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Progress Report

December 2003 **Report No. 03-69**

Services to Elders Program Has Improved Accountability and Oversight; Should Reduce Capitation Rate for Long-Term Care Pilot

at a glance

Since our 2001 report, the program has taken steps to improve its accountability and oversight mechanisms. However, the program should take additional steps to improve its efficiency by increasing CARES co-locations with the Department of Children and Families and service provider staff. It also should reduce the capitation rate for the Long-Term Care Community Diversion Pilot Project, as recommended by two contracted studies. In addition, the program should evaluate other client-specific outcomes and customer satisfaction to ensure the pilot's effectiveness.

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by the Department of Elder Affairs in response to a 2001 OPPAGA report on the Services to Elders Program.[1,2] This report presents our assessment of the extent to which the department has addressed the findings and recommendations included in our prior report.

Background

The Services to Elders Program administers services and long-term care programs for 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 provides 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 (CARES), Consumer Advocate Services, and Long-Term Care Pilot Projects.

The Services to Elders Program operates under the organizational mandates of the federal Older Americans Act of 1965.[3] 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, funding, administering,

[1] Section 11.45(7)(f), *F.S.*

[2] *Justification Review: Services to Elders Program, Department of Elder Affairs,* OPPAGA Report No. 01-66, December 2001.

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

and evaluating programs and services for the state's elders.

Florida's program operates through 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. The AAAs designate lead agencies in each county to provide case management services (in some cases lead agencies serve multiple counties). The 57 lead agencies in turn subcontract with over 1,200 local providers for client services, such as homemaking, home health, respite, and personal care; lead agencies also provide certain services themselves.

The program served 191,271 clients in Fiscal Year 2002-03.[4] The Legislature appropriated $334 million to the program for Fiscal Year 2003-04, with state general revenue accounting for 33% ($110.3 million) of this total and the remaining $223.7 million derived from various state and federal trust funds (see Exhibit 1). Over the past five years, the Legislature has increased funding by 39%.

Exhibit 1
The Program Is Funded with Trust Funds and State General Revenue

Revenue Source	Fiscal Year 2003-04 Appropriations
Grants and Donations Trust Fund	$ 574,399
Administrative Trust Fund	840,588
Tobacco Settlement Trust Fund	24,780,554
Operations and Maintenance Trust Fund	81,159,061
Federal Grants Trust Fund	116,298,918
Trust Funds Total	**$223,653,520**
State General Revenue	**110,294,481**
Total	**$333,948,001**

Source: Ch. 2003-397, *Laws of Florida.*

[4] This Fiscal Year 2002-03 client count does not include clients served in the CARES, Long-Term Care Ombudsman, and Public Guardianship Programs.

Prior Findings

In our 2001 report, we concluded that while program services helped clients live independently, the program was not achieving some of its legislative goals and needed to improve its operations to better meet client needs. We identified four primary areas in which improvements were needed: increasing the efficiency of the CARES nursing home pre-admission screening process; strengthening the program's performance accountability system; improving oversight of AAAs and providers; and evaluating the outcomes of the program's managed long-term care pilot project.

Laptop computers and co-locating could further increase CARES efficiency

Our prior report determined that the CARES process was successfully diverting many clients from nursing home care to less restrictive settings.[5] The program also had taken steps to increase its efficiency by improving data systems, providing personal computers to staff, and piloting the use of laptop computers to enable staff to immediately enter nursing home pre-admission screening assessments. In addition, in some areas the program had co-located CARES staff with service providers and financial eligibility offices of the Department of Children and Families (DCF), which helped CARES staff stay more informed about client status and the availability of home and community placements and allowed them to make quicker referrals to needed services. We recommended that the program improve its technology systems by fully implementing the laptop pilot project and increase co-locations with service providers and DCF financial eligibility offices whenever possible.

[5] Comprehensive Assessment and Review for Long-Term Services (CARES) is a nursing home pre-admission screening program that identifies clients' needs for long-term care, establishes their medical eligibility to receive Medicaid funding for long-term care, and recommends the least restrictive and most appropriate service placement.

Improved accountability system needed to ensure effective service delivery

Our prior report concluded that the program needed to improve its performance measurement system and hold providers more accountable for their performance. The program lacked sufficient and accurate data to help policymakers and program managers ensure that public monies were spent to achieve desired outcomes and to improve public services. We recommended that the program improve its data accuracy, modify its performance measures, and evaluate the effectiveness of its Alzheimer's Disease Initiative.

We also reported that the program needed to hold service providers more accountable for their performance in serving clients at imminent risk of nursing home placement and moving Community Care for the Elderly clients to the Medicaid waiver. Many private providers were not meeting contract requirements to give high priority to imminent risk clients and to move clients to the Medicaid waiver. We recommended that the program more closely monitor providers' compliance with these contract requirements and sanction providers that did not comply.

Ineffective guidance and oversight of AAAs and providers diminished program efficiency and effectiveness

Our prior report identified weaknesses in monitoring by headquarters and AAAs that increased the likelihood of policy misinterpretation by both AAAs and service providers. We noted that historically, the program's headquarters has had many oversight weaknesses, including a lack of written guidelines explaining monitoring objectives and a lack of standard requirements for documenting and reporting monitoring results. We reported that the program developed a new monitoring system to address these deficiencies, but had not fully implemented it due to needed modifications identified by program officials. In addition, AAA monitoring of providers was problematic because monitoring procedures and instruments varied significantly throughout the state and in some cases were insufficient to ensure adequate financial controls within some lead agencies. We recommended that the program establish minimum standards for AAA monitoring procedures and instruments and improve its oversight by taking corrective actions when AAAs and providers failed to comply with contract agreements.

We also reported that the program had 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. We recommended that the program update its client services manual, standardize definitions and institute an absolute unit rate limit for program service units, and enhance procedures for identifying, allocating, and reporting administrative costs.

Managed long-term care pilots showed potential but should be improved and more fully evaluated

Our prior repot noted that the program had implemented a Long-Term Care Community Diversion Pilot Project and was in the planning stages of implementing two additional pilot projects. However, the pilot was experiencing difficulty recruiting providers because its capitation rate did not integrate Medicaid and Medicare funds and potential providers were concerned that the rate would be insufficient to cover the costs of caring for very frail elderly clients. We recommended that the program petition the federal Centers for Medicaid and Medicare Services to pursue waivers that integrated Medicare and Medicaid services under one provider.

We also reported that the program had not yet fully evaluated the costs and outcomes of the Long-Term Care Community Diversion Pilot Project. We recommended that the program contract for a comprehensive evaluation of the diversion pilot that addresses the areas required by s. 430.709, *Florida Statutes*. [6]

[6] The law required the program to review and assess the actual cost for the provision of services to participants. In addition,

Current Status

The program has taken steps to implement our recommendations. The program has increased its use of technology in CARES screening, improved its performance measurement system, strengthened provider monitoring, and standardized service definitions and procedures for reporting administrative costs. The program also has integrated Medicaid and Medicare services under a single provider and has more fully evaluated its Long-Term Care Community Diversion Pilot Project. However, the program should reduce the capitation rate and further evaluate client-specific outcomes and assess customer satisfaction in its pilot project.

The program has used information technology to improve CARES efficiency, but could increase co-locations

As we recommended, the program has improved its CARES nursing home pre-admission screening process by enhancing its technology systems. The program has enhanced the functionality of its two major information systems, the CARES Management System and the Client Information Referral Tracking System, to collect, edit, and process information. The program also is drafting policy for electronically sharing the client assessment information between the two systems, which will eliminate double data entry requirements and increase data reliability. This enhancement will be implemented in the first quarter of 2004. In addition, in September 2003, the program established a data sharing agreement with DCF, which will allow CARES staff to have access to DCF's client data and significantly reduce the amount of time required for a client to be enrolled in a Medicaid waiver program. The program has temporarily suspended its CARES laptop pilot project until these changes are complete.

However, the program has not increased the number of co-locations of CARES staff with DCF or service provider staff since our prior report. As of September 2003, 7 of the 20 CARES offices were co-located with DCF or service provider staff, and the program will analyze 3 leases that expire in 2004 with the goal of co-locating CARES and DCF eligibility staff. We continue to believe that increasing the number of co-locations between CARES and DCF and/or service provider staff will improve the efficiency with which CARES refers clients to needed services.

The program has strengthened its accountability system to better assess program performance

As we recommended, the program has improved its accountability system through several initiatives. These include taking steps to improve data accuracy, establishing new performance measures, and enhancing contract requirements regarding serving imminent risk and Medicaid waiver clients.

The program has significantly improved the accuracy of data for abused and neglected elders referred from DCF and for clients at imminent risk of nursing home placement. Fiscal Year 2002-03 data showed that 2,735 elder abuse referrals (96.6%) were common to both DCF and DOEA data systems, which is a considerable improvement from Fiscal Year 2001-02 performance when only 42.3% of referrals were common to both systems (see Exhibit 2). Similarly, the discrepancy in the reported number of referrals of clients at imminent risk of nursing home placement between CARES and providers was only 15 referrals in Fiscal Year 2002-03, compared to 506 referrals in Fiscal Year 2000-01.[7] These data improvements should result in more timely tracking and service delivery to these vulnerable adult populations.

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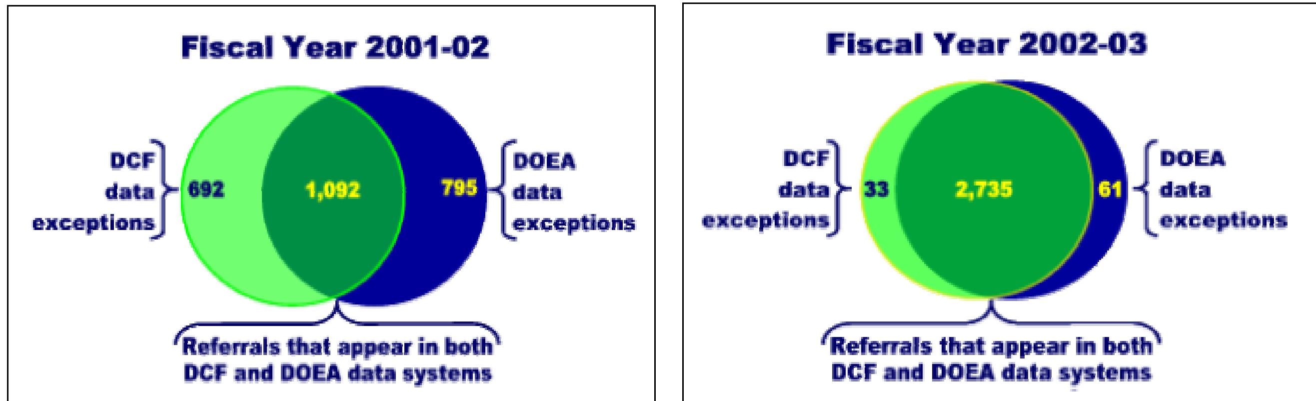
we recommended that the program's evaluation include a cost comparison of pilot participants with Medicaid waiver and nursing home clients, client-specific outcomes, customer satisfaction, hospitalization rates, and an actuarial analysis of the pilot's capitation rate.

[7] In Fiscal Year 2002-03, CARES reported referring 2,296 clients to providers, while providers reported receiving 2,311 imminent risk referrals.

Exhibit 2
Data on Number of Elder Abuse Referrals Has Improved Between Departments' Data Systems[1]



[1] Data exceptions are referrals made in one system that do not have a match in the other system.

Source: OPPAGA analysis of DOEA data.

The program also has established new performance measures and assessments to better monitor the effectiveness of services.

- To better measure caregiver services, the program proposed and the 2003 Legislature approved a new performance measure: "percent of caregivers whose ability to continue to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor)." This new measure will better assess the likelihood of future care giving, since both the caregiver and the assessor determine the caregiver's ability to continue providing care. It will also better evaluate the quality of caregiver support services, because it identifies a specific timeframe for follow-up.
- In addition to its legislative performance measure monitoring clients' nutritional risk, the program has developed a supplemental assessment to capture other nutritional service outcomes. Based on client surveys, the assessment reports participation frequency, consumer satisfaction, dietary changes as a result of participation, and the extent to which the program serves as a linkage to other benefits and services.
- The program has established measures to assess the effectiveness of caregiver support services in the Alzheimer's Disease Initiative. As we recommended, the program now measures caregiver satisfaction, caregiver "burnout" prevention, and cost-effectiveness. [8]

The program also has taken steps to improve its performance in transferring Community Care for the Elderly clients to the Medicaid waiver and serving imminent risk clients. Program reports and procedures are in place to assist both headquarters and AAAs in monitoring local providers' compliance with contract requirements related to the two issues. In addition, DCF and DOEA approved a Model Coordination Agreement in July 2002. This agreement established a partnership to facilitate communication and cooperation in the completion of Medicaid eligibility determination among the agencies and providers, so that clients can more quickly be determined eligible and begin receiving Medicaid services.

[8] Caregiver satisfaction measures the percentage of caregivers who think that home and community-based services help them "a lot" to be better caregivers. Caregiver "burnout" prevention measures the percentage of caregivers that think that home and community-based services enabled them to provide care for a longer period of time.

These initiatives have increased efficiency and helped the program serve more clients in Medicaid waiver; however, due to an increase in Medicaid expenditures, the program has served fewer imminent risk referrals. During Fiscal Year 2002-03, the program moved 3,036 CCE clients to the Medicaid waiver, leaving 9.9% (1,190) of the Medicaid-probable clients in CCE. This is an improvement from Fiscal Year 2000-01 when 13.4% of the Medicaid-probable clients were receiving CCE services at the end of the year. However, the program served 72.8% (1,658 of 2,279) of the imminent risk referrals in Fiscal Year 2002-03, which is a decline in performance from Fiscal Year 2000-01 when the program served 83.6% of the referrals. [9] Program officials attribute the decline to an increase in Medicaid expenditures for its current clients, which limited the number of new clients who could be served.

The program has improved oversight of AAAs and providers

As we recommended, the program has improved its oversight capacity by establishing a new monitoring system for AAAs and lead agencies. Under this system, headquarters monitors the AAAs, which in turn must monitor lead agencies using a monitoring instrument with similar components. The system establishes four progressively more intensive levels of monitoring—critical measures, desk review, technical assistance, and full review. The level of monitoring for each agency is dependent on its performance, with more intensive monitoring required for agencies found to have operating deficiencies. At a minimum, all agencies are monitored using the critical measures, and all must submit a corrective action plan for any deficiencies found during monitoring. The program completed initial monitoring using this system in September 2003.

The program also has established standard definitions for providers' service units and has enhanced procedures for reporting administrative costs. To assure common interpretation and implementation, the program standardized service and unit definitions and included them in its *Home and Community-Based Services Handbook*, which was added to the master agreements with the AAAs that took effect on January 1, 2003. In March 2003, the program also developed a simplified process for AAAs to use to allocate their indirect costs to services. These guidelines should provide consistency in reporting unit costs and help program officials hold providers more accountable for any excessive administrative costs. In addition, the program is updating its *Client Services Manual* to further enhance consistency in the delivery of services and expects it to be completed by December 31, 2003.

However, the program has not yet instituted standards for setting unit rates or rate limits. Without these standards, the program does not have a basis for negotiating prices for services and cannot ensure their cost-efficiency. The program has hired a consultant with expertise in rate setting and contracting and anticipates establishing standardized unit rates by December 2003.

The program has taken steps to improve long-term care services, but can increase cost-effectiveness by reducing the diversion pilot's capitation rate and evaluating critical outcomes

As we recommended, the program has obtained a federal waiver to integrate Medicaid and Medicare services under one provider. On November 19, 2002, DOEA received final approval from the federal Centers for Medicare and Medicaid Services to begin implementation of the Program of All-Inclusive Care for the Elderly, which provides acute and long-term care services by integrating both Medicaid and Medicare funds in one capitation rate. Initial enrollment began in February 2003.

[9] The performance measure eliminates duplicate referrals, which explains the difference between 2,279 and 2,311 referrals reported in footnote 7.

The program has taken steps to evaluate the Long-Term Care Community Diversion Pilot outcomes. The program contracted with The Florida Policy Exchange Center on Aging at the University of South Florida to conduct this study. The October 2003 report concluded that the pilot cost an average of $944 more per month per enrollee than other similar programs and that the difference could not be explained by a difference in client frailty level. While the study did not fully evaluate the pilot's cost-effectiveness, it concluded that the monthly capitation rate was difficult to justify. [10]

In addition, the program contracted for an actuarial analysis of the capitation rate methodology. This study concluded that the capitation rate should be reduced from $2,342 per month to $1,540. As a result, in November 2003, the program and AHCA submitted a proposal to CMS that would gradually reduce the current capitation rate to the recommended rate over the next three years while allowing for regional differences. [11] The reduced rate will enable the program to serve more clients in a community-based setting and save general revenue dollars.

However, these evaluations have not yet assessed other critical program outcomes, including client-specific outcomes addressing quality of care and quality of life and customer satisfaction with support services and with the choice of services and providers. With the significant increase in funding for the pilot project from $29.5 million in Fiscal Year 2002-03 to $68.1 million in Fiscal Year 2003-04, we believe that it is critical for the state to have additional information on the pilot project's outcomes and cost-effectiveness. Consequently, we believe that the program should expand its evaluations to address these areas.

[10] The study analyzed data on client frailty levels and five outcomes, including inpatient hospital days, outpatient claims, nursing home days, death rates, and cost of Medicaid services.

[11] The program plans to reduce the capitation rates annually over the next three years beginning in January 2004. During the first year, the statewide average capitation rate will be $2,020, with regional capitation rates ranging from $1,921 in PSA 2 to $2,124 in PSAs 9 and 11. The projected statewide average capitation rates for the second and third years will be $1,765 and $1,540; however, the regional capitation rates may change depending upon each contracted health plan's situation and experience.

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