 2001, 13% of Florida's elders aged 60 and over had incomes below the federal poverty level, and 25% of elders 65 and over were living alone during Fiscal Year 2000-01. By providing support services, the program can help delay or prevent these persons from being placed in nursing homes, which is cost-effective for the state and beneficial to clients and their families. In Fiscal Year 2000-01, home and community-based services cost between $2,628 and $10,250 a year per elder, compared to $42,847 annually for nursing home placement.

Florida has the largest percentage and second highest number of elders in the nation

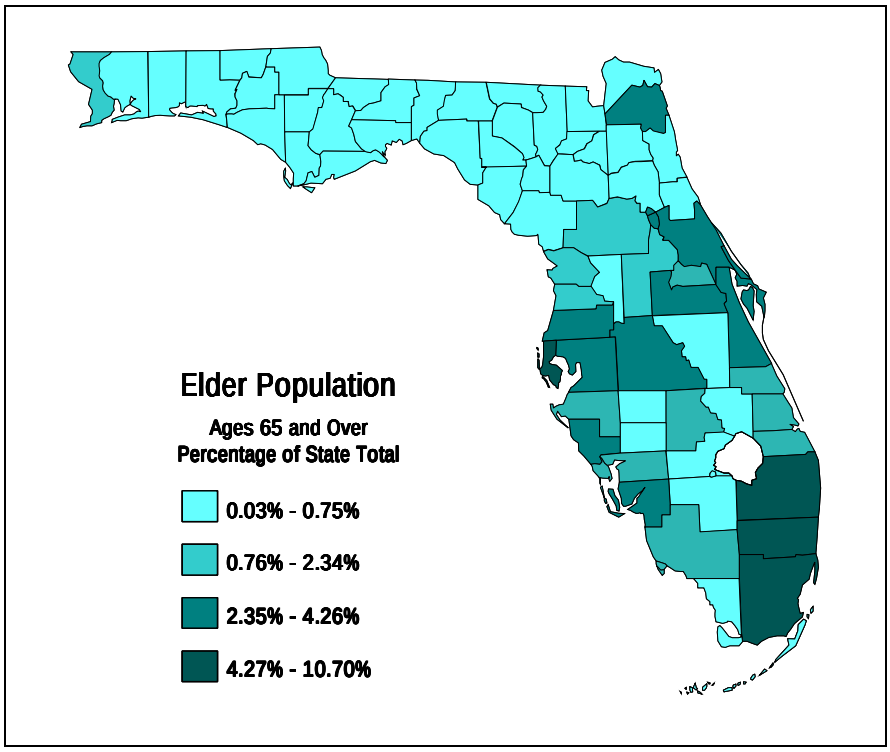
The Services to Elders Program is important to the state. Florida has the largest percentage and second highest number of elders in the nation. As shown in Exhibit 7, 17.6% of Florida's population is over the age of 65, compared to 12.4% nationally.

Exhibit 7
In 2000, Florida Had the Largest Percentage of Elders in the Nation

	Percentage of Population 65+	Total Number Elders 65+	Total Population All Ages
Florida	**17.6%**	**2,807,597**	**15,982,378**
Pennsylvania	15.6%	1,919,165	12,281,054
New York	12.9%	2,448,352	18,976,457
California	10.6%	3,595,658	33,871,648
Texas	9.9%	2,072,532	20,851,820
United States	**12.4%**	**34,991,753**	**281,421,906**

Source: United States Census Bureau, Census 2000.

Exhibit 8
Elders Are Concentrated in Southern Florida



Source: U.S. Census Bureau.

If the program were discontinued, the overall costs for the state to provide long-term care for elders would increase, because many individuals who currently receive services in community-based settings would no longer be able to obtain these services and would likely be placed in a nursing home. In addition, discontinuing the program would increase the burden placed on families who care for frail elderly relatives by removing the availability of respite and other services needed by those caregivers.

The program is appropriately placed in the Department of Elder Affairs

We found no compelling reason to transfer the Services to Elders Program from the Department of Elder Affairs to another state agency. Such a move in effect would dismantle the department, which Florida voters created by constitutional amendment in 1991 to focus exclusively on the needs of elders. In addition, the move possibly would achieve no cost savings because the state still would have to provide the same level of services to the same number of clients. Although some states provide aging services through their respective social service agencies, others like Florida have a separate agency responsible for planning for and meeting the needs of their elder citizens. As of September 2001, 23 states and the District of Columbia, including the states with the largest elder populations (California, Florida, New York, Pennsylvania, and Texas), have designated separate departments to focus exclusively on the special needs of their elders (see Appendix B).

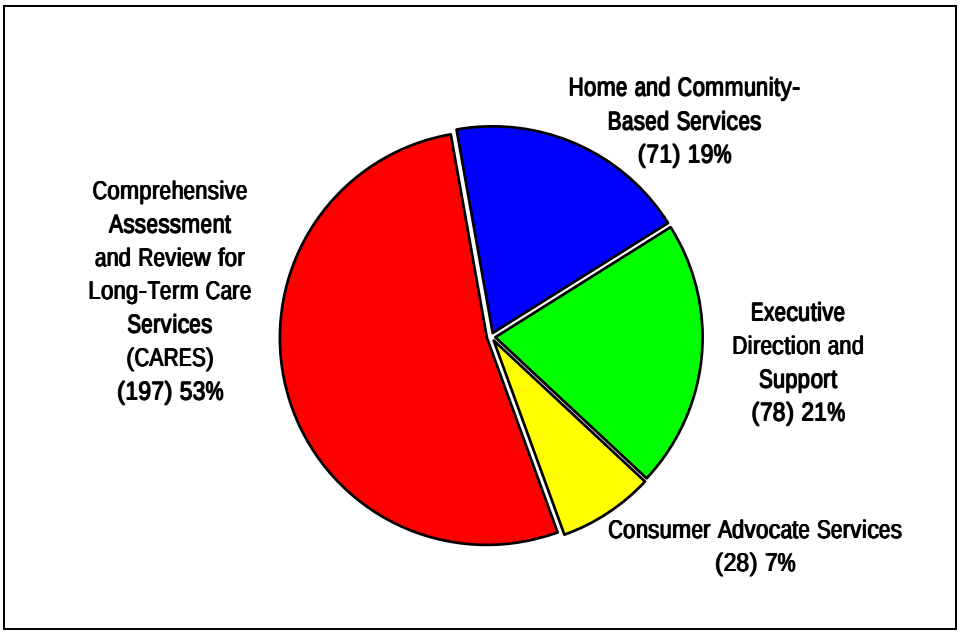
The program is substantially privatized and potential for further outsourcing is limited

Most program services are contracted through the Area Agencies on Aging, lead agencies, and local service providers

The program is substantially privatized. Most of the program's services are delivered through contracts with the state's 11 Area Agencies on Aging, 53 lead agencies, and over 1,100 local service providers. According to program officials, contracted services account for 94% of the program's budget, while the remaining 6% pays for oversight and administrative functions, such as contract monitoring and nursing home pre-admission screening.

Approximately 6% of program resources, $17.3 million, is appropriated for 374 FTE staff positions. As shown in Exhibit 9, the majority (197) of the program's positions are Comprehensive Assessment and Review for Long-Term Care Services (CARES) management, assessment, and support staff, 78 are executive direction and support positions, 71 are Home and Community-Based Services staff who primarily administer and oversee the program's contracts, and 28 are consumer advocate services staff who are in the Long-Term Care Ombudsman Program and the Office of the Statewide Public Guardian.

Exhibit 9
The Majority of Positions Are Concentrated in the CARES Program



Source: Chapter 2001-253, *Laws of Florida.*

The program has outsourced its personnel function

The program has taken some steps to increase efficiency in its executive direction and support function by outsourcing some activities. In Fiscal Year 1999-00, the program outsourced three personnel positions through an interagency agreement with the Florida Department of Health (DOH), which now provides payroll processing and human resources activities for the department. These activities will be outsourced to the private sector under the state's overall initiative to privatize state personnel services. Also, the program proposed to privatize the 11 positions responsible for providing training to assisted living facility staff in its Fiscal Years 2001-06 Long Range Program Plan (LRPP). The salaries and benefits for these positions total $476,700.

Privatizing the remaining positions has limitations, and any decision to privatize should be carefully considered. For example, privatizing some of the 177 non-CARES positions could result in a loss of federal funds. More than half of the 177 positions are fully or partially federally funded. Federal guidelines require that state employees must perform these functions in order to remain eligible for funding. In addition, program officials questioned whether privatizing the CARES program would result in a loss of indirect federal funds, which are projected to be $1.3 million in Fiscal Year 2001-02.

Although privatizing CARES positions is feasible and would decrease the state workforce, the existing CARES system is achieving desired results, and we did not identify a compelling reason to privatize this function.[7]

- For example, the current operations are successful, and changing administration might jeopardize success. As discussed in Chapter 3, the CARES Program is performing well and is exceeding its legislative performance standards for diverting clients from nursing homes.
- The current system appears to be cost-effective, and privatization may increase costs rather than produce cost savings. The CARES function uses registered nurses to medically assess clients. Currently, the CARES Program hires registered nurses at a lower rate (approximately $32,000) than the average salary of registered nurses in Florida ($45,974). In addition, there is a critical shortage of nurses throughout the nation and Florida. Florida is projected to need 34,000 additional registered nurses by 2006. In order to attract nurses, hospitals and other private providers are offering signing bonuses and other financial incentives. These additional costs might make it problematic for state-funded contracted providers to compete for qualified nurses.

Given these limitations, the Legislature and the department should carefully consider whether to further privatize program functions. Should the Legislature and the department decide to further privatize, department managers should

- thoroughly identify the services to be privatized and current state costs for these services;
- estimate the state's contract monitoring costs;
- review applicable federal regulation pertaining to privatizing these positions and seek appropriate waivers;
- include in the contract performance standards the desired reporting requirements; and
- establish a strong contract oversight mechanism for monitoring the contractors.

[7] More than half (53% or 197) of the program's employees conduct nursing home pre-admission screenings, which are accomplished through the CARES program.

Chapter 3

Program Generally Meets Goals, But Could Serve More High-Risk Clients, Measure Results of Some Services

Introduction

The primary mission of the Services to Elders Program is to provide prompt and appropriate services to help clients remain in their own homes and communities rather than be placed in more costly nursing homes. Program services, such as adult day care, personal assistance with daily living activities (e.g., meal preparation, bathing, and grooming), and respite for caregivers, help clients avoid or delay more costly institutional care. Therefore, program success benefits both clients and the state; clients are able to remain in their own homes, and the state achieves significant cost savings.

To assess the program's performance in achieving its goals, we analyzed Fiscal Years 1999-00 and 2000-01 performance-based program budgeting (PB^2) measures and other relevant performance information. We determined that the program has substantially met its legislative performance standards. Specifically, the program

- has exceeded its legislative goal to divert elders from nursing home care; it diverted 11,002 clients from nursing home placement for at least one month, achieving a cost avoidance of $31.5 million;
- has not met its legislative goal of providing services within 72 hours to the highest priority client group (i.e., clients who are abused or neglected), and fell short of meeting its goal of serving the second highest priority client group (i.e., clients at imminent risk of nursing home placement);
- has exceeded its legislative goal of limiting the percentage of clients who are probably eligible for Medicaid funding from being served in state-funded programs, successfully transferring 1,951 state general revenue clients to the Medicaid waiver, achieving a $6.6 million federal match;

- has exceeded its legislative goal to improve the nutritional status of new high-risk clients, but should do a better job of measuring the results of these services;
- has substantially met the legislative goal for the percentage of caregivers who reported that they were very likely to provide care; and
- has appeared to provide beneficial services to clients with Alzheimer's disease and their caregivers, but did not establish measures to assess effectiveness.

The program has been successful in diverting clients from nursing home placement

A primary program goal is to prevent unnecessary or premature nursing home placement. Helping elders remain in the least restrictive, most appropriate, and most cost-effective settings is important for two reasons. First, research shows that most elders would prefer to remain in their homes or other community settings rather than be placed in a nursing home. Second, the cost of home and community-based care is less than nursing home care. The average monthly cost for home and community-based Medicaid waiver services is $709, while the average monthly cost for nursing home care is $3,570. [8]

As a part of the federally mandated pre-admission screening program for Medicaid nursing home applicants, the program has established Comprehensive Assessment and Review for Long-term Care Services (CARES). This program utilizes registered nurses and social workers to identify clients' needs for long-term care, establish their medical eligibility to receive Medicaid funding for long-term care, and recommend the least restrictive and most appropriate service placement, with an emphasis on allowing clients to remain in their own homes or in other community placements.

Program has exceeded goal for diverting clients from nursing home placement

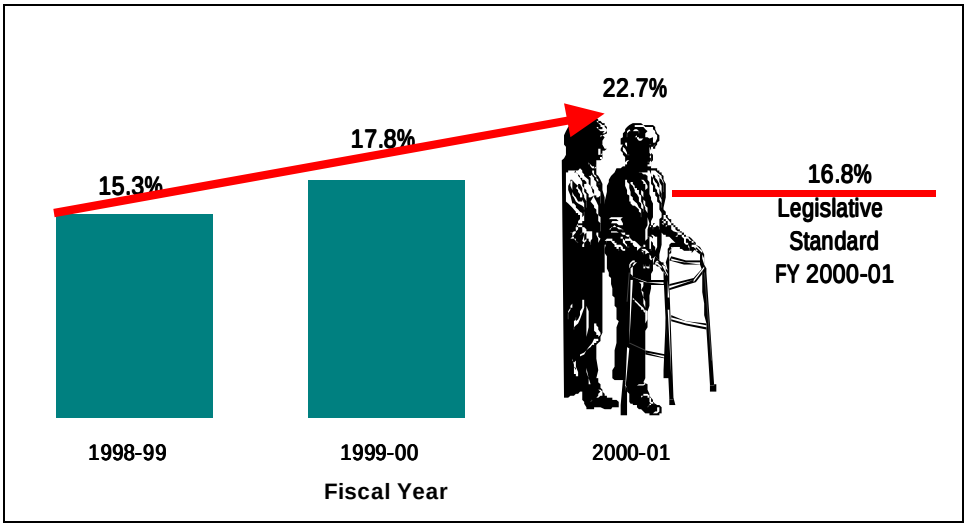
The Legislature established a standard that the program should divert 16.8% of clients assessed by CARES. In Fiscal Year 2000-01, CARES staff assessed 48,416 clients applying for nursing home Medicaid eligibility and diverted 22.7% (11,002), significantly exceeding the legislative standard. In addition, the program has improved its performance in the past three years (see Exhibit 10). By diverting these clients from nursing home placement for at least one month, the program achieved a cost avoidance of $31.5 million in state and federal Medicaid nursing home costs.

The CARES Program also assesses other types of clients. In addition to assessing the 48,416 Medicaid nursing home applicants, the program

[8] The cost includes federal and state funds.

conducted 14,670 assessments on other Medicaid program applicants. Assessors also conducted 6,396 Continued Residency Reviews on Medicaid nursing home residents to verify their continued need for nursing home level of care and certified 5,520 assessments conducted by lead agency staff on Medicaid nursing home applicants.

Exhibit 10
The Program Has Increased the Percentage of Clients Diverted from Nursing Home Placement



Source: Florida Department of Elder Affairs.

Program officials attribute the increase in the number of diversions to three factors. First, over the past three fiscal years, the Legislature authorized 36 new positions to implement the Hospital-Based Assessments initiative. This initiative placed staff in hospitals to assess patients earlier in their long-term care decision-making process and before they enter a nursing home. Once patients enter a nursing home, it becomes much more difficult to divert them to the community, because they have become more impaired or have spent their resources for the nursing home stay. Second, CARES increased efficiency through the use of information technology. The program improved its data system in September 1999 and since then has doubled the number of personal computers for staff. These improvements allowed staff to enter their own assessments, which management believes increased staff efficiency by reducing data entry time and errors. Also, the program is piloting the use of laptop computers, so that staff can enter assessments immediately. Third, CARES staff attempted to share office space with service providers and financial eligibility staff from the Department of Children and Families whenever possible. This initiative helped staff stay more informed about client status and the availability of home and community placements.

Another factor we found that contributed to this performance is the program's experienced, stable workforce. Approximately one-third of CARES employees have been in their positions for more than 10 years. As of June 2001, 4% of CARES positions were vacant, compared to the statewide average of 9% for all state employee positions.

While the program is diverting clients, program officials noted that it is not possible to divert some clients from nursing homes largely due to factors outside the program's control. According to the program's CARES Barrier Report for Fiscal Year 2000-01, 2,232 clients were recommended for home or community-based placement, but were nonetheless placed in nursing homes because the situations described below prevented them from remaining in the community.

- Many clients did not have caregivers to help them stay in the community. Research indicates that the lack of a caregiver is one of the primary reasons for elders not being able to stay in their own homes and subsequently being placed in a nursing home. Of the 2,232 clients CARES recommended for home and community-based services placed in nursing homes during the 2000-01 fiscal year, 1,626 (72.8%) did not have caregivers.
- Some clients were placed in a nursing home before home and community-based services began. In Fiscal Year 2000-01, 195 clients (8.7%) were on waiting lists for services, such as the Medicaid waivers, when they were placed in a nursing home.
- Because program services are voluntary, some clients and their families refused services. In Fiscal Year 2000-01, 171 clients or their families (7.7%) refused placement in a home or community-based setting and were placed in a nursing home.
- Some clients need specialized community services that are in limited supply, such as assisted living facilities that offer mental health services, if they are to stay in community settings. Of the 2,232 clients placed in a nursing home, 132 (5.9%) were placed there because of a lack of available specialized community placement services.
- The remaining 108 (4.9%) clients were not placed in the community for various reasons, including being financially ineligible for services or unable to pay for services.

Additional funding for Medicaid waiver programs should help to increase the number of diversions. In Fiscal Year 2001-02, the Legislature appropriated an additional $18 million for three Medicaid waiver programs (Home and Community-Based Services, Assisted Living for the Elderly, and Nursing Home Diversion). These funds will allow the program to serve approximately 2,800 more clients in home and community settings. Clients benefiting from these additional funds will include existing clients transferring to Medicaid waiver programs, new clients, and CARES diversion clients.

The program has not met the goal for serving abused and neglected and imminent-risk clients

To ensure limited state resources are spent wisely, the program has established priority categories for clients to receive program services and has contractually required service providers to serve these client groups before other clients. Two of the highest risk categories are abused and neglected clients and clients at imminent risk of nursing home placement. Giving priority to these two groups is important to prevent further abuse and neglect and to avoid physical and mental deterioration that could lead to nursing home placement.

The Legislature established two performance standards for serving these two client groups. First, the program providers are to serve 95% of the clients referred from the Department of Children and Families' (DCF) Adult Protective Services Program within 72 hours who are in need of immediate services to prevent further harm. [9] DCF refers some elderly clients determined to be at-risk of further abuse and neglect to the program for in-home services. If the program does not intervene quickly, these clients are at greater risk of further harm or even death. Second, the program providers are to serve 90% of the clients that CARES staff determine to be at imminent risk of entering or staying in a nursing home as soon as possible. If these clients do not promptly receive services, they are very likely to remain or be placed in a nursing home with diminished likelihood of ever being served in the community. Not serving imminent-risk clients is costly since it costs an average of $3,570 for a month of nursing home placement compared to an average of $709 a month for home and community-based waiver services.

Program has not met goal for serving abused and neglected clients within 72 hours

From January to June 2001, DCF referred 491 abused and neglected clients to the program providers, of which 460 (93.7%) were served within 72 hours. [10] Thus, the program did not meet the Fiscal Year 2000-01 legislative goal of serving 95% of this target population within 72 hours. We could not compare this performance to that of prior years because the program's data has historically been incomplete or inaccurate. Two prior OPPAGA reports found that the program has lacked reliable data on the number of abused and neglected clients referred from the Department of Children and Families (DCF) and how timely it provided services to these persons. [11] The program has implemented most of our recommendations

[9] Program providers are public or non-profit organizations (i.e., area agencies on aging, lead agencies, and other local agencies) responsible for providing services to individuals at the local level.

[10] The program implemented changes in its methodology for calculating this measure in January 2001. Therefore, only six months of data is available using the revised methodology.

[11] *Preliminary Report Referrals and Service Provision for Elder Victims of Abuse, Neglect, or Exploitation,* Report No. 98-29, December 1998, and *Program Review: High-Risk Elder Victims of Abuse, Neglect, or Exploitation Quickly Served; Data Problems Remain,* Report No. 01-04, January 2001.

to improve its data integrity and reporting procedures, which in the future should enable the Legislature to compare the program's performance over time.

The program did not meet the legislative standard for serving clients at imminent risk of nursing home placement. CARES assessors define clients at imminent risk if they are one of the following:

- individuals in nursing homes under Medicaid who could be transferred to the community;
- individuals in nursing homes whose Medicare coverage is exhausted and who may be diverted to the community;
- individuals in nursing homes that are closing and who can be discharged to the community; and
- individuals whose mental or physical health condition has deteriorated to the degree that self-care is not possible, no capable caregiver is available, and institutional placement will occur within 72 hours. [12]

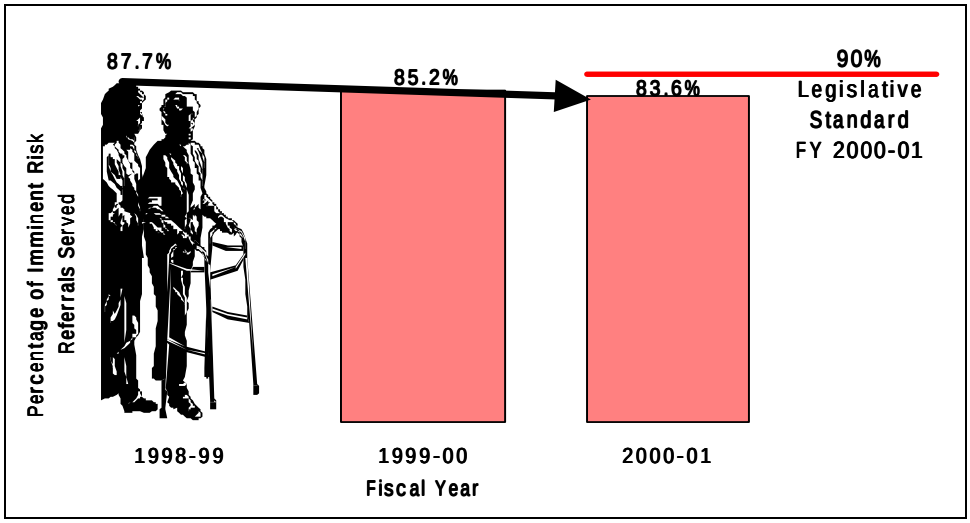
Program has not met goal of serving 90% of clients who are at imminent risk of nursing home placement

In Fiscal Year 2000-01, the program providers served 2,178 (83.6%) of the 2,604 clients that CARES staff determined to be at imminent risk of entering or staying in a nursing home. Providers would have needed to serve 165 additional clients to meet the legislative performance standard of serving 90% of CARES imminent-risk referrals. In addition, the program's performance in serving this group has declined over the past three years (see Exhibit 11). [13]

[12] Individuals who have been assessed and are pending enrollment in the Long-Term Care Community Diversion Project are also classified as imminent risk.

[13] In Fiscal Year 2000-01, CARES staff reported referring 506 more clients than the 2,604 clients the providers reported receiving. CARES and program staff are in the process of reconciling this discrepancy.

Exhibit 11
The Program Has Served Fewer CARES Imminent-Risk Referrals



Source: Florida Department of Elder Affairs.

Over 420 imminent-risk clients did not receive services in Fiscal Year 2000-01

The program's failure to meet the legislative performance standard means that 426 imminent-risk clients did not receive services in the 2000-01 fiscal year. Of the imminent-risk clients who were not served in Fiscal Year 2000-01, 118 clients received services after the fiscal year ended. [14] Of the clients who were placed on a waiting list for services, 206 clients were removed from the waiting list. Of these, 32 clients were removed because they were placed in a nursing home, and 24 died. If the program could have served and diverted the 32 clients that were placed in a nursing home to community-based services for one month, it could have avoided $26,877 in general revenue nursing home costs. As of September 2001, 168 imminent-risk clients remained on the waiting list for services.

Program officials identified three factors that hindered their ability to serve imminent-risk clients. First, some providers spent allocated funds on existing clients and, thus, could not immediately serve imminent-risk clients and placed them on waiting lists. Second, some clients could not be located because they had been moved by their families or were hospitalized. Third, in some cases providers may not have served imminent-risk clients as high priority as required by contract. Program officials reported that some local agencies may not agree with the policy and may not have followed it. However, the program could not identify any providers that have violated this requirement and, thus, none have been sanctioned. Because of these factors, the program should closely monitor local providers' compliance with the contract requirement to serve these clients and sanction providers that do not comply.

[14] Fiscal Year 2000-01 data on the outcomes for imminent-risk referrals is a duplicated count, because clients could be enrolled in multiple programs.

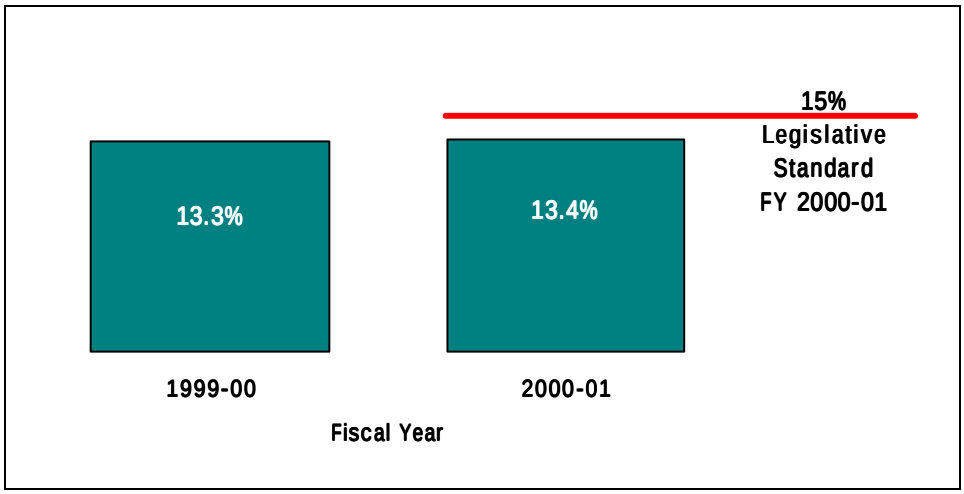
The program has transferred 1,951 general revenue clients to Medicaid waiver programs, earning over $7 million in federal funds

One of the performance-based program budgeting measures that shows how efficiently and effectively the program is using limited long-term care resources is the percentage of Community Care for the Elderly (CCE) clients defined as "probable Medicaid eligible" who remain in state-funded programs. The program's objective is to maximize the number of clients served on Medicaid waiver programs, which are matched with 56% federal dollars, and to enroll and serve only non-Medicaid eligible clients in the CCE program, which is funded exclusively with general revenue funds. In Fiscal Year 2000-01, the Legislature set a performance standard that no more than 15% of CCE clients who were most likely eligible for Medicaid services remain in the CCE program.

Program has exceeded goal for transferring clients from state-funded programs to Medicaid programs

In the 2000-01 fiscal year, the program exceeded this standard by successfully transferring 1,951 clients from state-funded CCE programs to Medicaid services. Of the 16,914 clients in the CCE program, only 13.4% (2,270) that were defined as probable Medicaid-eligible clients remained in general revenue funded CCE program. This level of performance has been consistent for the past two fiscal years (see Exhibit 12).

Exhibit 12
The Program Has Exceeded Its Legislative Goal by Keeping the Percentage of Probable Medicaid-Eligible Clients in State-Funded Programs Under 15%



Source: Florida Department of Elder Affairs.

The program exceeded this goal in Fiscal Year 2000-01, in part, by contractually requiring providers to review all CCE clients to determine if they met Medicaid waiver eligibility requirements. The contract also required providers to encourage these clients to apply for waiver services, and the program's contract monitoring staff reviewed compliance with this requirement.

The program has taken additional steps to transfer more clients from state-funded services to Medicaid services in Fiscal Year 2001-02. First, the program revised its contracts to require providers to terminate services for CCE clients screened as Medicaid waiver probable if they do not apply for waiver services. Second, the program transferred $2.25 million in general revenue from the CCE program to the Medicaid waiver to serve more clients under the waiver. Program officials estimate that these changes will reduce the percentage of Medicaid-eligible clients who are served in state-funded programs to 6.15% in Fiscal Year 2001-02 and enable the program to serve approximately 1,000 more clients with Medicaid funding. Consequently, officials requested that the legislative standard be changed to 6.15%.

Clients waited an average of 5.9 months for Medicaid eligibility determination

However, barriers may prevent the program from meeting the 6.15% standard in Fiscal Year 2001-02. First, some clients may not meet the income and asset requirements to be eligible for Medicaid waiver services or may refuse to apply because of their perceptions of the stigma associated with federally funded programs. Second, the current Department of Children and Families (DCF) Medicaid waiver financial eligibility process can be labor-intensive and time-consuming, which may make it difficult for some frail elders to complete. In August 2001, 1,274 clients were applying for the Medicaid waiver program and waiting an average of 5.9 months for eligibility determination. However, the program is working with DCF to improve the eligibility determination process. Third, program officials stated that provider agencies might be reluctant to transfer CCE clients because they lose the funding for and control over client services. Fourth, some providers we interviewed were unaware of the Fiscal Year 2001-02 contract provision that requires them to terminate clients screened as Medicaid waiver probable from CCE who do not apply for waiver services. These barriers could result in an inefficient use of state funds because clients who could be served on the partially federally funded Medicaid waiver are receiving general revenue funded CCE services. The program monitors adherence to these policies, but should monitor more closely to ensure that eligible clients are being transferred to the waiver.

The program has been effective at providing nutritional and caregiver services, but should do a better job of measuring the results of services

The program provides nutritional support services to elders to enhance their quality of life and prevent unnecessary or premature placement in a nursing home. Adequate nutritional support for elders is important to lessen their physical decline and to reduce their need for additional, more costly long-term care services. The program has implemented several initiatives to help improve the nutritional status of clients. In Fiscal Year 2000-01, the program assessed the nutritional status of 12,575 clients and provided numerous nutritional support services, including home-delivered meals, congregate meals, nutritional education, and counseling. Also, the 11 Area Agencies on Aging (AAAs) incorporated nutritional strategies into their strategic plans, and the program monitored the performance of each planning and service area's (PSA's) nutritional programs during contract monitoring. To measure the program's effectiveness in providing nutritional support services, the Legislature established a performance measure of the percentage of new clients with high-risk nutrition scores whose nutritional status improved a year later.

The program also provides caregiver support services to aid in preventing premature or unnecessary nursing home placement. Caregiver support services are vital, because research shows that one of the most significant predictors of nursing home placement is the lack of a caregiver. The success of many of the program's home and community-based services depends on the services of a stable caregiver. The program provides many services to support caregivers, including respite care, adult day care, and training and education. To measure the program's effectiveness in caregiver support services, the Legislature established a performance measure of the percentage of caregivers who self-report they are very likely to continue to provide care to a client.

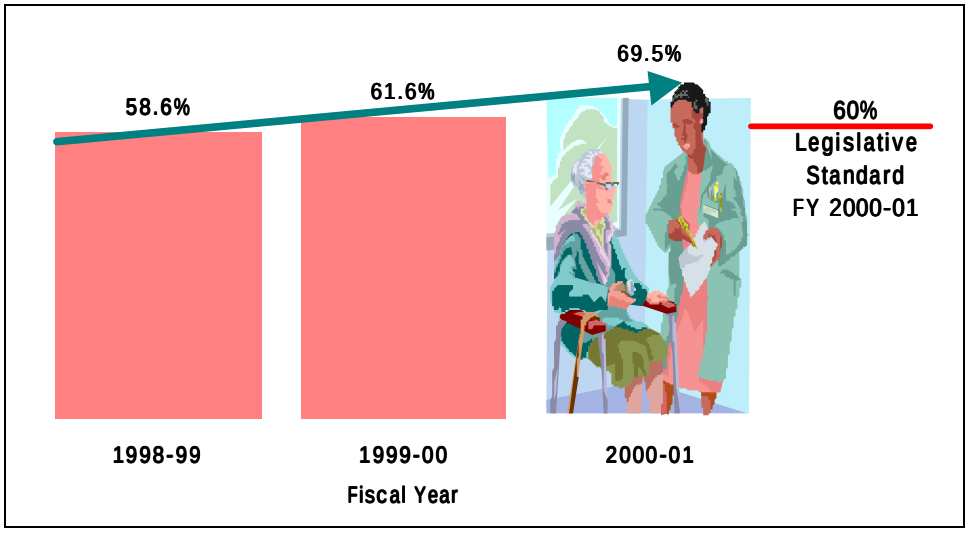
The program has exceeded the goal of improving client nutritional status, but needs better assessments

To assess clients' nutritional status, the program uses an assessment form required by the federal Administration on Aging. This form gauges a client's nutritional status by asking questions such as, "Do you eat at least two meals a day?" and "Do you eat some fruits and vegetables every day?" Based on the answers to these questions, a caseworker assigns clients a nutrition score from 0 to 21. If clients score between a 5.5 and 21, they are considered at high risk of malnutrition.

Program has exceeded goal for improving the nutritional status of high-risk clients

The program has exceeded the legislative standard that 60% of new high-risk clients have improved nutritional status after one year. In Fiscal Year 2000-01, 69.5% (3,883) of new clients assessed to be at high nutritional risk improved their nutritional status a year later, meaning that 30.5% (1,705) of high-risk clients did not improve their nutrition score. As shown in Exhibit 13, the program's performance on this measure has increased over the past three years.

Exhibit 13
The Percentage of New High-Risk Clients with Improved Nutritional Status Has Increased



Source: Florida Department of Elder Affairs.

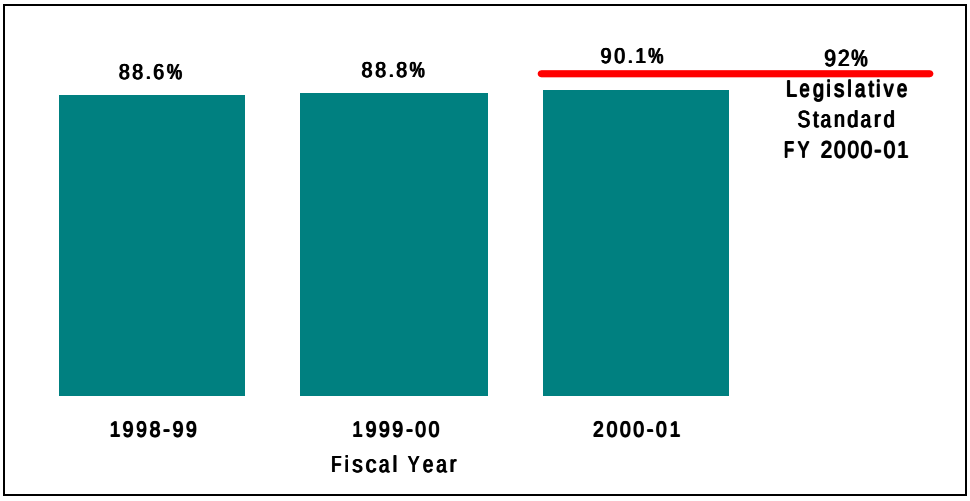
However, the federally required assessment instrument needs to be improved to more accurately measure nutritional improvement and change over time. For example, the assessment asks clients if they have any problems with their teeth, mouth, or throat that make it hard for them to chew or swallow. Program officials stated that better questions would be to ask the clients if they had been provided meals that were easier for them to chew or swallow or if their difficulty had been addressed. The program is currently involved in a federal Administration on Aging pilot project to test an assessment that asks questions about nutritional changes. Even though the results of the pilot are not known, program staff doubts that it will provide sufficient information on improvements in clients' nutritional status. To measure improvements in clients' nutritional status, the program should utilize a supplemental assessment that gathers adequate information about nutritional improvements.

Program has largely met standard for percentage of caregivers who would likely continue to provide care, but needs to improve measure

The majority of caregivers reported that they were very likely to continue to provide care

The program has substantially met the legislative standard for the percentage of caregivers who reported that they were very likely to continue to provide care. When clients do not have caregivers, they are at increased risk of being placed in a nursing home, because they are unable to care for themselves. In Fiscal Year 2000-01, 90.1% (13,575) of the 15,061 caregivers reported that they were very likely to continue to provide care, just under the legislative standard of 92%. As shown in Exhibit 14, the program's performance on this measure has improved over the past three years.

Exhibit 14
The Percentage of Caregivers Who Reported That They Were Very Likely to Continue to Provide Care Has Improved Slightly Over Time



Source: Florida Department of Elder Affairs.

Several factors may prevent some caregivers from continuing to provide care. For example, caregivers are often frail spouses with their own physical and emotional problems that may impede their ability to provide care. Research shows that caregivers are commonly in fair-to-poor physical health and have high rates of depression. Also, the ability of a caregiver, frail or not, to provide care may change as the client deteriorates and his/her needs change.

To account for these factors, the information used in the measure should be augmented with information from the assessor. In the current measure, a program caseworker asks the caregiver the likelihood that he/she will continue to provide care. However, the caregivers may not

have a realistic picture of their own ability to continue. Relying solely on the caregivers to assess whether they will continue to provide care does not provide a comprehensive picture of the likelihood of future caregiving. A better gauge of the caregiver's ability would be to also factor in the caseworker's assessment of the caregiver's ability, since the assessor might have a more objective assessment of the caregiver's mental and physical health than the caregiver.

Alzheimer's Disease Initiative has appeared to meet client and caregiver needs; should do a better job of measuring service results

Alzheimer's disease is an overwhelming, chronic, mind- and behavior-altering illness that affects more than 370,000 Floridians. To provide a continuum of services to meet the needs of individuals with Alzheimer's disease and their caregivers, the Legislature established the Alzheimer's Disease Initiative (ADI) in 1985. Program services are intended to help clients stay at home longer without being institutionalized, thus providing cost savings to the state. For example, program data indicated a cost avoidance for Fiscal Year 2000-01 of $2,235 for each month an ADI client was kept out of the nursing home. In Fiscal Year 2000-01, the ADI program served over 8,200 clients at a cost of $12 million.

While the program has not established performance measures for this initiative, clients' caregivers appear to be satisfied with program services. [15] However, the program needs to collect better information about the impact the initiative has in delaying or avoiding institutionalization for this population.

Because Alzheimer's is a progressive disease, individuals with the disease generally have different needs at various times throughout the course of the disease. To address these varying levels of needs, the Alzheimer's Disease Initiative offers services, which include case management, facility-based and in-home respite care, day care, client evaluation and referral, research at memory disorder clinics, and training of caregivers and health professionals, through four components.

- Thirteen Memory Disorder Clinics throughout the state provide diagnosis, research, treatment, and referral services for persons with Alzheimer's disease.
- Four Model Day Care programs test, in conjunction with Memory Disorder Clinics, therapeutic models and deliver day care services in a safe environment where Alzheimer's patients congregate for the day and socialize with each other.

[15] *Florida Alzheimer's Disease Initiative Evaluation, June 1998,* Williams Stern & Associates.

- Respite Care programs in all 67 counties offer caregiver relief or rest for a specified period of time.
- The Resource Database and Brain Bank, a central database that memory disorder clinics enter client information, is used to identify potential patients for specific studies, as well as for collaborative research projects.

Alzheimer's Disease Initiative has appeared to meet client and caregiver needs

The primary goal of ADI is to provide a continuum of services to meet the changing needs of individuals with Alzheimer's disease and their caregivers. Based on our interviews with stakeholders, ADI appears to be meeting the needs of clients and caregivers; respite care is especially useful in helping clients stay at home. A 1998 independent evaluation showed that caregivers were generally satisfied with program services. This is consistent with findings from our interviews with stakeholders that program services are needed and useful. [16]

Many Alzheimer's patients require care 24 hours per day. Research shows that the presence of a caregiver is the single most critical factor in keeping Alzheimer's patients out of the nursing homes. About 70% of people with Alzheimer's disease live at home, where families provide 75% of the care at no cost to the state. [17] Respite care provides relief to caregivers from the constant, continued supervision, companionship, and therapeutic and personal care they must give to a functionally impaired person. In Fiscal Year 2000-01, 3,396 clients' caregivers received respite care.

The program has not established performance measures to gauge the effectiveness of these services

While the program collects data on ADI clients, program managers have not established formal performance measures and do not routinely use the data to assess the impact of services. For example, program staff collects data on the cost of providing respite care, but does not assess the impact this service may have on keeping ADI clients out of nursing homes. The program should develop measures that assess the impact of services that support caregivers, the degree to which caregivers are satisfied with the services they receive, and the number of Alzheimer's patients who are being kept out of nursing homes. Examples of potential measures would be

- frequency of respite provided to caregivers;
- number of caregivers receiving training;
- percentage of clients who remain in the community or home for one year or more after they start receiving services;
- percentage of participating clients satisfied with the ADI services;
- number and type of referrals that are made to particular resources; and

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[16] We interviewed representatives from the Alzheimer's Association, Area Agencies on Agencies, and lead agencies.

[17] *National Conference of State Legislatures, Alzheimer's Disease on Related Dementias: A Legislative Guidebook,* January 2000.

- frequency of referral follow-up to determine the outcomes of the referrals.

Conclusions and Recommendations

The Services to Elders Program is generally meeting legislative goals, but improvements are needed. Specifically, the program has met its legislative goal to divert elders from nursing home care and exceeded its legislative goal of limiting the percentage of clients who are probably eligible for Medicaid funding from being served in state-funded programs. However, the program fell short of meeting its goal to serve abused and neglected clients within 72 hours and did not meet the standard for serving clients at imminent risk of nursing home placement. The program exceeded its legislative goal to provide nutritional and caregiver support services to clients, but should do a better job of measuring the impact of these services. Finally, the program provided beneficial services to clients with Alzheimer's disease and their caregivers, but should establish measures to assess effectiveness.

To improve performance in these areas, we recommend that the program implement the changes below.

- Increase the use of technology to improve the efficiency of CARES staff assessments by fully implementing the laptop pilot project. Currently, assessment information from the laptops cannot be downloaded to the main computer system. We recommend that the program make the implementation of this capability a priority. In addition, CARES staff should continue to co-locate with service providers whenever possible in order to collaborate more closely with service provider and Department of Children and Families financial eligibility staff.
- To ensure that accurate data is reported to the Legislature and other policymakers, the program should continue to improve and monitor the accuracy of the data on abused and neglected clients.
- To make sure that imminent-risk clients are served, the program should closely monitor local providers' compliance with the contract requirements to serve these clients and sanction providers that do not comply. Also, the program should routinely reconcile data between CARES and service providers to ensure that accurate information about these clients is available.
- To maximize the number of Medicaid-eligible clients who are transferred from the Community Care for the Elderly program to the waiver, the program should improve efforts to inform clients about the Medicaid waiver program, work with the Department of Children and Families to improve the timeliness of the financial eligibility process, and monitor the provider agencies' adherence to the

contractual requirements for transferring clients more closely and sanction providers that do not comply.

- To better assess clients' nutritional status, the program should design a supplemental nutritional assessment that better measures a client's improvement over time by Fiscal Year 2002-03. The program should also continue to work on the federal Administration on Aging pilot project, which tests an assessment that asks questions about nutritional changes.
- To better measure the likelihood of a caregiver continuing to provide care, the program should change its performance measure. One option is to incorporate the case manager's assessment about the likelihood of the caregiver continuing to provide care. Another option is to measure the quality of caregiver support services. This measure should reflect how many caregivers who self-report that they are very likely to provide care are still providing care a year later.
- To ensure that the Alzheimer's Disease Initiative is providing beneficial services, the program should track information that measures the impact of caregiver support services. The information should include the degree to which caregivers are satisfied with the services they receive and to what extent Alzheimer's patients are being kept out of nursing homes.

Chapter 4

The Program Needs to Improve Oversight of Providers

Effective program management and oversight is critical for the Services to Elders Program, because private agencies provide 94% of program services and the program's service delivery system is multi-layered. The program operates through contracts with 11 Area Agencies on Aging (AAAs). These agencies are public or non-profit private entities responsible for planning and monitoring elder services within their planning and service areas. The AAAs contract with 53 lead agencies to provide case management and to ensure service integration and coordination for elder services within their areas. Lead agencies may also directly supply core services or may subcontract with other providers.

- Although the program generally delivers effective services to Florida's elder population (see Chapter 3), we found deficiencies with its oversight system that diminish the program's efficiency and effectiveness.

Ineffective program guidance and oversight of providers diminish program efficiency and effectiveness

Given the structure of its service delivery system, the program needs to establish strong management, monitoring, and oversight mechanisms that ensure effective services are provided to Florida's elders and resources are maximized. However, we concluded that the program has not provided AAAs, lead agencies, and local service provider agencies with clear guidance and timely technical assistance to enable them to effectively implement policy changes. As a result, confusion and inconsistencies in how program services are to be delivered have developed among providers.

Inadequate technical assistance and communication has led to inconsistent practices

Providers complained about insufficient guidance and assistance from headquarters staff

AAA and lead agency directors complained that the program's headquarters has not provided adequate communication and technical assistance. Specifically, the directors asserted that the headquarters has not provided clear and timely communication regarding policies and procedures. Headquarters usually communicates with AAAs by fax or mail and then asks them to notify lead agencies of policy changes and contract amendments. However, it has not ensured that the AAAs and lead agencies receive the changes. Many directors, especially from the lead agencies, claimed that they are often uninformed or confused about new policies or changes to current policies.

Many directors also complained that headquarters staff does not answer their questions in a timely manner or provide enough guidance once they have received the new or changed policies. Several AAA directors stated that headquarters staff has not provided technical assistance when needed. As a consequence, AAAs indicated that they are sometimes unable to answer lead agency questions about policies and cannot properly implement program policy through their contracts with lead agencies. In addition, the directors noted that the program's *Client Services Manual* is outdated and has not been updated or finalized since 1998.

Inconsistent provider practices resulted in inefficient and ineffective use of program resources

This inadequate oversight and guidance has resulted in several inconsistent practices, including the inefficient and ineffective use of program resources.

- The program's contract requirement to terminate Medicaid eligible clients from Community Care for the Elderly (CCE) services has been inconsistently implemented. Prior to 2001, providers were only required to encourage clients to apply to the Medicaid waiver program. In order to maximize federal funding, program management implemented a contract change in July 2001 that requires providers to terminate probable Medicaid-eligible clients from the CCE program if they do not apply for Medicaid waiver services. Elders can receive the same services through the Medicaid waiver, which receives 56% of its funding from federal revenue, as they can through CCE, which is fully funded by state general revenue.

  However, several directors told us that they were confused about the contract change and did not terminate Medicaid-eligible clients. Consequently, the contract change has been inconsistently implemented, potentially resulting in an inefficient use of general revenue funds. Subsequent to our fieldwork, program staff issued a memorandum explaining the new contract to all AAAs on November 2, 2001.

- The program has inconsistently implemented its methodology for calculating unit costs. In 1998, the program changed its contract funding methodology from cost reimbursement to unit cost in order to improve its ability to track the types, quantities, and costs of services provided to clients. However, a 2001 Auditor General report found that the lead agencies have inconsistently applied the unit cost methodology. [18] AAA and lead agency directors complained that the headquarters' written instructions do not provide clear and comprehensive guidance for applying the unit cost methodology. These directors also asserted that headquarters staff has not provided adequate training to ensure that providers have sufficient knowledge to appropriately allocate administrative cost within the unit cost structure.

  This inconsistent application of the unit cost methodology has resulted in wide-ranging unit costs. For example, the Auditor General found that CCE case management unit rates ranged from $13.59 to $40.50 per unit. AAA directors expressed concerns that not following a uniform unit cost methodology has also allowed lead agencies to have excessive administrative costs. The Auditor General evaluated 44 of the 53 lead agencies and found that the administrative costs ranged from 0.3% to 47.3% of their total expenditures. Therefore, some lead agencies may be spending more state funds on administration and less money on direct services. Subsequent to the Auditor General's report, the program has assembled a task force to establish uniform standards, so that administrative costs can be properly allocated to the various services and excessive costs can be minimized.

Headquarters and Area Agencies on Aging monitoring has been inadequate, increasing the chances of policy misinterpretation

Inadequate program monitoring has compounded the inadequate guidance given to service providers. A good monitoring system should provide program managers with detailed information on the performance of individual providers, so that program staff can identify and implement best practices to improve program services and client outcomes. Monitoring should also include a strong disciplinary system that sanctions providers not meeting program standards. In the

program's multi-level system, each entity is responsible for performing administrative and program monitoring of contracted providers annually.

[18] *Contracted Services Administered by the Department of Elder Affairs, Operational Audit,* Auditor General Report No. 02-047, September 2001.

The program's headquarters' staff monitors the 11 AAAs, the AAAs monitor the 53 lead agencies, and the lead agencies monitor direct service providers.

Headquarters has not fully implemented its new monitoring system

The program's monitoring system has a history of weaknesses. A 1999 Auditor General Report cited many oversight weaknesses, including not having a documentation standard to govern what information was collected and the employment of personnel without adequate knowledge and experience. [19] It also stated that one office within the department lacked written guidelines explaining monitoring objectives, required frequency of on-site visits, procedural examples, and requirements for documenting and reporting monitoring results. In response to this criticism, the program developed a new oversight system that uses a monitoring-by-exception process to address five key areas (governance, data integrity, targeting/prioritization, consumer satisfaction, and due process/grievance). Each key area has standards and specific indicators that allow the monitors to determine if the AAAs have achieved the standards based on site visits and ongoing data report reviews. If the AAA does not achieve these standards, a second monitoring visit may be conducted.

The program conducts two types of monitoring (program and administrative) but has not yet fully implemented this new monitoring system. [20] Starting in September 2000, headquarters has conducted on-site program monitoring of all AAAs according to this method. However, headquarters continues to conduct administrative monitoring according to the old method and will not monitor using the new process until modifications are made and baseline criteria are established. No target date has been set for the implementation of the administrative monitoring-by-exception process.

AAA monitoring of providers has been inconsistent

Monitoring by the AAAs continues to be problematic. The AAAs have monitored the lead agencies, but the procedures are not standardized across the state like headquarters. The 2001 Auditor General's report found that the monitoring procedures and instruments used by the AAAs varied significantly and in some cases were not sufficient. As a result, AAA and lead agency directors noted that some AAAs monitor more frequently than others and emphasized different program areas. This inconsistency has contributed to weak financial controls within some lead agencies. For example, in 2001, the department's inspector general reviewed two lead agencies and found instances of unallowable costs, improper cost allocations, duplicate billings, ineligible clients, and unreconciled bank statements.

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[19] *Operational Audit of the Florida Department of Elderly Affairs*, Auditor General Report No. 13518, July 1999.

[20] Program monitoring assures that the provider's performance contributes to meeting program goals and objectives. Administrative monitoring ensures that contracted service providers are accountable for the funds received and that funds are spent in accordance with the terms of the contract.

Stronger monitoring and corrective sanctioning of AAAs and providers are needed

These findings indicate that stronger monitoring and corrective sanctioning of both AAAs and providers are needed. The program headquarters espouses a plan that corrects a contract violation and brings an AAA into compliance and requires them to provide headquarters with a brief summary of problem(s) and proposed corrective action plans and time frames for implementation at the provider level. Measures against an AAA or provider may include rescinding area agency or provider designation, placement of the AAA/provider on probationary status, enforcing financial penalties for nonperformance, imposing a moratorium on AAA/provider action, and unannounced special monitoring. Headquarters reported that no AAAs had been sanctioned in over 10 years. While certain Area Agencies on Aging have taken corrective actions against providers, other AAAs have not. When AAAs fail to comply with contract agreements, program headquarters should take corrective actions against them and enforce the AAAs to take corrective actions against providers as needed.

Headquarters staff turnover rate, problematic leadership contributed to oversight problems

These problems have been exacerbated by high turnover in headquarters staff and problematic agency leadership. The oversight positions had a 13.52% turnover rate, which was significantly higher than the average turnover rate of 7.04% for all state agencies for calendar year 2000. [21, 22] In addition, as of August 31, 2001, 10.1% of the oversight positions were vacant. Several AAA and lead agency directors claimed that the high staff turnover has affected the timeliness of technical assistance and policy and procedure clarification.

Problematic executive leadership within the Department of Elder Affairs may have also contributed to the deficiencies with program management, oversight, and monitoring mechanisms. In several interviews, directors stated that they were not pleased with the leadership from the Secretary's Office and were generally dissatisfied with headquarters administration. In September 2001, the Secretary of the Department of Elder Affairs resigned, and an interim Secretary is currently serving as agency head.

[21] *Florida Department of Management Services Annual Workforce Report,* January through December 2000.

[22] The turnover rate does not include CARES, Long-Term Care Ombudsman, and Public Guardianship positions, because these programs do not provide guidance and management to the AAAs or service providers. This rate includes July 2000 through August 2001.

Conclusions and Recommendations

Due to the multi-layered structure of the elder care system, program managers must provide strong oversight of the AAAs, lead agencies, and direct service providers to ensure fiscal integrity and quality services. To improve the current program management and oversight systems, we recommend that the program take the actions discussed below.

- By the end of Fiscal Year 2001-02, program officials should establish target dates for updating all sections of the *Client Services Manual*. Once the manual has been updated, they should submit the manual to the proper rule-making authorities, so that it becomes a legally binding document.
- Program officials should enhance written instructions to provide clear and comprehensive guidelines for all policies and procedures as the *Client Services Manual* is updated. Also, by the end of Fiscal Year 2001-02, they should provide training and technical assistance to AAAs and lead agencies to address at least two unclear policies: the termination of CCE clients who refuse to transfer to services under the Medicaid waiver and the application of cost allocation and unit cost methodologies.
- By the end of Fiscal Year 2001-02, program officials should standardize definitions for program service units to the extent possible, so that a state rate for each service can be established, and enhance procedures for identifying, allocating, and reporting administrative costs. Once clear definitions and procedures have been established, these officials should institute an absolute unit rate limit for each type of service based upon a market analysis and set a reasonable standard for administrative costs by the end of Fiscal Year 2002-03.
- Program officials should establish minimum standards for AAA monitoring procedures and instruments by the end of Fiscal Year 2001-02.
- Program headquarters should take corrective actions upon all AAAs that fail to comply with contract agreements within a reasonable time as specified by headquarters and enforce AAAs to correct incompliant providers as needed.

Chapter 5

Managed Long-Term Care Pilots Have Potential for Delaying Nursing Home Placement

Background

Managed care offers potential benefits for acquiring acute and long-term care services for the elderly

Like several other states, Florida is experimenting with using a managed care approach for acquiring acute and long-term care services for the elderly. [23] Managed care offers two potential benefits. First, the managed care organization (MCO)—rather than the program—assumes full financial responsibility for providing all services needed to improve the clients' functioning. Second, MCOs rely heavily on case managers to work very closely with clients to assist them in non-traditional ways, such as administering medication to avoid medication overload and arranging for environmental services to install ramps and grab-bars in the home. These services help to improve and maintain the clients' quality of life to prevent or delay nursing home placement.

In 1997, the Legislature authorized the Department of Elder Affairs to work with the Agency for Health Care Administration to implement long-term care community diversion pilot projects. [24] As of September 2001, the program had implemented the Long-Term Care Community Diversion Pilot and was in the planning stages of implementing two additional pilots—Program for All Inclusive Care for the Elderly (PACE) and Social Health Maintenance Organization (SHMO).

From the inception of the Long-Term Community Diversion Pilot Project in December 1998 through August 2001, expenditures paid for client services totaled $36.9 million, of which $20.7 million (56%) were federal funds and $16.2 million (44%) were state general revenue funds. Currently, the diversion pilot has 844 enrollees.

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[23] Managed care is an organized system of managing health care to control costs through a capitation rate, while ensuring accessible, effective, and efficient care of clients.

[24] Community diversion is a strategy that places participants in the most appropriate care settings and provides comprehensive home and community-based services of sufficient quantity, type, and duration to prevent or delay the need for long-term placement in a nursing facility.

Pilots designed to provide cost savings by experimenting with alternative service provision methods

All three pilot projects are designed to demonstrate the cost-effectiveness of paying a capitation rate to MCOs for the provision of a continuum of long-term care services to frail and Medicaid eligible clients. However, each pilot differs in terms of eligibility criteria and types of services offered. See Appendix C for details on eligibility criteria and services provided.

- *The Long-Term Care Community Diversion Pilot Project* is designed to provide less costly community-based services to frail elders who are at-risk of needing nursing home care. The diversion pilot's participants receive all the services that are typically covered through the program's Medicaid waiver programs (i.e., assisted living, case management, respite) and additional services, such as prescription drugs, Medicare coinsurance and deductible, and physician services. These services are intended to help elder clients stay healthier longer in order to delay or avoid placement in more costly nursing homes. [25]
- *Program for All-Inclusive Care for the Elderly (PACE)* has not been implemented, even though it was authorized by the 1998 Legislature. [26] PACE is designed to be a fully integrated model and will build on the diversion pilot by providing acute and long-term care services to the very frail elderly and by integrating both Medicaid and Medicare funds in one capitation rate. PACE has a unique service delivery system, whereby adult day care centers deliver services and multi-disciplinary teams provide case management. [27] Although the PACE pilot has not been implemented, program officials reported that the application has been submitted to the Centers for Medicaid and Medicare (formerly Health Care for Financing Administration, HCFA) for approval and that the target implementation date is June 2002.
- *Social Health Maintenance Organization (SHMO)* is not yet a defined pilot program. However, program officials anticipate that SHMO will deliver a comprehensive package of acute and long-term care services within an integrated capitation rate. Also, program officials hope that SHMO will address the needs of the dually eligible (Medicaid and Medicare) population, including those who are very frail and

[25] The annual cost per client in the diversion pilot is $28,100, which is $14,700 less than the average annual cost for nursing home care of $42,800. The cost per client in the diversion pilot is $21,100 more than the average cost of serving clients on the Medicaid waivers, which is $7,000. However, this cost does not provide prescription drugs, coinsurance payments, or nursing home care.

[26] Program staff reported that a delay in Centers for Medicaid and Medicare's (formerly Health Care for Financing Administration, HCFA) final approval of the PACE regulation subsequently led to delays in implementing Florida's PACE pilot.

[27] These teams include primary care physicians and nurses, physical, occupational and recreational therapists, social workers, home health aides, dietitians, and drivers.

chronically ill, and provide preventive long-term care services to individuals whose health is in the early stages of decline or at risk of decline. Program staff has not identified an implementation date for SHMO.

If successful, these pilots would provide two important benefits. First, the state would achieve cost savings because the capitation rate is generally lower than the average cost for nursing home care. Second, clients would benefit because the services they receive would enable them to remain physically and mentally healthier for a longer period of time, which should help delay or even avoid their being institutionalized.

Initial problems in implementing Long-Term Care Community Diversion Pilot Project appear to be resolved

Because managed long-term care is a new and complex business for the health management organization industry, the program experienced problems designing and implementing the Long-Term Care Community Diversion Pilot. Program staff reported two primary reasons for the problems: (1) providers were reluctant to assume full risk for managed long-term care and (2) the diversion pilot's capitation rate lacked the integration of Medicaid and Medicare funds.

Providers were reluctant to participate in the Long-Term Care Community Diversion Pilot Project because of the risk factor and lack of a capitation rate for Medicare services

Providers (MCOs) were initially reluctant to assume full risk. When the diversion pilot was initiated, only four providers submitted applications to participate, and later one pulled out citing that the Medicare rate to pay for acute care services was not adequate to offset the risk of high-cost medical care participants.[28] Program staff reported that this pilot took longer than anticipated to be established because providers were unwilling to take the risk associated with providing a range of services to a frail and chronically ill population. Providers' fears seemed to stem from their limited experience dealing with capitation for this population. For example, studies show that no valid and reliable risk-adjustment methodology to ensure that payments will cover the costs of providing care to people with chronic illnesses and disabilities is available. In addition, actuaries have limited experience and data useful for measuring the financial risk of undertaking managed long-term care health needs.

However, according to program officials, the problem of recruiting providers to participate in this pilot seems to be resolved. Program staff reported that some MCOs are less fearful about the financial risk now that the diversion pilot has existed for some time and more knowledge and information on how to manage long-term care is available. In fact,

[28] The four managed care organizations include Beacon Health Plans, Inc.; Orlando Regional Health System; Physicians Healthcare Plans, Inc.; and United Healthcare of Florida, Inc. However, Orlando Regional Health System withdrew its application.

program staff indicated that additional MCOs are now asking to participate in the diversion pilot, and the existing providers want to expand to other counties in the state. [29]

The diversion pilot capitation rate lacked an integration of Medicaid and Medicare funds

Lack of Medicaid and Medicare integration exacerbated problems with recruiting providers for the diversion pilot. Because the diversion pilot's capitation rate lacked an integration of Medicaid and Medicare funds, providers perceived the rate would be insufficient to cover the costs of caring for very frail elderly clients. [30] The integration of acute and long-term care services holds considerable promise for improving care for elder persons and persons with physical disabilities. By integrating Medicaid and Medicare, providers of managed care plans would operate within a unified financing arrangement that could reduce the financial risk which some MCOs fear.

Since the planned designs for the PACE and SHMO pilots include the integration of Medicaid and Medicare in the capitation rate, the impact of this impediment may be lessened in the future. The department is working with the Center for Medicare and Medicaid Services to get approval for easier integration of acute and long-term care services. [31]

The Legislature should continue the Long-Term Care Community Diversion Pilot Project

The diversion client population is frailer than clients in Medicaid waiver

As required by s. 430.709, *Florida Statutes*, the program contracted for an evaluation of the Long-Term Care Community Diversion Pilot Project. The Florida Policy Exchange Center on Aging at the University of South Florida conducted the evaluation. [32] The evaluation was presented to the department in November 2001. It found that the diversion pilot was serving the target population, in that clients being served were more impaired than clients in the Medicaid Waiver Program, which provides similar services. For example, the diversion clients have problems with an average of 4.3 activities of daily living (ADL), while the Medicaid wavier

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[29] Currently, the Long-Term Care Community Diversion Pilot is in Orange, Osceola, Palm Beach, and Seminole counties.

[30] Integration of Medicaid and Medicare means combining both fund sources and services into one capitation rate. This integration allows managed care organizations to coordinate and provide acute and long-term elder care under one umbrella. The benefit of integration is that it gives managed care organizations the flexibility to provide a complete, comprehensive, seamless system of services to the elderly.

[31] A consultant with the University of South Florida's Florida Policy Exchange Center on Aging reported that MCO case managers are working with Medicare service providers to coordinate and manage the client's full continuum of medical and long-term care even though the capitation rate for the Long-Term Care Community Diversion Pilot Project is not financially integrated.

[32] *Preliminary Evaluation of Medicaid Waiver Managed Long-Term Care Diversion Programs: Final Report*, Jennifer R. Salmon, Ph.D., and Glenn Mitchell, II., Ph.D., November 1, 2001, University of South Florida, Florida Policy Exchange Center on Aging, Tampa, FL 33620.

clients have problems with an average of 2.9 ADLs. [33] In addition, more diversion clients (86%) reported that they received all the long-term care services they needed than did the Medicaid waiver clients (75%).

Program evaluation did not assess cost-effectiveness

Although the law requires that the evaluation include a careful review and assessment of the actual cost for the provision of services to participants, the evaluation did not assess the cost-effectiveness of the pilot. According to the evaluation and one of the evaluators, contractors declined to provide cost information, citing that they were not required to provide such information by contract with the department and that such information was deemed a proprietary issue. Thus, the evaluators could not compare the cost of serving clients in the diversion pilot with the cost of serving clients in the Medicaid Waiver Program. [34]

Preliminary data indicates that the pilot is serving the frailest elders, thus fulfilling its mission of being an alternative to nursing home care. Since the pilot's annual capitation rate is $28,000 per client and the annual nursing home cost is $42,000 per client, it appears that the pilot is cost-effective and should be continued. Current revenue shortfalls present a barrier to expansion at this time; in any event, the pilot should continue to collect information, which enables stakeholders to assess the program's future success.

Conclusions and Recommendations

Managed long-term care is a new and complex business for the health management organization industry. Although the program experienced problems implementing the first of three long-term care pilot projects, it is moving along with implementation plans for PACE and SHMO.

Accordingly, we recommend that the program

- petition the Centers for Medicaid and Medicare Services (formerly the Health Care Finance Administration, or HCFA) to pursue waivers that achieve the integration of Medicaid and Medicare services under one provider. This integration may make it easier for the program to find providers for managed long-term care in general and for the SHMO pilot in particular.

As required by s. 430.709, *Florida Statutes*, the program contracted for an independent evaluation of the Long-Term Care Community Diversion Pilot Project. However, the preliminary evaluation did not report on the cost of services, as required by law, nor did it assess client outcomes.

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[33] Activities of daily living include dressing, grooming, bathing, eating, transferring in and out of a bed or chair, walking, climbing stairs, toileting, and controlling bladder/bowel.

[34] According to program staff, the department plans to contract with the University of South Florida to conduct a more comprehensive and focused evaluation by the end of Fiscal Year 2001-02.

Knowing whether clients are receiving the appropriate services to achieve the program's desired outcomes is essential.

Therefore, we recommend that the Legislature

- require the department to closely monitor contract providers to ensure that the elder enrollees are receiving the adequate care they need to delay or avoid nursing home placement and properly sanction contractors that do not meet this desired outcome.

We also recommend that the program

- contractually require providers to report cost information and
- contract for a comprehensive evaluation for the Long-Term Care Community Diversion Pilot Project that addresses the areas required by law. At a minimum, the evaluation should include
  - a cost comparison of pilot participants with Medicaid waiver and nursing home clients;
  - client-specific outcomes, such as whether clients' desires are being met in terms of choice of services and providers and their right to privacy;
  - continuity of security, and whether the client is getting the necessary support from MCO case management to meet desired outcomes;
  - a comparison between the pilot's frequency of incidents of preventable hospitalization and the national average; and
  - an actuarial analysis of the capitation rate of the pilot project.

Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513(3), *Florida Statutes,* provides that OPPAGA program evaluation and justification reviews shall address nine issue areas. Our conclusions on these issues as they relate to the Department of Elder Affairs' Services to Elders Program are summarized in Table A-1.

Table A-1
Summary of the Program Evaluation and Justification Review of the Services to Elders Program

Issue	OPPAGA Conclusions
The identifiable cost of the program	The Services to Elders Program was appropriated $306,843,280 and was authorized 374 positions for Fiscal Year 2001-02. State general revenue appropriations account for 37% and appropriations from trust funds account for 63% of the total appropriation.
The specific purpose of the program, as well as the specific public benefit derived therefrom	The purpose of the Services to Elders Program is to plan, develop, coordinate, and administer services critical for assisting the state's elder citizens to age with dignity and to remain independent as long as possible. Many elders are frail, have difficulty caring for themselves, and are economically disadvantaged, increasing their risk of nursing home placement. As of January 2001, 13% of Florida's elders aged 60 and over had incomes below the federal poverty level, and 25% of elders 65 and over were living alone during Fiscal Year 2000-01. By providing support services, the program can help delay or prevent these persons from being placed in nursing homes, which is cost-effective for the state and beneficial to clients and their families. In Fiscal Year 2000-01, home and community-based services cost between $2,628 and $10,250 a year, compared to $42,847 annually for nursing home placement. The Services to Elders Program is important to the state. Florida has the largest percentage and second highest number of elders in the nation. As shown in Exhibit 7, 17.6% of Florida's population is over the age of 65, compared to 12.4% nationally.
Progress towards achieving the outputs and outcomes associated with the program	The Services to Elders Program has substantially met its legislative performance standards, but could more effectively serve high-risk clients and measure the results of some services. During Fiscal Year 2000-01, the program ▪ exceeded its legislative goal to divert elders from nursing home care; the program diverted 11,002 clients from nursing home placement for at least one month, achieving a cost avoidance of $31.5 million; ▪ did not meet its legislative goal of providing services within 72 hours to the highest priority client group (i.e., clients who are abused or neglected), and fell short of meeting its goal of serving the second highest priority client group (i.e., clients at imminent risk of nursing home placement); ▪ exceeded its legislative goal of limiting the percentage of clients who are probably eligible for Medicaid funding from being served in state-funded programs; ▪ exceeded its legislative goal to improve the nutritional status of new high-risk clients, but should do a better job of measuring the results of these services; ▪ substantially met the legislative goal for the percentage of caregivers who reported that they were very likely to provide care; and ▪ appears to have provided beneficial services to clients with Alzheimer's disease and their caregivers, but did not establish measures to assess effectiveness.

Issue	OPPAGA Conclusions
An explanation of circumstances contributing to the state agency's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, *F.S.,* associated with the program.	**CARES Nursing Home Diversions.** Program officials attributed their ability to divert clients from nursing home placement, in part, to the Legislature authorizing 36 new positions to implement the Hospital-Based Assessments initiative. This initiative placed staff in hospitals to assess patients earlier in their long-term care decision-making process and before they enter a nursing home. In addition, CARES increased efficiency through the use of information technology and attempts to share office space with service providers and financial eligibility staff from the Department of Children and Families whenever possible to stay more informed about client status and the availability of home and community placements. Another factor that contributed to the performance is that the program had an experienced, stable workforce. Approximately one-third of CARES employees have been in their positions for more than 10 years. As of June 2001, 4% of CARES positions were vacant, compared to the statewide average of 9% for all state employee positions. **Abused and neglected clients.** The program contractually required providers to serve abused and neglected clients before all others. In the past, the program had difficulty tracking and reporting information on these clients, but is implementing initiatives to address these concerns. **Imminent-risk clients.** Program officials identified three factors that hindered their ability to serve imminent-risk clients. First, some providers spent allocated funds on existing clients and, thus, could not immediately serve imminent-risk clients and placed them on waiting lists. Second, some clients could not be located because they had been moved by their families or were hospitalized. Third, in some cases providers may not have served imminent-risk clients as high priority as required by contract. Program officials reported that some local agencies may not agree with the policy and may not have followed it. **Medicaid waiver transfers.** The program contractually required providers to review all Community Care for the Elderly (CCE) clients to determine if they met Medicaid waiver eligibility requirements. The contract also required providers to encourage these clients to apply for waiver services, and contract monitoring staff reviewed compliance with this requirement. **Nutritional support programs.** The program implemented several strategies to help improve the nutritional status of clients. In Fiscal Year 2000-01, the program assessed the nutritional status of 12,575 clients and provided numerous nutritional support services, including home-delivered meals, congregate meals, nutritional education, and counseling. Also, the 11 Area Agencies on Aging (AAAs) incorporated nutritional strategies into their strategic plans, and the program monitored the performance of each PSA's nutritional programs during contract monitoring. **Caregiver support programs**. The program provided many services to support caregivers, including respite care, adult day care, and training and education. **Alzheimer's Disease Initiative.** While the program did not establish performance measures for this initiative, caregivers of clients appeared to be satisfied with program services. However, the program needs to collect better information about the impact the initiative has in delaying or avoiding institutionalization for this population.
Alternative courses of action that would result in administering the program more efficiently and effectively	**CARES Nursing Home Diversions**. To increase the use of technology to improve efficiency of CARES staff assessments, the program should fully implement the laptop pilot project. Currently, assessment information from the laptops cannot be downloaded to the main computer system. We recommend that the program make the implementation of this capability a priority. In addition, CARES staff should continue to co-locate with service providers, whenever possible, in order to collaborate more closely with service providers and Department of Children and Families financial eligibility staff. **Abused and neglected clients**. To ensure that accurate data is reported to the Legislature and other policymakers, the program should continue to improve and monitor the accuracy of the data on abused and neglected clients. **Imminent-risk clients.** To make sure that imminent risk clients are served, the program should closely monitor local providers' compliance with the contract requirements to serve these clients and sanction providers that do not comply. Also, the program should routinely reconcile data between CARES and service providers to ensure that accurate information about these clients is available. **Medicaid waiver transfers**. To maximize the number of Medicaid-eligible clients who are transferred from the Community Care for the Elderly (CCE) program to the waiver, the program should improve efforts to inform clients about the Medicaid waiver program, work with the

Issue	OPPAGA Conclusions
	Department of Children and Families (DCF) to improve the timeliness of the financial eligibility process, and monitor the provider agencies' adherence to the contractual requirements for transferring clients more closely and sanction providers that do not comply. **Nutritional support programs**. To better assess clients' nutritional status, the program should design a supplemental nutritional assessment that better measures a client's improvement over time by Fiscal Year 2002-03. The program should also continue to work on the federal Administration on Aging pilot project, which tests an assessment that asks questions about nutritional changes. **Caregiver support programs**. To better measure the likelihood of a caregiver continuing to provide care, the program should change its performance measure. One option is to incorporate the case manager's assessment about the likelihood of the caregiver continuing to provide care. Another option is to measure the quality of caregiver support services. This measure should reflect how many caregivers who self-report that they are very likely to provide care are still providing care a year later. **Alzheimer's Disease Initiative.** To ensure that the Alzheimer's Disease Initiative is providing beneficial services, the program should track information that measures the impact of caregiver support services. The information should include the degree to which caregivers are satisfied with the services they receive and to what extent Alzheimer's patients are being kept out of nursing homes. **Improving program oversight**. To improve the current program management and oversight systems, we recommend that the program take the actions discussed below. ▪ By the end of Fiscal Year 2001-02, program officials should establish target dates for updating all sections of the *Client Services Manual*. Once the manual has been updated, they should submit the manual to the proper rule-making authorities, so that it becomes a legally binding document. ▪ Program officials should enhance written instructions to provide clear and comprehensive guidelines for all policies and procedures as the client services manual is updated. Also, by the end of Fiscal Year 2001-02, they should provide training and technical assistance to AAAs and lead agencies to address at least two unclear policies: the termination of CCE clients who refuse to transfer to services under the Medicaid waiver and the application of cost allocation and unit cost methodologies. ▪ By the end of Fiscal Year 2001-02, program officials should standardize definitions for program service units to the extent possible, so that a state rate for each service can be established, and enhance procedures for identifying, allocating, and reporting administrative costs. Once clear definitions and procedures have been established, these officials should institute an absolute unit rate limit for each type of service based upon a market analysis and set a reasonable standard for administrative costs by the end of Fiscal Year 2002-03. ▪ Program officials should establish minimum standards for AAA monitoring procedures and instruments by the end of Fiscal Year 2001-02. ▪ Program headquarters should take corrective actions upon all AAAs that fail to comply with contract agreements within a reasonable time as specified by headquarters and enforce AAAs to correct incompliant providers as needed. **Managed long-term care.** To ensure that the program is properly implementing and evaluating long-term care pilots we recommend that the program ▪ petition the Centers for Medicaid and Medicare Services (formerly the Health Care Finance Administration, or HCFA) to pursue waivers that achieve the integration of Medicare and Medicaid services under one provider; this integration may make it easier for the program to find providers for managed long-term care in general and for the Social Health Maintenance Organization (SHMO) pilot in particular; ▪ contractually require providers participating in the Long-Term Care Community Diversion Pilot Project to report cost information; and ▪ contract for a comprehensive evaluation for the Long-Term Care Community Diversion Pilot Project that addresses the areas required by law. At a minimum, the evaluation should include – a cost comparison of pilot participants with Medicaid waiver and nursing home

Issue	OPPAGA Conclusions
	clients; – client-specific outcomes, such as whether clients' desires are being met in terms of choice of services and providers and their right to privacy; – continuity of security, and whether the client is getting the necessary support from MCO case management to meet desired outcomes; – a comparison between the pilot's frequency of incidents of preventable hospitalization and the national average; and – an actuarial analysis of the capitation rate of the pilot program. We also recommend that the Legislature ▪ require the department closely monitor contract providers to ensure that the elder enrollees in the Long-Term Care Community Diversion pilot are receiving the adequate care they need to delay or avoid nursing home placement and properly sanction contractors that do not meet this desired outcome.
The consequences of discontinuing the program	If the program were discontinued, the overall costs for the state to provide long-term care for elders would increase because many individuals who currently receive services in community-based settings would no longer be able to obtain these services and would likely be placed in a nursing home. In addition, discontinuing the program would increase the burden placed on families who care for frail elderly relatives by removing the availability of respite care and other services needed by those caregivers.
Determination as to public policy, which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or in part	This program provides beneficial services to program clients and to Florida's citizens. This review identifies several alternatives for improving program services.
Whether the information reported pursuant to s. 216.03(5), *F.S.,* has relevance and utility for the evaluation of the program	The majority of the program's measures used for this review were comprehensive, measured program outcomes and reflected the most critical functions of service provision.
Whether state agency management has established controls systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports	The department has established sufficient procedures that reasonably ensure that the performance data used in this review, for background and informational purposes only, are reasonably accurate.

Appendix B

States Have Varying Department Structures for Senior Services

States With Separate Departments for Senior Services = 24

1. **Alabama -** Department of Senior Services
2. **California -** Department of Aging
3. **District of Columbia -** District of Columbia Office on Aging
4. **Florida -** Department of Elder Affairs
5. **Hawaii -** Hawaii Executive Office on Aging
6. **Idaho -** Commission on Aging
7. **Illinois -** Department on Aging
8. **Iowa -** Department of Elder Affairs
9. **Kansas -** Department on Aging
10. **Louisiana -** Governor's Office of Elderly Affairs, Elderly Protective Services
11. **Maryland -** Department of Aging
12. **Massachusetts -** Executive Office of Elder Affairs
13. **Michigan -** Office of Services to the Aging
14. **Minnesota -** Board on Aging
15. **New Mexico -** State Agency on Aging
16. **New York -** New York State Office for the Aging
17. **Ohio -** Department of Aging
18. **Pennsylvania -** Department of Aging
19. **Rhode Island -** Department of Elderly Affairs
20. **Tennessee -** Commission on Aging and Disability
21. **Texas -** Department of Aging
22. **Vermont -** Department of Aging and Disabilities
23. **Virginia -** Department for the Aging
24. **West Virginia -** West Virginia Bureau of Senior Services

States With Senior Services Housed Under Health and Human Services or Other State Agencies = 27

1. **Alaska -** Commission on Aging, Division of Senior Services, Department of Administration
2. **Arizona -** Aging and Adult Administration, Department of Economic Security
3. **Arkansas -** Division of Aging and Adult Services, Department of Human Services
4. **Colorado -** Aging and Adult Service, Department of Human Services
5. **Connecticut -** Division of Elderly Services, Department of Social Services
6. **Delaware -** Division of Services for Aging and Adults with Physical Disabilities, Department of Health and Social Services
7. **Georgia -** Division of Aging Services, Department of Human Resources
8. **Indiana -** Bureau of Aging and In-Home Services, Division of Disability, Aging, and Rehabilitative Services
9. **Kentucky -** Office of Aging Services, Cabinet for Health Services
10. **Maine -** Bureau of Elder and Adult Services, Department of Human Services
11. **Mississippi -** Division of Aging and Adult Services, Department of Human Services
12. **Missouri -** Division of Aging, Department of Social Services
13. **Montana -** Office on Aging, Senior and Long-Term Division, Department of Public Health and Human Services
14. **Nebraska -** Division on Aging, Department of Health and Human Services
15. **Nevada -** Division of Aging Services, Department of Human Resources
16. **New Hampshire -** Division of Elderly and Adult Services, Department of Health and Human Services
17. **New Jersey -** Division of Senior Affairs, Department of Health and Senior Services
18. **North Carolina -** Division of Aging, Department of Health and Human Services
19. **North Dakota -** Aging Services Division, Department of Human Services
20. **Oklahoma -** Aging Services Division, Department of Human Services
21. **Oregon -** Senior and Disabled Services Division, Department of Human Services
22. **South Carolina -** Office of Senior and Long-Term Care Services, Department of Health and Human Services
23. **South Dakota -** Office Adult Services and Aging, Department of Social Services
24. **Utah -** Division of Again and Adult Services, Department of Human Services
25. **Washington -** Aging and Adult Services Administration, Department of Social and Health Services
26. **Wisconsin -** Bureau of Aging and Long Term Care Resources, Department of Health and Family Services
27. **Wyoming -** Office on Aging, Department of Health

Note: This analysis includes the 50 states and the District of Columbia.
Source: National Association of State Units on Aging.

Appendix C

Long-Term Care Pilot Projects' Eligibility Criteria and Delivered Services

Project Name	Eligibility Criteria	Services Provided	Client Enrollment as of September 1, 2001	Capacity
Long-Term Care Community Diversion	▪ Age 65 or older ▪ Medicare eligible ▪ Medicaid eligible up to Institutional Care Program (ICP) ▪ Reside in project service area ▪ Determined by CARES to be at risk of nursing home placement and meet one or more of five clinical criteria ▪ Determined by CARES to be a person who can be safely served with home and community-based services	**Long-Term Care Services includes such services as** ▪ Adult Day Health ▪ Assisted Living ▪ Case Management ▪ Consumable Medical Supply ▪ Delivered Meals ▪ Homemaker ▪ Respite Care ▪ Nursing Facility **Acute Care Services includes such services as[1]** ▪ Community Mental Health ▪ Medicare Co-Insurance and Deductible ▪ Prescribed Drugs ▪ Transportation	844	2,300
Program of All Inclusive Care for the Elderly (PACE)	▪ Age 55 or older and meet clinical and financial criteria ▪ Medicaid clinically and financially eligible ▪ Medicaid only ▪ Medicare only who meet clinical criteria	▪ Same as the Long-Term Community Care Diversion ▪ All Medicare Covered Services	No Enrollment—Planning Stage	300
Social Health Maintenance Organization (SHMO)	▪ All Medicare and Medicaid eligible ▪ Medicare beneficiaries not eligible for Medicaid	▪ All Medicaid and Medicare Covered Services	No Enrollment—Planning Stage	Not Yet Determined

[1]These services are covered to the extent that they are not covered by Medicare or are reimbursed by Medicaid pursuant to Medicaid's Medicare cost-sharing policies.

[2] The waiver for the Long-Term Care community Diversion pilot allows for a capacity of 2,300 enrollees, but enrollment in the program is limited by legislative appropriations. The pilot, based on current appropriations, has reached capacity.

Source: Department of Elder Affairs.

Appendix D

Response from the Department of Elder Affairs

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Department of Elder Affairs to review and respond.

The Secretary's written response is reprinted herein beginning on page 49.

JEB BUSH
GOVERNOR

LUIS C. MORSE
ACTING SECRETARY

A Community for Life: Elder Ready, Child Friendly, Family Focused

December 14, 2001

John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 112
Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

Enclosed is the Department of Elder Affairs' response to recommendations of the OPPAGA Justification Review of the Services to Elders Program.

Thank you for your hard work and thorough evaluation of the department's services and activities. We are pleased that your investigation confirmed that the Services to Elders Program is appropriately placed in the Department of Elder Affairs and that the department is providing vital, cost effective services benefitting elders and the state. We thank you for recognizing, and are proud of the fact, that the department has substantially met its legislative performance standards, exceeding most goals.

The department concurs with your recommendations for ways to further improve or evaluate program performance. We will develop a plan for implementing your recommendations and will track our progress over the next year. Please contact Marshall E. Kelley at 414-2000 if you have any questions with the enclosed response.

Recognizing the importance of our elders to our culture, I remain. . .

Sincerely,

/s/
Luis C. Morse
Acting Secretary

LCM/gl
Enclosure

4040 ESPLANADE WAY ■ SUITE 315 ■ TALLAHASSEE, FLORIDA 32399-7000
(850) 414-2000 ■ FAX (850) 414-2004 ■ TDD (850) 414-2001

Department of Elder Affairs
Response to OPPAGA Recommendations

Chapter 3 - Program Generally Meets Goals, But Could Better Serve High-Risk Clients, Measure Impact of Some Services

Recommendation 1: Increase the use of technology to improve the efficiency of CARES staff assessments by fully implementing the laptop pilot project. Currently, assessment information from the laptops cannot be downloaded to the main computer system. We recommend that the program make the implementation of this capability a priority. In addition, CARES staff should continue to co-locate with service providers whenever possible in order to collaborate more closely with service provider and Department of Children and Families financial eligibility staff.

Concur. The department now has electronic assessments accessible via laptops. What still needs to be done is the ability to merge or synchronize assessments into the database so they do not have to be re-keyed to enter them. It is estimated this project will take approximately one month of a programmers time. Current staff is not available at this time to accomplish this task. The department is looking at the possibility of contracting out this project.

The department agrees with the idea of collocating with service providers. This is an ongoing activity where options are explored several months before current CARES leases are about to expire. Consideration is given to the cost of moving verses staying.

Recommendation 2: To ensure that accurate data is reported to the Legislature and other policymakers, the program should continue to improve and monitor the accuracy of the data on abused and neglected clients.

Concur. Measures implemented in response to the January 2001 OPPAGA review of the High-Risk Abuse, Neglect and Exploitation referrals received by the Department has enabled the Department to capture much more accurate information on the referrals. Reports are run monthly, reviewed and faxed to each AAA by the program unit to ensure that collection of this data remains a high priority. The interagency committee comprised of DOEA, DCF, AAA and provider staff, continues to meet to identify issues and suggest improvements in the operational protocol for this initiative.

Recommendation 3: To make sure that imminent-risk clients are served, the program should closely monitor local providers' compliance with the contract requirement to serve these clients and sanction providers that do not comply. Also, the program should routinely reconcile data between CARES and service providers to ensure that accurate information is available on these clients.

Concur. Although the percentage of the imminent risk served decreased slightly from 1999-2000 to 2000-2001, the number of imminent risk referrals served increased significantly from 1,395 to 2,178. This can be attributed to the increase generally in persons identified by CARES as imminent risk, while funding in the Community Care for the Elderly program, where most consumers initially receive services, increased marginally.

Program monitors reviewed compliance with the contract prioritization language during the last fiscal year and plan to do so again this year. A CIRTS report has just been developed which will assist program monitors, at both the DOEA and the AAA level, to more regularly review provider compliance.

Local protocals between AAAs, CARES and Lead Agencies, will be amended to include monthly reconciliation of CARES and CIRTS reported information.

Recommendation 4: To maximize the number of Medicaid-eligible clients that are transferred from the Community Care for the Elderly program to the waiver, the program should improve efforts to inform clients about the Medicaid waiver program, work with the Department for Children and Families to improve the timeliness of the financial eligibility process, and monitor the provider agencies' adherence to the contractual requirements for transferring clients more closely and sanction providers that do not comply.

Concur. The department has taken action to strengthen contract language and clarify its position on more cost effectively serving those eligible for Medicaid waiver programs. Additionally, DOEA and DCF staff have met and are working to lessen the amount of time for eligibility determination.

Recommendation 5: To better assess clients' nutritional status, the program should design a supplemental nutritional assessment that better measures a client's improvement over time by Fiscal Year 2002-03. The program should also continue to work on the federal Administration on Aging pilot project to test an assessment that asks questions about nutritional changes.

This recommendation needs further analysis of economic impact. The department's Nutrition Advisory Council has also recommended and tested a supplemental nutritional assessment. However, the department has chosen, based on the National Aging Program Information System (NAPIS) requirements, not to require its implementation for all meal recipients. The decision was based on the cost of implementation, lack of data collection ability, and corresponding reduction of available meals required to cover the additional assessment and data collection costs. Alternatively, consumers receiving nutrition risk reduction and nutrition counseling, who are those individuals assessed at high nutritional risk, do receive expanded nutritional evaluations. These data are not collected at the state

level. A more thorough analysis of the cost and benefits of expanding the nutrition assessment on a state-wide basis would need to be completed.

The evaluation unit continues to work with the Administration on Aging on federal performance issues, including the nutritional assessment, under a federal grant received for this purpose.

Recommendation 6: To better measure the likelihood of a caregiver continuing to provide care, the program should change its performance measure. One option is to incorporate the case manager's assessment about the likelihood of the caregiver continuing to provide care. Another option is to measure the quality of caregiver support services. This measure should reflect how many caregivers who self-report that they are very likely to provide care are still providing care a year later.

Concur. The department concurs with the need to more effectively measure the impact service interventions have on the ability of caregivers to continue providing care. Information is currently collected from both the caregiver's and the assessor's view on the caregiver's likeliness of continuing to provide care. This data element is factored into the prioritization for service delivery. The department will revise the methodology for the performance measure to include both the caregiver and assessor's opinions. CIRTS captures all information from the caregiver assessment for State General Revenue funded programs. The department will explore additional performance measures using data already available.

Recommendation 7: To ensure that the Alzheimer's Disease Initiative is providing beneficial services, the program should track information that measures the impact of caregiver support services. The information should include the degree to which caregivers are satisfied with the services they receive and to what extent Alzheimer's patients are being kept out of nursing homes.

Concur. More effective measures of the impact of services on preventing or delaying institutionalization are needed. The department's evaluation unit is currently working with the Administration on Aging to develop a caregiver survey instrument that would be effective as a performance measure for caregiver services.

Chapter 4 - The Program Needs to Improve Oversight of Providers

Recommendation 1: By the end of Fiscal Year 2001-02, program officials should establish target dates for updating all sections of the client services manual. Once the manual has been updated, they should submit the manual to the proper rule-making authorities, so that it becomes a legally binding document.

Concur. A workshop was held on October 8th for the purpose of beginning the process to update and revise the *Client Services Manual*. Names of interested parties willing to

work on specific sections of the manual were collected. A time schedule of meetings for each section will be developed and published prior to the end of the 2001-2002 Fiscal Year.

Recommendation 2: Program officials should enhance written instructions to provide clear and comprehensive guidelines for all policies and procedures as the client services manual is updated. Also, by the end of Fiscal Year 2001-02, they should provide training and technical assistance to AAAs and lead agencies to address at least two unclear policies: the termination of CCE clients who refuse to transfer to services under the Medicaid waiver and the application of cost allocation and unit cost methodologies.

Concur. Contract language regarding provision of services to persons determined Medicaid waiver probable has been strengthened and clarified in a recent contract amendment. AAA's will be advised to discuss this policy with providers and CIRTS reports will be reviewed for compliance. These reports will be available to the AAAs to assist them in managing provider compliance.

Training on the department's current unit cost methodology was offered to AAAs at a Fiscal Officers meeting in June 2001. The department has since assisted with two of the AAA's Unit Cost Methodology training sessions. Additionally, at the recommendation of the State Auditor, a task force has been formed, comprised of members representing the spectrum of agencies involved in service delivery, to review policies and procedures relating to costing methods. That task force begins meeting in January and is expected to provide recommendations which will standardize the accounting methodology for DOEA service costs.

A template for the Statement of Functional Expenses by program is being developed for the department's audit attachment to be included in the Master Agreement to enable AAAs to make better comparisons of historical audited costs with the costs projected using the unit cost methodology. The task force mentioned in the previous paragraph will assist in the development of the template.

Recommendation 3: By the end of Fiscal Year 2001-02, program officials should standardize definitions for program service units to the extent possible, so that a state rate for each service can be established, and enhance procedures for identifying, allocating, and reporting administrative costs. Once clear definitions and procedures have been established, these officials should institute an absolute unit rate limit for each type of service based upon a market analysis and set a reasonable standard for administrative costs by the end of Fiscal Year 2002-03.

Concur. The task force described above (response to recommendation 2) will begin the process for implementing this recommendation. Service unit definitions will be reviewed as part of the *Client Services Manual* revision.

Recommendation 4: Program officials should establish minimum standards for AAA monitoring procedures and instruments by the end of Fiscal Year 2001-02.

Concur. Compliance requirements were outlined during the 2000-2001 contract year and minimum requirements were given to AAAs. Contract language was strengthened to require monitoring of sub-recipients at least annually for compliance with contract clauses required to be passed down and with program requirements included in the *Client Services Manual*. Monitoring standards will be reviewed and updated as part of the *Client Services Manual* revision process. Minimum standards were shared with AAAs for their use with service providers during the 2000-20001 monitoring cycle.

A clause was added to the 2000 Master Agreement requiring AAAs to report within 48 hours, provider problems that could potentially result in interruption of services to the department. Both of the special investigations initiated by DOEA's Inspector General were a result of the AAA's notification in compliance with this clause.

The task force will make recommendations regarding best practices Monitoring instruments for AAAs to monitor subrecipients.

Recommendation 5: Program headquarters should take corrective actions upon all AAAs that fail to comply with contract agreements within a reasonable time as specified by headquarters and enforce AAAs to correct incompliant providers as needed.

Concur. Under its new agency leadership the department continues to review agreement with Area Agencies and policies regarding corrective actions and sanctions. This will also be reviewed with the AAAs in regards to their contracts with providers.

Chapter 5 - Managed Long- Term Care Pilots Have Potential for Delaying Nursing Home Placement

Recommendation 1: Petition the Centers for Medicaid and Medicare Services (formerly the Health Care Finance Administration, or HCFA) to pursue waivers that achieve the integration of Medicaid and Medicare services under one provider. This integration may make it easier for the program to find providers for managed long-term care in general and for the SHMO pilot in particular.

Concur. The department agrees with the action to pursue waivers that integrate Medicaid and Medicare services. Medicare HMO providers however, have been pulling out of Florida citing inadequate Medicare reimbursement policies. The department has little or no control over this. Although the managed long-term care programs are not financially integrated, the programs are designed to utilize case managers to coordinate and maximize care between Medicare and Medicaid services. According to Jennifer Salmon, Investigator for a program evaluation contracted for by the department with the University of South Florida, Florida Policy Exchange Center on Aging, the model of care

coordination used in these programs may actually work to serve clients better than in a fully integrated program.

Recommendation 2: We recommend that the Legislature, require the department to closely monitor contract providers to ensure that the elder enrollees are receiving the adequate care they need to delay or avoid nursing home placement and properly sanction contractors that do not meet this desired outcome.

Concur. The department will be conducting on-site monitoring of the three providers beginning in January to ensure that enrolles are receiving the adequate care they need to delay or avoid nursing home placement. Also see response to Chapter 5, Recommendation 3.

Recommendation 3: We also recommend that the program

- **contractually require providers to report cost information and**
- **contract for a comprehensive evaluation for the Long-Term Care Community Diversion project that addresses the areas required by law. At a minimum, the evaluation should include**
  - **a cost comparison of pilot participants with Medicaid waiver and nursing home clients;**
  - **client-specific outcomes, such as whether clients desires are being met in terms of choice of services and providers and their right to privacy;**
  - **continuity of security, and whether the client is getting the necessary support from MCO case management to meet desired outcomes;**
  - **a comparison between the pilots frequency of incidents of preventable**
  - **hospitalization and the national average; and**
  - **an actuarial analysis of the capitation rate of the pilot program.**

Concur, with further study needed for the first bulleted item. The department believes that providers should contractually provide service data. Provider cost information may be proprietary and give providers a reason for not participating. However, if accurate and complete service utilization data is reported, an experienced actuary will be able to determine the cost of providing services to enrollees and in turn recommend an appropriate capitation rate.

The department, in conjunction with the Agency for Health Care Administration (AHCA) is working to develop a proposal to conduct a comprehensive evaluation of the managed long-term care programs that will include comparisons of client outcomes, costs, care management and coordination, satisfaction and service utilizations with other Medicaid long-term care programs. The department, in conjunction with the Agency for Health Care Administration is also in the process of hiring an actuary to analyze the current capitation rates of all the Medicaid long-term care programs and make recommendations on the new capitation rate methodologies.

The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

John W. Turcotte, Director

June 20, 2002

Gema G. Hernandez, D.P.A.
3536 Gardenview Way
Tallahassee, FL 32309

Dear Dr. Hernandez:

I received your letter dated May 21, 2002, questioning one page in the December 2001 OPPAGA report, *Justification Review: Services to Elders Program, Department of Elder Affairs*. After reviewing the concerns expressed in your letter and the work of the analysts who conducted that project, I am responding to your request for further action by this office.

In deference to you as the former Secretary of the Department of Elder Affairs, I have directed that your letter and its Attachment 1 be added to the current electronic version of the report, listed in the index and attached as the "Response of the former Secretary." That report, numbered 01-66, may be accessed on our website, *The Florida Monitor*, at www.oppaga.state.fl.us.

The subject matter with which we deal is often controversial and subject to differing policy perspectives on the best use of limited public resources. Our reports are not politically motivated and are conducted by an independent, non-partisan staff. The Office of Program Policy Analysis and Government Accountability (OPPAGA), an independent unit of the Florida Legislature, has an international reputation for producing high quality products supported by thorough fieldwork and analysis, and a painstaking quality assurance process.

Sincerely,

John W. Turcotte
Director

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Gema G. Hernandez, D.P.A.
3536 Gardenview Way
Tallahassee, FL 32309

Dear Ms. Hernandez:

I received your letter dated May 21, 2002, questioning one page in a December 2001 report issued by this office titled "Justification Review: Services to Elders Program, Department of Elder Affairs." After reviewing the concerns expressed in your letter and the work of the analysts who conducted that project, I wanted to write in response to your requests for further action by this office.

As an independent office of the Florida Legislature, I can assure you that, although the subject matter with which we deal is often controversial and subject to differing policy perspectives on the best use of limited public resources, our report contents are not politically motivated. Rather, the Office of Program Policy Analysis and Government Accountability (OPPAGA) enjoys a national reputation for producing high quality products supported by solid fieldwork and analysis, and a thorough quality assurance process. This was the approach taken in the report you reference, and I take exception to your suggestion otherwise.

In deference to your role as the former Secretary of the Department of Elder Affairs, I have directed that your letter and its Attachment 1 be added to the current electronic version of the report, listed in the index and attached as the "Response of the former Secretary." That report, numbered 01-66, may be accessed on our website, the Florida Monitor, at www.oppaga.state.fl.us .

Sincerely,

John W. Turcotte
Director

Gema G. Hernandez, D.P.A.
3536 Gardenview Way
Tallahassee, Florida 32309

Certified Letter

May 21, 2002

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and Government Accountability
111 West Madison Street, Room 112
Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

On Monday May 20, 2002 in a job interview in Chicago an attorney for the corporation shared with me OPPAGA Report No.01-66 dated December 2001 titled Justification Review: Services to Elders Program Department of Elder Affairs.

The attorney pointed out statements on page 34 of the above mentioned report, statements that according to him could be construed as defamation of character and subject to legal action on the part of a private citizen that is being harmed with unsupported allegations. The attorney took the time to show me that in the body of the above mentioned report there is no evidence to support the conclusion which appears on page 34.

After reading the above mentioned report I have to concur with the attorney, specifically because 90% of the 55 page report uses words like: Program has exceeded expectations (page 23), Program has largely met expectations (page 25) Program has been effective (page 15) Program has exceeded from 60% to 69.5% (page 24), Program has expanded to 67 counties (page 27), Alzheimer's initiative has appeared to meet client satisfaction (page 26), Program has taken step to increase efficiency (page 12), current operations are successful (page 13), Program has exceeded goal for diverting clients from Nursing Homes (page 15), CARES performing well and exceeding legislative performance (page 13) Program substantially meets expectations (page 14), Program has achieved a 31.5 million in cost avoidance, Program has implemented most OPPAGA recommendations (page 19), Program has successfully transferred 1951 State clients to Medicaid (page 15), Program has taken additional steps to target resources to the most frail (page 27).

The above statements and other statements like them throughout the report are not indicative of a "problematic leadership" but of an effective leadership and management style.

Therefore the statement to wit

"Problematic executive leadership within the Department of Elder Affairs may have contributed to the deficiencies with program management, oversight, and monitoring mechanisms. In several interviews, directors stated that they were not pleased with the leadership from the Secretary's Office and were generally dissatisfied with headquarters administration. In September 2001, the Secretary of the Department of Elder Affairs resigned, and .....

The reference to the Secretary's resignation explicitly alludes, suggests and focuses the attention on the Secretary and not in the Secretary's Office (Deputy, Chief Financial Officer, Receptionist, Assistants) and not on headquarters. Headquarters refers to 126 employees, not just the Secretary.

All the statements that appear on Chapter 4 that precede these conclusions refer and mention the agency's headquarters staff, not the Secretary as the "problematic area". The selection of words the report uses and the position of the last statement explicitly alludes to the Secretary as the person at fault. However, all the other pages of praises and accomplishments fail to acknowledge the effectiveness of the Secretary in leading the department in exceeding in its performance. This leads us to believe such a statement was placed there for politically motivated reasons.

This is also the only page in the entire report that places subjective comments without verification of facts and memos and without affording the Secretary due process to present quantifiable and qualifiedly evidence to what the directors call "problematic"

There is plenty of evidence that spells out that what the Secretary was trying to do was to bring the type of accountability, cost methodologies and monitoring protocols very similar to what OPPAGA is recommending. Documents supporting this effort could be found in the Department's files. If they have been destroyed for unknown reasons I have kept copies that I can share with you at your convenience.

To mitigate the damage such statement have done to my reputation as an effective and competent leader it is my right to request that this letter and the response to other issues which appears on page 34 of the report become a permanent attachment to Report 0♦-66 unless the questionable paragraph is purged from the report.

Specifically I am requesting that if the words are left the following is done

1. My response and this letter to become Attachment E
2. Attachment E to be listed in the index of the report as the Secretary's response
3. A notation using typesetter 12 points or higher be added to page 34 indication that the Secretary's objections and evidence can be found in attachment E

4. Because the report has been widely disseminated (even to Chicago) all parties that have requested and received the existing report (a hard copy or via the internet) should be given the corrected version.

The report starts with a disclaimer that this is an objective, independent, and professional analysis. It said the project was conducted in accordance with applicable evaluation standards. At this time page 34 contradicts the above statement.

I hope this letter and this request will suffice to produce the expected changes.

Sincerely,

Gema G. Hernandez, D.P.A

Attachment 1
Reponses to OPPAGA REPORT 01-66
Information contained in page 34

Page 34 of the above mentioned report introduces information that is not covered in the report and is not supported by data, memos, emails or any other type of documents or information contained in the report.

The report cited on page 34 a high turnover rate of 13.5 % among the Department of Elder Affairs **oversight positions**. It compares the turnover rate for the Department **oversight positions only** with the average turnover rate for **all positions** in all other State agencies of 7.4%. The percentage produces a skewed picture and creates the optical illusion that the Department of Elder Affairs has a higher turnover rate. However, if the attrition rate **of all positions** at the Department is properly compared with the attrition rate **of all positions** at all other state agencies, the results are totally different. Elder Affairs has a lower turnover rate than the average turnover rate of all other state agencies, the Department 6.5% versus 7.4% for the other agencies.

The same is also true if we compare the turnover rate of **just Oversight positions** at AHCA, Children and Family and Health just to mention similar agencies. The Department has a much lower attrition rate on oversight positions only. Mixing oversight positions with all positions is not an equitable comparison.

When all positions are considered the Department came out with lower rate. The report itself support this conclusion when it states, and I quote:

- Page 17: As of June 1, 4% CARES positions were vacant, compared to the statewide average of 9% for all other state employee positions.

- Page 17: We found that what contributed to this performance is the program's experienced, stable workforce.

- Page 17: CARES employees have been in their positions for more than 10 years.

2. The report failed to mention that the departments are so different in the number of employees they have that percentages alone again skew the findings. For example, the Department of Elder Affairs has 374 Fts while Children and Family has 22,000 Health 17,000 and AHCA 15,000. 1% of 374 are 3 employees while 1% of 22,000 are 220 employees. The total number of oversight positions in the department is 71 and 13.5 percent of that is 9 positions. What the report is saying is that because 9 positions left the department there is "problematic leadership".

3. The position that provides oversight comes from two units, one the program unit, and the other one the fiscal unit. The program unit had no attrition in the almost 3 years I was there. The same individuals that were there when I came were there when I left. The fiscal unit is where the entire turnover has occurred and it is in

this fiscal unit where the 10.1% of the vacancies were found as of August. To put things in perspective, a 10.1% vacancy translates into 7 positions that were kept vacant, according to the director of that fiscal unit, to properly deal with the ongoing budget reductions and the anticipated budget cuts.

All the above facts point out that if there is a "problematic leadership" it existed in the fiscal unit. This is further supported by statements in page 32 and page 31 of the above report.

One final observation, the fact that OPPAGA has not established a baseline to determine what percentage of attrition begins to diminish the effectiveness of a department renders OPPAGA's conclusions as it pertains to page 34 null and unsupported.