



Several Factors Can Delay Eligibility Determination for Medicaid Long-Term Care

at a glance

Although the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills many functions, its primary function is to conduct medical eligibility determination for Medicaid nursing home care or other long-term care services. The CARES Program is also responsible for assisting elders who apply for the Nursing Home Diversion Program.

Delays in receiving physician forms, regional workload issues, and client unavailability can lengthen the time it takes the CARES Program to determine medical eligibility for long-term care services. To a large extent these factors remain outside the program's control. Delays in receiving physician forms, the financial eligibility determination process, and the Medicaid managed care payment system contribute most to the time that elapses before an individual can be enrolled in the Nursing Home Diversion Program.

Current state initiatives may help address these delays. The Legislature and agencies could consider other options, such as improving inter-agency electronic communication or reducing the CARES Program's workload, but each of these options has potential barriers to implementation.

Scope

As required by Ch. 2006-28, *Laws of Florida*, OPPAGA reviewed the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program. This report describes the functions of the CARES Program and answers four questions.

- What are the state's processes for determining eligibility for Medicaid long-term care services?
- What factors affect how long it takes CARES to conduct medical eligibility determination?
- What specific circumstances can delay an individual's enrollment in the Nursing Home Diversion Program?
- What options could the Legislature and agencies consider for improving the eligibility determination and enrollment processes for Medicaid long-term care services?

Background

Demand for long-term care services is growing as Florida's elder population continues to increase. In 2004, Florida led the nation with 16.8% of its population (2.9 million individuals) age 65 and older. By 2010, Florida's elder population is expected to reach nearly 3.5 million, with the largest increase in seniors age 85 and older.

As a consequence, state costs for Medicaid long-term care services are rising as well. Currently, the federal-state Medicaid program is the primary payer for long-term care services nationally and in Florida.

In Fiscal Year 2004-05, state spending for Medicaid long-term care services totaled \$2.47 billion, including \$2.23 billion spent for people on nursing home care and \$308 million (12.1% of the total) for community-based care for the elderly.¹

Individuals seeking Medicaid long-term care services must meet certain medical, income and asset criteria. Regardless of whether persons are seeking services in the community or in a nursing home, the basic medical requirements are the same; these standards are known as nursing home level of care criteria.^{2, 3} Federal rules require that individuals seeking Medicaid long-term care services can have income no higher than \$1,869 per month and assets totaling no more than \$2,000 (see Exhibit 1).

The primary function of the CARES Program is to conduct medical eligibility determination. The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program helps the state meet federal requirements to screen applicants for Medicaid long-term care services. States must screen individuals in order to prevent premature or unnecessary nursing home placement. Federal and state laws also require that people be served in the least restrictive setting possible; i.e., community-based rather than institutional services.

Although the CARES Program fulfills many functions, its primary function is to conduct medical eligibility determination for anyone applying for Medicaid nursing home care or other Medicaid long-term care services. The program also carries out other activities, such as screening all Medicaid nursing home applicants for mental illness and mental retardation and educating consumers, their families, social workers and others about home and community-based services. CARES also identifies nursing home residents who might be appropriate for community placement and also works with hospitals to identify elderly hospital patients who could be served in the community rather than proceeding to a nursing home upon discharge from the hospital. CARES also annually reviews Medicaid nursing home residents to ensure that they continue to require nursing home level of care. CARES must annually reassess for continued eligibility each Medicaid waiver enrollee.

¹ As of December 2005, Florida operated 13 Medicaid community-based waiver programs. Some programs serve people with specific injuries or conditions, such as the Traumatic Brain and Spinal Cord Injury waiver program and the Developmental Disabilities waiver program, while others serve broader groups of people who are aged or disabled. The CARES Program processes the medical eligibility determination for 10 of these programs, as well as Medicaid nursing home care, and the PACE program, a state Medicaid plan optional service. For more information see Appendix A.

² The state has three levels of nursing home services based on the severity of client medical condition, termed Skilled Nursing, Intermediate 1, and Intermediate II. These levels are explained in more detail in Appendix B.

³ The various state Medicaid home and community-based waiver programs also have unique criteria that applicants must meet such as having a diagnosis of dementia and need for assistance with many daily activities.

Exhibit 1

To Be Eligible for Medicaid Long-Term Care Services, Individuals Must Not Exceed Income and Asset Limits

Monthly Income Limits ¹	Asset Limits	Qualified Income Trusts	Transfers of Income and Resources
<ul style="list-style-type: none"> \$1,869 for an individual; \$3,738 for an institutionalized couple in the same facility² 	<ul style="list-style-type: none"> \$2,000 for an individual and \$3,000 for a couple If an individual or couple has income within the Medicaid for the Aged and Disabled (MEDS-AD) limit, they are entitled to an asset limit of \$5,000 or \$6,000, respectively.³ 	<ul style="list-style-type: none"> Individuals whose income is over the Institutional Care Program (ICP) income standard may still be eligible if they set up an income trust and deposit sufficient funds into a "qualified income trust" account in order to reduce their income outside the trust to within the income standard. 	<ul style="list-style-type: none"> Transfers of income or resources may affect eligibility if they are made within 60 months of the application for Medicaid.⁴ Certain transfers are allowable, for example transfers to a spouse or disabled adult child.

¹ In 2006, monthly income limits were \$1,809 for an individual and \$3,618 for a couple.

² Resources and income are considered differently for married individuals when one spouse is institutionalized and one spouse continues to live in the community.

³ Medicaid for the Aged and Disabled serves a small number of elders who are not eligible for Medicare.

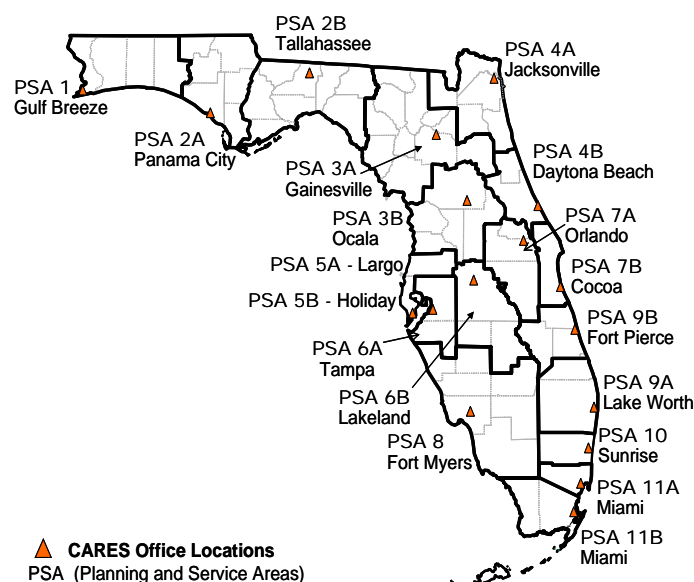
⁴ Changed from 36 to 60 months by the Deficit Reduction Act of 2005.

Source: Department of Children and Families, Economic Self-Sufficiency Program.

The Department of Elder Affairs (DOEA) administers the CARES Program through an inter-agency agreement with the Agency for Health Care Administration, which is the designated state Medicaid agency. For Fiscal Year 2006-07, the Legislature appropriated the program \$15.4 million, including \$3.9 million in state general revenue.

The program's 316 positions (248 employees and 60 OPS positions) for Fiscal Year 2006-07 are distributed statewide across 11 Planning and Service Areas (see Exhibit 2). CARES works in conjunction with other organizations in Florida's aging network including Area Agencies on Aging, lead agencies, and local service providers.^{4, 5}

Exhibit 2 CARES Program Offices Are Located Statewide



Source: Department of Elder Affairs.

The Nursing Home Diversion Program resulted in additional responsibilities for CARES. The role of the CARES Program changed significantly with the 1998 implementation of the Long-Term Care Community Diversion pilot program (commonly known as the Nursing Home Diversion Program). Since 1998, the program provides various services to help Nursing Home Diversion applicants, such as helping applicants with the financial eligibility determination process conducted by the Department of Children and Families and providing information needed to enroll applicants. The program also prepares the paperwork and provides other assistance to current clients who are transferring from one Nursing Home Diversion provider to another.

The Nursing Home Diversion program is one of several Medicaid home and community-based waiver programs aimed at delaying or preventing premature or unnecessary nursing home placement. However, it is unlike the other programs in two ways. First, the DOEA central office in Tallahassee administers the program, while other community-based waiver programs for elders are administered at both the state and local level. Second, unlike other long-term care programs, Nursing Home Diversion services are provided through managed care entities under contract with DOEA that provide and coordinate virtually all services (short-term medical or ongoing long-term care services) that an individual may need.

For Fiscal Year 2006-07, the Legislature appropriated \$196 million for the Nursing Home Diversion Program. The Legislature also added 1,000 additional slots to increase the program's total capacity to 10,000 recipients at any one time.

⁴ DOEA contracts with 11 Area Agencies on Aging, which operate as public or non-profit organizations. The agencies plan, fund, coordinate, and monitor programs and services for individuals in their planning and service areas. Area Agencies on Aging designate and contract with lead agencies in each county to provide case management, which includes collecting medical information. In some cases, lead agencies serve multiple counties.

⁵ Local lead agencies are private non-profit agencies or county governments that contract with Area Agencies on Aging to coordinate services for elders. Lead agencies subcontract with over 1,200 local providers for client services, such as homemaking, home health, respite, and personal care; some lead agencies also provide certain elder services themselves.

Questions and Answers—

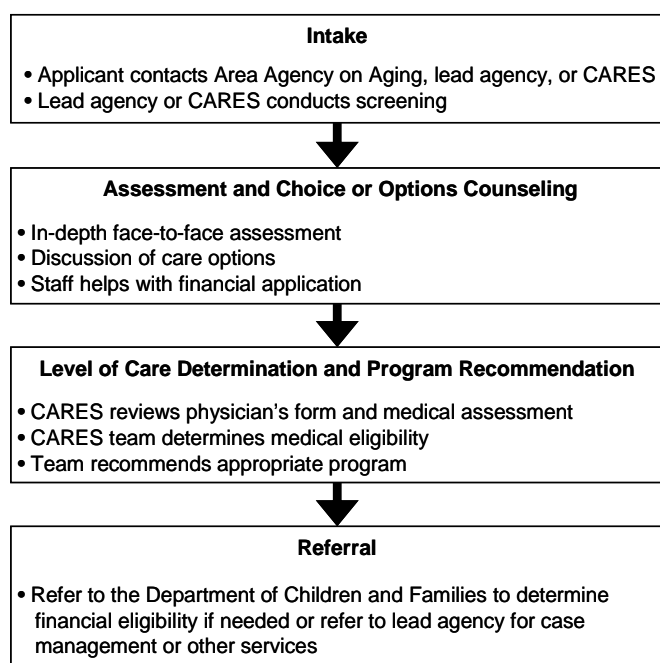
What are the state's processes for determining eligibility for Medicaid long-term care services?

Determining eligibility for Medicaid long-term care services involves separate medical and financial eligibility determination processes. These processes are conducted by two state agencies (the Departments of Elder Affairs and Children and Families) with local elder services agencies also participating. The medical and financial eligibility determination processes both require multiple steps and extensive documentation.

CARES and local lead agencies conduct medical eligibility determination

As illustrated in Exhibit 3, the medical eligibility determination process generally involves four major steps: intake, medical assessment and choice or options counseling, level of care determination and program recommendation, and referral.

Exhibit 3 Medical Eligibility Process Conducted by CARES and Lead Agencies Has Four Major Steps



Source: OPPAGA analysis of CARES Program information.

Intake. The intake process begins when an individual seeking long-term care assistance or the person's caregiver contacts CARES, an Area Agency on Aging, or a local lead agency. Intake workers collect basic information from the individual about service needs and may conduct a brief screening.⁶

Assessment and choice or options counseling. The CARES Program next conducts the medical assessment for anyone seeking Medicaid nursing home placement or placement into certain waiver programs, such as the Nursing Home Diversion Program. For other Medicaid long-term care waiver programs, local lead agencies or other contracted entities collect the information needed for the medical assessment.⁷ Appendix A describes the role of CARES and other entities in conducting medical assessments for various Medicaid waiver programs.

CARES staff or staff working for a local lead agency must contact the individual and set up an appointment to conduct a face-to-face interview to collect medical information and discuss options for services. The full medical interview takes 1½ to 2½ hours to complete. Staff collect information on the person's medical history; current physical, functional, and cognitive challenges; and need for services. These interviews are typically conducted at the person's place of residence, often with a caregiver present.

Once the medical information is collected, staff counsel the individual and his or her caregivers about available services the person may be medically eligible to receive. If the person is interested in a managed care program such as Nursing Home Diversion, federal rules require states to guarantee that people are given sufficient

⁶ Technically, lead agencies gather medical information but do not perform the medical evaluation required by federal law. To fulfill federal requirements, CARES reviews the information gathered by the lead agencies and makes the determination of medical eligibility.

⁷ In Fiscal Year 2005-06, the CARES program and lead agencies conducted 74,903 Medicaid assessments. CARES also conducted 10,794 Continued Residency Reviews and 1,521 New Admission Reviews for people living in nursing homes. CARES conducts Continued Resident Reviews for active Medicaid nursing home recipients to determine if they continue to meet Level of Care criteria. CARES conducts New Admission Reviews for a sample of individuals whose nursing home stay is expected to exceed 20 days, regardless of funding source for the nursing home placement, to identify those individuals with potential to return to the community.

information to make informed choices about programs and services. To fulfill the federal requirements, CARES staff provide applicants with choice counseling to explain the different waiver programs and providers, help applicants understand the concept of managed care, and discuss the enrollment process. Nursing Home Diversion applicants must sign a “freedom of choice” form and choose a specific provider.

Staff also help applicants complete the application for requesting Medicaid financial eligibility determination from the Department of Children and Families. They provide clients with other forms that must be completed, including the “3008” physician form, consent forms, and a freedom of choice form. (See Exhibit 4 for a list of forms that must be completed.) By completing and signing the physician form, the physician is certifying that the individual requires a nursing home level of long-term care services.

Exhibit 4

The CARES Medical Eligibility Determination Requires Several Documents

Documents needed for the CARES Program to determine medical eligibility:

- Initial Referral Form (either the CARES Intake Form or the DCF Form 3007)
- Enrollment Data form (609) for Nursing Home Diversion Waiver applicants
- Comprehensive assessment of applicants’ physical, functional, and cognitive status known as the “701B” Assessment
- Physician Form (3008)
- Freedom of Choice Form (608) for Nursing Home Diversion Waiver applicants
- Informed Consent Form (CF-ES 2040)
- Authorization to Use or Disclose Health Information (Form 182)

Source: OPPAGA analysis of CARES Program information.

Level of care determination and program recommendation. Regardless of whether or not CARES or a lead agency collects the information for the medical assessment for long-term care services, CARES must make all final determinations on whether individuals meet the medical and functional eligibility for Medicaid nursing home care and 11 of the state’s long-term care programs. When a local lead agency collects the medical information, CARES must review the

information and make a final determination of eligibility.

After completing the medical assessment, CARES issues a Level of Care determination. At least once each week, CARES medical teams meet in their respective offices to review long-term care applications. These teams are composed of assessors, nurses and medical doctors. The teams consider the client’s assessment, the physician form, and other relevant documents to determine each individual’s eligibility for long-term care services. Based on the individual’s eligibility and needs, the teams recommend the most appropriate, least restrictive program to provide services.

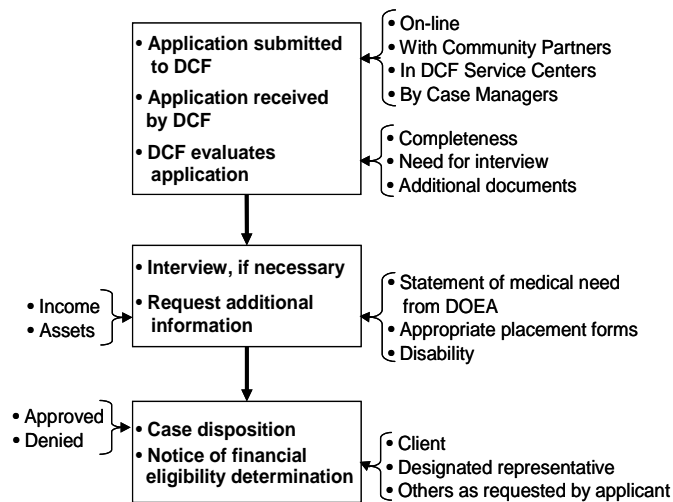
Referral. The last step in the medical eligibility process is referral. CARES refers clients to the lead agency if it conducted the original medical assessment, and the lead agency would then help the applicant go through the steps necessary to establish financial eligibility with the Department of Children and Families (DCF) Economic Self-Sufficiency Program and then begin receiving services. CARES refers other applicants, such as those seeking Nursing Home Diversion services, to DCF to begin the financial eligibility determination process. CARES assessors send DCF the client’s completed application for financial assistance, necessary medical documentation, and copies of any financial documents that the assessor has collected.

If an individual does not meet the medical eligibility criteria for any Medicaid long-term care programs, CARES may refer the person to a lead agency where the person may be able to receive non-Medicaid funded services, such as meals on wheels or Community Care for the Elderly.

The Department of Children and Families conducts financial eligibility determination

The DCF Economic Self-Sufficiency Program determines financial eligibility for all state Medicaid programs, including nursing homes and community-based programs. As illustrated in Exhibit 5, the financial eligibility process includes three major steps: application for assistance, interview and requests for additional documentation, and case disposition.

Exhibit 5 The Financial Eligibility Determination Process Has Three Major Steps



Source: OPPAGA analysis of Department of Children and Families information.

Application for assistance. Individuals seeking Medicaid long-term care services must submit an application for assistance to DCF.⁸ Applications may be submitted in person, on-line through the DCF ACCESS Florida system, by fax, or via a paper form. Although individuals can submit applications without providing all necessary documents, DCF cannot make a final decision about financial eligibility without supporting documents (see Exhibit 6).

⁸ Applicants who receive Medicaid medical care in the community or Supplemental Security Income (SSI) are automatically financially eligible for long-term care services once they meet medical criteria. These applicants can be directly enrolled for services. Likewise, applicants who are referred to CARES by DCF may have already been processed for financial eligibility and can be referred to a waiver provider or a nursing home. Individuals in another form of Medicaid long-term care only participate in a brief partial financial eligibility review, and do not need to submit a new application.

Exhibit 6 Extensive Documentation Is Needed for Long-Term Care Financial Eligibility Determination

Documents Needed for Institutional Care Program/ Home and Community-Based Services Applicants¹

- Alien status (if non-citizen)
- Disability (if under age 65)
 - Documented through receipt of Social Security Disability Insurance or Supplemental Security Income, or Disability determined through District Medical Review Team—will require individual to provide medical documents
- Appropriate Placement
 - Form 2515 (*Certification of Enrollment Status for Home and Community-Based Services*) provided by case management agency for waiver applicants. Telephone contact (or Form 2506) with nursing facility for Institutional Care Program applicants
- Level of Care provided by CARES
- Asset ownership
 - Documentation of all assets owned, other than first vehicle and vehicles over seven years of age
 - DCF staff evaluate whether applicant has transferred assets
- Income
 - Economic Self-Sufficiency has data exchange with the Social Security Administration and the Florida Retirement System to verify income
 - Client or designated representative requested to provide documentation of other sources of income
- Out-of-pocket medical expenses
 - Medical expenses not covered by insurance or other third party can be deducted from a person's income when determining the amount the patient must pay monthly when admitted to a nursing home or other facility
- For any other information provided that is questionable, documentation or verification may be requested

¹ Applicants who receive Social Security benefits, Supplemental Security income, or Medicare are exempt from new requirements effective July 1, 2006, that require Medicaid applicants to provide documentation of citizenship and identity.

Source: Department of Children and Families, Economic Self-Sufficiency Program.

Interview and request for additional documentation. DCF staff review applications and accompanying documentation to determine whether the individual needs to visit the DCF office for an interview. When possible, DCF contacts the applicant by phone to resolve questions and then notifies the applicant in writing when additional documents are needed in order to verify finances. An applicant must submit the necessary documents within 10 days or request an extension or DCF may deny the application.

Sometimes DCF's review of an individual's financial history may uncover the person's name on bank accounts, property tax rolls, or pension plans that the person failed to include in the application. When this happens, DCF must determine whether these accounts or property still exist and should be counted as assets.

Disposition. If the applicant's income and assets fall within specified limits, DCF approves the application and sends a notice to the applicant and his or her designated representative. If the applicant fails to provide needed documents or has income or assets that exceed criteria, DCF will deny the application. If DCF denies the application, the person may reapply at any time.

What factors affect how long it takes CARES to conduct medical eligibility determination?

Three factors can lengthen the time it takes CARES to determine medical eligibility for long-term care services: delays in receiving physician forms, regional workload issues, and client unavailability. The physician form creates the most significant delays. While all three factors contribute to wide variation in how long it takes for CARES to determine medical eligibility, to a large extent these factors remain outside the program's control.

To ensure that elders are served in the least restrictive, most appropriate setting, it is important to determine eligibility for long-term care services in a timely manner. Delays in determining eligibility may result in placing a frail elder in a nursing home rather than a community setting because the individual's family is no longer able to care for the elder at home.⁹

⁹ Medicaid rules allow nursing homes to admit individuals who have not completed all the necessary paperwork. Once the individual has met the requirements and becomes eligible, the nursing home can be paid retroactively.

There is a wide variation in time to determine medical eligibility

Under its interagency agreement with the Agency for Health Care Administration, CARES must determine medical eligibility within 15 workdays once all required documentation has been submitted.¹⁰ There is limited data available to assess the length of time taken by CARES to determine medical eligibility. Using this limited data, we were able to measure this time period for only about 10% of clients seeking long-term care services.^{11, 12}

In the cases we could assess, it generally took the CARES Program approximately five weeks (32 calendar days) to complete medical eligibility determination from the time of initial contact by an applicant. Medical eligibility determination took four weeks for applicants who were able to provide required documents prior to their CARES assessment. For applicants who did not have required documents prior to assessment, the CARES medical eligibility determination process took six weeks. Once applicants have submitted all required documentation, it took the program an average of a week to complete medical eligibility determinations. However, these time frames varied widely, from 6 to 85 calendar days from initial contact to a completed CARES medical eligibility determination.¹³

¹⁰ The CARES Program's internal standard is 12 workdays once referral documents are complete. In addition, the Legislature has directed CARES to make eligibility determinations for Nursing Home Diversion clients within no more than 22 calendar days after receipt of an application.

¹¹ Department of Elder Affairs' data systems do not include the date of initial contact for individuals whose applications are managed through local lead agencies. Without an initial contact date, we were not able to calculate how long the eligibility process takes for these individuals. The figures reported here reflect the length of time to determine medical eligibility for new enrollees in the Nursing Home Diversion program and are discussed in greater detail later in this report in response to Question 3.

¹² Timeframes include the time taken for applicants to gather and submit required documentation.

¹³ For 90% of applicants, medical eligibility determination was completed within 6 to 85 days, while 5% were completed in less than 6 days and 5% took longer than 85 days.

To identify the factors that affect the length of time that it takes CARES to complete a medical eligibility determination, we analyzed CARES data, conducted file reviews, and interviewed CARES assessors and supervisors. We focused this analysis on cases for which CARES conducts the full assessment rather than reviewing Medicaid information collected by other entities.¹⁴ Our analysis showed that three factors contribute most to lengthening the time it takes CARES to determine medical eligibility: delays in receiving physician forms, regional workload issues, and client unavailability.

CARES medical assessments can be delayed due to waiting for physician forms, regional workload issues, and client unavailability

Delays in receiving physician forms. Federal law requires the information from the physician form before CARES can complete an eligibility determination. The physician form documents that the applicant needs the level of care provided in a nursing home. CARES staff we spoke with around the state indicated that difficulty in obtaining from the client's physician a signed, complete physician form creates significant delays.

As shown in Appendix C, if applicants already have the physician form by the time they were assessed, CARES completes the medical eligibility determination in an average of 26.6 days (four weeks). If applicants do not have the physician form at the time of their assessment, the average time is 39.4 days (six weeks). Applicants who already have the physician form at the time of assessment may either already receive Medicaid long-term care services, or live in a facility with an available physician to certify that they are in medical need of long-term care services. Clients who live at home or with a caregiver may not have already gathered necessary documentation.

Delays in receiving completed forms from physicians can occur for various reasons. In some

instances, the doctor may not want to complete the form until the individual comes in for an office visit. Physician offices may also delay in returning the form because of the time it takes to complete it or because of concerns or confusion about the form. Others may not fully understand the form and thus provide incomplete information or fail to sign it.

To address this problem, the department sends a cover letter to physicians along with the form to educate them about the importance of the form and explain the necessity of completing its various elements. In August 2006, the department also revised the form to emphasize community-based care. In the past, the form emphasized nursing home services. Despite these efforts, CARES still experiences delays in receiving forms or receives forms that are incomplete and must be returned to physicians. CARES officials estimated that one in seven physician forms are incomplete when submitted.

Regional workload issues. CARES offices throughout the state face different workload challenges that can lengthen the time it takes to complete medical eligibility determinations. These workload challenges can be grouped into three areas: travel time, the presence of the Nursing Home Diversion Program and its providers, and needing to help clients who face a loss of eligibility.

First, travel time for assessment staff influences eligibility determination timeliness in certain parts of the state, particularly in central and south Florida. CARES offices assign referrals to staff based on zip codes in these areas to minimize travel times, and staff told us they try to group client visits to reduce travel. Nevertheless, staff in these areas indicated that they often spend an hour to an hour and a half each day driving to client sites. Traffic congestion can further increase travel times in urban areas such as Pasco and Pinellas counties, while distance between clients needing visits can also be a factor.

¹⁴ For certain waiver programs such as Nursing Home Diversion, CARES conducts the full medical assessment rather than having part of the process conducted by a lead agency. In these cases, the CARES assessor must contact the consumer, set up the appointment, and travel to the consumer's residence in order to conduct the assessment. The assessor must also discuss the consumer's service options and, if necessary, obtain information from the consumer's physician.

Second, the presence of the Nursing Home Diversion Program and its providers also significantly affects regional workload for CARES offices. As of January 2007, the Nursing Home Diversion program served 8,844 enrollees in 29 counties. The CARES Program's responsibility for Nursing Home Diversion applicants is greater than for other types of long-term care services. In these counties, CARES staff conduct face-to-face medical assessments and annual reassessments of these clients, help them with the financial eligibility process, and oversee enrollment with providers. These additional responsibilities can slow eligibility determination. In areas where Nursing Home Diversion is not available, the program's workload does not include these various responsibilities.

Although the Legislature has increased the number of CARES positions in recent years (from 252 positions in Fiscal Year 2003-04 to 316 positions for Fiscal Year 2006-07), the number of clients being referred to CARES for Nursing Home Diversion placement has also increased.¹⁵ The Nursing Home Diversion Program has grown from 977 participants in July 2003 to 8,844 in January 2007.

The program's workload also is increased in an unpredictable manner by assisted living facilities that subcontract with Nursing Home Diversion providers. These providers can refer current clients to be assessed for the Nursing Home Diversion Program as well as new or potential clients. OPPAGA's analysis of CARES data determined that 30% of all new Nursing Home Diversion enrollees in Fiscal Year 2005-06 were referred by an assisted living facility; in some south Florida areas, up to 74% of enrollees were referred by these facilities.¹⁶

Assisted living facilities may refer clients because they have a financial incentive to increase their residents' participation in the Nursing Home Diversion program. The facilities may receive higher daily per diem rates under the Nursing Home Diversion program than from other Medicaid waiver or private pay sources.¹⁷ The facilities may also contract with a different Nursing Home Diversion provider to receive higher reimbursements and therefore want current residents switched to the new diversion provider. These referrals not only cause an increase in the CARES Program's workload from a volume increase in the number of medical assessments, but also from current clients who request to switch providers. When current clients request to switch to another provider, CARES choice counsels the clients, coordinates the transition to prevent a loss of services, and sends enrollment materials to the new provider.

The third workload issue is that CARES assessors put aside work for new applicants to help current clients who are in danger of losing eligibility. According to assessors, clients might temporarily lose eligibility for a variety of reasons, including living in a assisted living facility that has switched from one Nursing Home Diversion provider to another, not receiving a notice of re-determination of Supplemental Security Income benefits from the Social Security Administration because it was sent to the wrong address after the client moved, losing or overlooking a notice from Social Security that a re-determination is due because the client has dementia or memory problems, or having the client or provider case manager overlook a notice that a DCF Medicaid re-determination of benefits is due. If a client loses Medicaid eligibility, then the provider can terminate services and it may take weeks or months to get the client through the eligibility determination process to receive services again.

¹⁵ Fiscal Year 2003-04 positions included 204 employees and 43 OPS positions. Fiscal Year 2006-07 positions included 248 employees and 60 OPS positions.

¹⁶ In Planning and Service Area 10, 42% of applicants were referred by assisted living facilities, while in Areas 11A and 11B, 68% and 74% of applicants were referred by assisted living facilities, respectively.

¹⁷ The Assisted Living for the Elderly waiver pays a state monthly rate of \$868 per month. The amount nursing home diversion providers may pay an assisted living provider varies by provider. One diversion provider told us their rate is \$1,100 per month and increases slightly if the client has dementia. Stakeholders we spoke with said that diversion providers may also offer incentives to assisted living facility providers such as paying 100% of the monthly per diem even if the client is in the hospital for the month.

Client unavailability. Finally, the medical eligibility determination process can be delayed by difficulty contacting clients to set up appointments. In particular, these visits can be delayed when elders are ill or in the hospital, as CARES does not conduct assessments of persons who are gravely ill or in a hospital since these persons could not be safely served in the community. Instead, CARES waits until the persons can be safely discharged from the hospital prior to conducting an assessment.

The program also sometimes delays assessments if the applicant's family is traveling from out-of-state to attend the assessment. CARES staff attempt to include family members or caregivers in order to obtain complete information on the individuals' needs.

What circumstances can delay an individual's enrollment in the Nursing Home Diversion Program?

Our review of DOEA and DCF data, client files, and interviews with stakeholders concluded that three factors contribute most to the time that elapses before an individual can be enrolled in the Nursing Home Diversion Program: delays in receiving physician forms, the financial eligibility process, and the Medicaid managed care payment system.

OPPAGA analysis of CARES and DCF data for Nursing Home Diversion enrollees in Fiscal Year 2005-06 found that it took, on average, 97 days (about three months) for applicants to go through the medical and financial eligibility determination processes and be enrolled in the program (see Appendix C). Some applicants were enrolled within a shorter timeframe because they did not have to go through the full financial eligibility determination process.¹⁸ The average time for these applicants to be enrolled was 71 days (10 weeks).

¹⁸ If applicants are Supplemental Security Income (SSI) recipients, they are automatically Medicaid eligible and do not have to apply for a financial eligibility determination. Applicants who are already receiving other Medicaid waiver services do not have to complete the full financial eligibility determination process. About 39% of applicants for the Nursing Home Diversion Program did not have to go through the complete financial eligibility determination process.

Nursing Home Diversion enrollment delays occur due to waiting for physician forms, financial eligibility determination, and the managed care enrollment process

Delays in receiving physician forms. As with clients seeking other long-term care services, elders seeking enrollment in the Nursing Home Diversion program often have difficulty obtaining a complete, signed physician form. CARES data shows that it takes an average of 23 days to receive a physician form for Nursing Home Diversion applicants.

Financial eligibility determination. Federal rules give the Department of Children and Families a maximum of 45 days to make a financial eligibility determination for aged and disabled applicants.¹⁹ As shown in Appendix C, the financial eligibility determination process for Nursing Home Diversion applicants can take an average of 34 days (about five weeks), and range from 6 to 84 days.^{20, 21}

This process can be delayed if applicants have difficulty gathering the documents that DCF needs to evaluate whether they are eligible. Although CARES staff work with clients to prepare the request for assistance and may also help collect necessary documentation, applicants may provide incomplete or inaccurate financial information. If the client does not provide the additional information, the enrollment request can be delayed or denied.

The financial eligibility determination process can also be delayed because DCF and CARES are experiencing communication barriers in three areas: differences in electronic capabilities, DCF failure to notify CARES when it contacts some applicants, and DCF's reliance on a centralized call center.

¹⁹ If a determination of disability is required, DCF has 90 days.

²⁰ This timeframe includes the time taken for transmittal of information between CARES and DCF and time allowed for applicants to submit documentation to DCF. An applicant has 10 days to submit additional information but can request an extension while trying to gather documents. DCF does not count these client delays in measuring compliance with the federal 45-day timeframe for establishing financial eligibility.

²¹ For 90% of applicants, financial eligibility determination was completed within 6 to 84 days, while 5% were completed in less than 6 days and 5% took longer than 84 days.

First, CARES and DCF experience communication difficulties due to differences in their capabilities to send information back and forth electronically. As part of modernization efforts, the Department of Children and Families has been streamlining its application processes and moving toward a paperless system. The new system emphasizes submitting electronic applications for assistance through an on-line data system. Although DCF will accept paper or faxed applications, it prefers electronic submission of all applications. However, CARES often submits paper applications and other documents, and stakeholders report that the DCF on-line application process is difficult for frail elders and their caregivers to use, particularly those with limited computer and internet experience or capabilities.²² CARES staff also do not have the equipment needed to scan documents or submit applications on-line while conducting client assessments. As a result, CARES assessors generally help clients complete paper applications for financial eligibility determination and transmit them to DCF along with the level of care determination and other documents.²³

The second communication problem is that CARES assessors may not receive notification when DCF requests additional documentation from applicants or finishes its financial eligibility determination. While DCF prefers that applications are submitted electronically, it communicates with applicants and case managers through paper documents. For example, DCF notifies applicants by mail to ask for additional documentation of income and assets or to notify them that their application has been approved or denied. CARES assessors do not always receive copies of these notices and thus are not able to help applicants move their applications forward.

This can be problematic if frail elders do not understand that DCF needs additional documentation or misplace the notice. CARES staff also cannot proceed with enrolling clients if they have not received notice that the individual is approved for Medicaid.

DCF officials indicate that there is no statewide policy to notify CARES or case managers about DCF's communication with applicants during eligibility determination for Medicaid home and community-based services. While some DCF offices may take the initiative to notify CARES or local case management agencies, other offices may not. As a result, CARES staff may be delayed in moving the application forward since eligibility notices are being mailed to the client or client's family member.

A third communication problem occurs because of DCF's increased reliance on its centralized call center approach to handling calls about applications. DCF has begun routing most calls to its Economic Self-Sufficiency Program through centralized call centers. CARES staff, as well as other stakeholders in the elder services system, report experiencing difficulty quickly identifying and reaching the applicable DCF workers who are handling applications, which makes it more difficult to help clients through the financial eligibility determination process. These stakeholders also commented that there appear to be fewer DCF workers who are familiar with and can answer questions about the complexities of Medicaid waiver applications.

During our review, CARES and DCF administrators met and discussed communication problems created by the centralized call centers. DCF administrators agreed to ensure that CARES staff have a designated DCF contact person in each district that can help with problems instead of requiring CARES staff to work through the call centers.

²² DCF is relying on "partner" entities, such as community social service organizations, churches, and libraries to assist applicants who have difficulty with the on-line application system. Applicants can also visit DCF field offices to submit paperwork, but this can be a hardship for frail elders.

²³ In some CARES offices, staff collects and submits all client income and asset documents. These offices do this as part of their own initiative to expedite the financial eligibility process.

Managed care payment system. The third primary factor we identified that can delay enrollment for Nursing Home Diversion applicants is the state's Medicaid managed care payment process. As shown in Appendix C, an average of 34 days (five weeks) elapses between DCF completing clients' financial eligibility determination and the clients becoming enrolled into the Nursing Home Diversion Program. This time period exists because in order to enroll a client, the Nursing Home Diversion provider must enter the enrollee's information in the provider's data system and submit this information to the Medicaid fiscal agent system.²⁴

These delays can be attributed to the timing of applicants' approval for long-term care and data errors submitted by providers. Managed care services are usually paid on the first day of each month to cover that month's services. To be eligible for payment in a particular month, the recipient must be enrolled by a cut-off date the prior month.²⁵ If the cut-off date is missed, the client cannot be enrolled until the following month's enrollment cycle, which can cause a delay of up to six weeks before the client will receive services.

Enrollment delays also occur if there are errors in the enrollment information submitted by providers. Providers must submit enrollment data on all clients at the same time each month. If a provider makes an error in any data field for any applicant, none of the provider's clients can be electronically enrolled. When these errors occur, Agency for Health Care Administration staff must manually enroll the applicants into the Medicaid fiscal system, which delays their enrollment.

Agency for Health Care Administration officials are working with a new Medicaid fiscal agent to make data system changes that are expected to improve managed care enrollment. The new fiscal agent system is currently in the

developmental stage and AHCA officials expect the system to be effective in March 2008.²⁶

What options could the Legislature and agencies consider for improving the eligibility determination and enrollment processes for Medicaid long-term care services?

Current state initiatives may help address delays in the eligibility determination and enrollment process. The Legislature and agencies could consider other options, such as improving inter-agency electronic communication and addressing the CARES Program's workload, but these options have potential barriers to implementation.

Current state initiatives may help address delays in the eligibility determination and enrollment process

Florida, like some other states, has taken steps to shorten the time needed to determine eligibility for Medicaid long-term care services. For example, several states, including Florida, have worked to develop a single point of entry to centralize and streamline access to elder care services. The Florida Legislature directed the Department of Elder Affairs to establish Aging Resource Centers to serve this purpose. However, thus far, implementation of the Aging Resource Center model has been limited to three pilot sites.²⁷

Several states have implemented "presumptive eligibility" whereby applicants can start receiving services once they are determined medically eligible but before they go through the financial eligibility determination process. For example, Washington state authorizes social workers to approve services for up to 90 days for clients who meet medical eligibility criteria and appear to meet financial criteria. However, under

²⁴ Once the financial application is approved, CARES sends an enrollment packet to the provider that includes all the necessary paperwork about the client.

²⁵ The "cut-off" date is currently 4:00 PM on the Wednesday preceding the second to last Saturday of the month.

²⁶ AHCA officials indicated that the new fiscal agent contract will still require some type of monthly cut-off date in order for services to be paid on the first day of the following month.

²⁷ The department selected the area agencies in Fort Lauderdale, Orlando, and St. Petersburg as pilot sites. For further information about the initiative, see *Aging Resource Center Has Not Moved Beyond the Pilot Sites*, OPPAGA [Report No. 06-62](#), September 2006.

presumptive eligibility, the state bears the financial risk if the applicant is subsequently determined not to be financially eligible for Medicaid services.

The 2006 Florida Legislature authorized a new Medicaid Pending status for clients, which is similar to presumptive eligibility. Under this legislation, Nursing Home Diversion providers can begin serving clients who meet medical criteria, even if financial eligibility has not been determined. The major difference between this new initiative and presumptive eligibility is that the provider bears the risk that clients will not be financially eligible for services. Nursing Home Diversion providers have the option to recover their costs from applicants whose financial eligibility is denied. DOEA and Agency for Health Care Administration officials began allowing applicants to receive services under the Medicaid Pending initiative in January 2007.

Given that the new Medicaid Pending policy is only recently implemented, we could not assess its success in helping to improve client's access to services. The Legislature may wish to direct the Department of Elder Affairs or OPPAGA to evaluate the outcome of the Medicaid Pending policy one year after the policy is fully implemented. The evaluation could include a review of how many providers are actively accepting applicants under the system, the extent to which Medicaid Pending clients have been determined to meet financial eligibility, the extent to which clients were deemed not to be financially eligible, and whether the providers required clients to pay for services received.

Another pending Florida initiative that may shorten the time taken for enrollment is that, as discussed earlier, the Agency for Health Care Administration is currently working with a new Medicaid fiscal agent to make changes in the enrollment system for managed care clients. However, these changes are not expected to be in place until 2008.

The Legislature and agencies could consider other options, but each has barriers to implementation

Due to the federal documentation requirements, as well as the complexity of Florida's elder

services system, there are no easy answers for improving the state's eligibility determination and enrollment processes for Medicaid long-term care services. Federal law requires states to conduct both a medical and financial eligibility determination process for Medicaid long-term care services and specifies the documentation that applicants must provide. While we identified several options for the Legislature, Department of Elder Affairs, and the Department of Children and Families to consider that could improve these processes, each has barriers to implementation and/or other disadvantages. These options are to

- facilitate the physician forms,
- improve inter-agency electronic communication,
- reduce CARES workload by transferring some Nursing Home Diversion responsibilities to another entity,
- use a managed care lock-in to reduce the incentive for provider switching,
- fund an enrollment broker, and
- require simultaneous medical and financial eligibility determination.

Facilitate physician forms. The Legislature could direct DOEA, and the Board of Medicine to work together to better educate and encourage doctors to complete the medical eligibility forms. The Legislature could also consider directing the Department of Elder Affairs to work toward establishing a system that would enable physicians to submit these forms electronically. Electronic submission could reduce the time it takes for physicians to complete and submit these forms. However, electronic submission could require physicians to invest in data systems needed to electronically submit the forms and could potentially raise confidentiality concerns because the forms contain private health information.

Improve interagency electronic communication. The Legislature could direct CARES and DCF to work toward improved electronic communication. CARES and DCF officials agreed that electronic communication could help decrease the time required to determine eligibility for long-term care services. However, efforts to integrate existing agency data systems could be costly and require

funding for computer enhancements. The system would need to be designed to protect the confidentiality of client financial and medical information.

During our review, DCF agreed to designate a contact person for each CARES office and avoid the need for CARES staff to work through the DCF call center. The department needs to ensure that when turnover in staff occurs, CARES offices are notified of changes and new contact information.

Reduce CARES workload by transferring some Nursing Home Diversion responsibilities to another entity. Although locating Nursing Home Diversion program administration within a state agency may have been desirable when it was first created as a pilot project in 1998, the program now operates in 29 counties in the state. The Legislature could consider outsourcing client assistance and related activities to the Area Agencies on Aging or to private case management agencies. Authorizing the Area Agencies to provide local administrative services for the program would centralize funding and administration of Medicaid long-term care waivers. Authorizing private case management agencies to provide client assistance for the program is feasible, but could create a conflict of interest if these agencies also provide waiver services.

Transferring Nursing Home Diversion responsibility would allow CARES to focus on its primary role of making medical level of care determinations. However, this change would likely require the Agency for Health Care Administration to apply to the federal Centers for Medicaid and Medicare for an amendment to the Medicaid waiver that authorizes the Nursing Home Diversion program. Federal rules make waiver amendments a time consuming and challenging process. Another barrier to implementation is that current program funding may not be sufficient to cover the added cost of paying another entity to provide these services.

Use a managed care lock-in to reduce the incentive for provider switching. The Legislature could create a managed care lock-in for Nursing Home Diversion clients similar to rules for current Medicaid Health Maintenance Organization (HMO) participants. A lock-in would require

clients to stay with their providers for one year and allow switching to other providers only at the time of annual reassessment unless the clients had specified circumstances such as a change in health status requiring more extensive services.

The advantage of a lock-in is that it would reduce the opportunity for assisted living facility providers to increase the CARES Program's workload by requesting the program to switch enrollment for all facility residents to different Nursing Home Diversion providers.

However, there are two major disadvantages to a lock-in. First, it would reduce client flexibility to choose different providers, which might in turn make the Nursing Home Diversion program less attractive to some elders. Second, according to Agency for Health Care Administration officials, a lock-in would require a fundamental change in the administration of the waiver and would require the agency to request a waiver amendment from the federal government.

Fund an enrollment broker for Nursing Home Diversion. The Legislature could consider funding an enrollment broker to process paperwork for Nursing Home Diversion clients. Such a broker is used for Medicaid managed care programs, and the Department of Elder Affairs and the Agency for Health Care Administration have discussed the possibility of enrollment broker services for the Nursing Home Diversion program in the past. However, there is no funding available for these services under the state's current enrollment broker contract for Medicaid-managed care.²⁸

Contracting with an enrollment broker to process paperwork for new diversion enrollees could reduce the need for manual enrollments due to errors in provider data. In addition, the enrollment broker could lessen some of the CARES Program's workload by reducing the enrollment paperwork it processes for clients. However, this change would not affect other CARES responsibilities such as assessing new clients for medical eligibility, assisting new Nursing Home Diversion applicants through the medical and financial eligibility determination

²⁸ The Department of Elder Affairs estimated that an enrollment broker for the Nursing Home Diversion program would cost \$137,000 annually.

processes, and providing choice counseling when Nursing Home Diversion clients switch providers.

Require the simultaneous submission of medical and financial applications. Finally, the Legislature could direct CARES and DCF to process medical and financial applications at the same time. Simultaneous eligibility determination could reduce the overall time it takes to determine eligibility for long-term care services. However, this option could increase DCF's workload. If DCF were to process long-term care applications without medical eligibility information from CARES, it would have to process each client for multiple Medicaid eligibility groups and then switch the client over to a Medicaid long-term care waiver once CARES submitted the needed documents. DCF would have to request additional documentation from the client and process the application for a second time.

Simultaneous submission may not be necessary if the new Medicaid Pending initiative is successful. If clients and providers use the option to provide services under the Medicaid Pending initiative, providers would begin serving clients while their applications are being processed by DCF. This would reduce the time for clients to receive services thus making the Medicaid financial eligibility determination and enrollment processing time less significant. Accordingly, the Legislature should wait until the Medicaid Pending initiative can be evaluated before pursuing this option.

Agency Responses

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Agency for Health Care Administration, the Department of Elder Affairs, and the Department of Children and Families for each to review. A written response was received from the Department of Elder Affairs and has been reproduced here in Appendix D.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

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Gary R. VanLandingham, OPPAGA Director

Appendix A

CARES' Responsibilities for State Long-Term Care Programs

The CARES Program processes the medical eligibility determination for Medicaid nursing home care and 11 of the state's other long-term care programs. As shown in the table below, CARES conducts the medical assessment for 5 of the 11 programs, and reviews and approves the medical information collected by another entity for the remaining 6 programs. CARES makes the level of care determinations for all 11 programs.

Medicaid Programs	State Agency Responsible for Administering the Waiver	Department of Elder Affairs' Role
Programs for Which CARES Conducts the Medical Assessments		
Adult Day Health	Agency for Health Care Administration in conjunction with the Department of Elder Affairs	CARES Program conducts medical assessments and makes level of care determination.
Nursing Home Diversion	Department of Elder Affairs in conjunction with the Agency for Health Care Administration	Department of Elder Affairs administers the Nursing Home Diversion Program. CARES Program conducts medical assessments and makes level of care determinations.
Program of All-Inclusive Care for the Elderly (PACE)	Department of Elder Affairs in conjunction with the Agency for Health Care Administration	Department of Elder Affairs administers the PACE program. CARES Program conducts medical assessments and makes level of care determinations.
Channeling	Agency for Health Care Administration	CARES Program conducts medical assessments and makes level of care determination.
Frail Elder	Agency for Health Care Administration	CARES Program conducts medical assessments and makes level of care determination.
Programs for Which CARES Reviews the Medical Information Collected by Other Entities		
Adult Cystic Fibrosis	Department of Health in conjunction with the Agency for Health Care Administration	CARES Program reviews client medical information collected by program case managers and makes level of care determination.
Aged and Disabled Adult	Department of Elder Affairs and Department of Children and Families in conjunction with the Agency for Health Care Administration	The Department of Elder Affairs allocates waiver spending authority to each of the 11 area agencies on aging, which subcontract with lead agencies to collect medical information. CARES Program reviews the information and makes level of care determinations.
Alzheimer's Disease	Agency for Health Care Administration in conjunction with the Department of Elder Affairs	CARES Program reviews medical information and makes level of care determination.
Assisted Living for the Elderly	Department of Elder Affairs in conjunction with the Agency for Health Care Administration	The Department of Elder Affairs allocates waiver spending authority to each of the 11 area agencies on aging, which subcontract with lead agencies to collect medical information. CARES reviews the information and makes level of care determinations.
Project AIDS Care	Agency for Health Care Administration in collaboration with the Department of Children and Families, the Department of Elder Affairs, and the Department of Health	CARES Program reviews medical information and makes level of care determination.
Traumatic Brain and Spinal Cord Injury	Department of Health in conjunction with the Agency for Health Care Administration	CARES Program reviews medical information and makes level of care determination.

Source: OPPAGA analysis of CARES Program information.

Appendix B

Florida Has Three Levels of Nursing Home Care, Skilled, Intermediate I, and Intermediate II

The state has three levels of Medicaid nursing home services based on the severity of client medical condition, termed Skilled Nursing, Intermediate I, and Intermediate II. The table below describes the differences in the three levels.

Skilled Nursing	Intermediate I	Intermediate II
<ul style="list-style-type: none"> Services must be ordered by and remain under the supervision of a physician 	<ul style="list-style-type: none"> Services must be ordered by and remain under the supervision of a physician 	<ul style="list-style-type: none"> Limited health care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision
<ul style="list-style-type: none"> Sufficiently medically complex to be performed by or under the direct supervision of a registered nurse or other health care professionals for safe and effective performance 	<ul style="list-style-type: none"> Services are medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic reassessment, planning or intervention by licensed nursing or other health professionals 	<ul style="list-style-type: none"> Individuals must be ambulatory, with or without assistive devices
<ul style="list-style-type: none"> Required on a daily basis 	<ul style="list-style-type: none"> Services are required to be performed under the supervision of licensed nursing or other health professionals 	<ul style="list-style-type: none"> Individuals must demonstrate independence in activities of daily living
<ul style="list-style-type: none"> Services are reasonable and necessary to the treatment of a specific documented illness or injury 	<ul style="list-style-type: none"> Services are necessary to achieve the medically desired results to ensure the comfort and safety of the applicant or recipient 	<ul style="list-style-type: none"> Individuals must not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision
<ul style="list-style-type: none"> Services are consistent with the nature and severity of the Individual's condition or the disease state or stage 	<ul style="list-style-type: none"> Services are consistent with the nature and severity of the Individual's condition or the disease state or stage 	
Examples:	Examples:	Examples:
<ul style="list-style-type: none"> intravenous medications or fluids 	<ul style="list-style-type: none"> Administration of routine or stabilized dosages of oral medication, eye drops or ointments 	<ul style="list-style-type: none"> Administration of routine oral medication
<ul style="list-style-type: none"> Colostomy or ileostomy care 	<ul style="list-style-type: none"> Administration and adjustment of medication for pain and the monitoring of results and side effects 	<ul style="list-style-type: none"> Assistance with mobilization when transferring, when climbing steps or manipulating a wheel chair
<ul style="list-style-type: none"> Naso-pharyngeal and tracheotomy aspiration 	<ul style="list-style-type: none"> Tracheotomy care when the individual's condition is stable but the individual is unable to care for the tracheotomy due to physical, mental, or medical reasons 	<ul style="list-style-type: none"> Assistance with bathing, dressing, and grooming
<ul style="list-style-type: none"> Treatment of widespread infected or draining skin disorders 	<ul style="list-style-type: none"> Changes of dressings, sterile or aseptic for non-infected postoperative or chronic conditions 	<ul style="list-style-type: none"> Assistance with colostomy care which the recipient ordinarily provides
<ul style="list-style-type: none"> Management and monitoring of medication on a daily basis, for example for drugs whose dosage requirements may change rapidly 	<ul style="list-style-type: none"> Decubitus care involving superficial, non-infected lesions and preventive measures when a resident is susceptible to decubitic formation 	<ul style="list-style-type: none"> Routine measurement and recording of vital signs and weights, including being alert to symptoms and readings corresponding to abnormal conditions of the resident

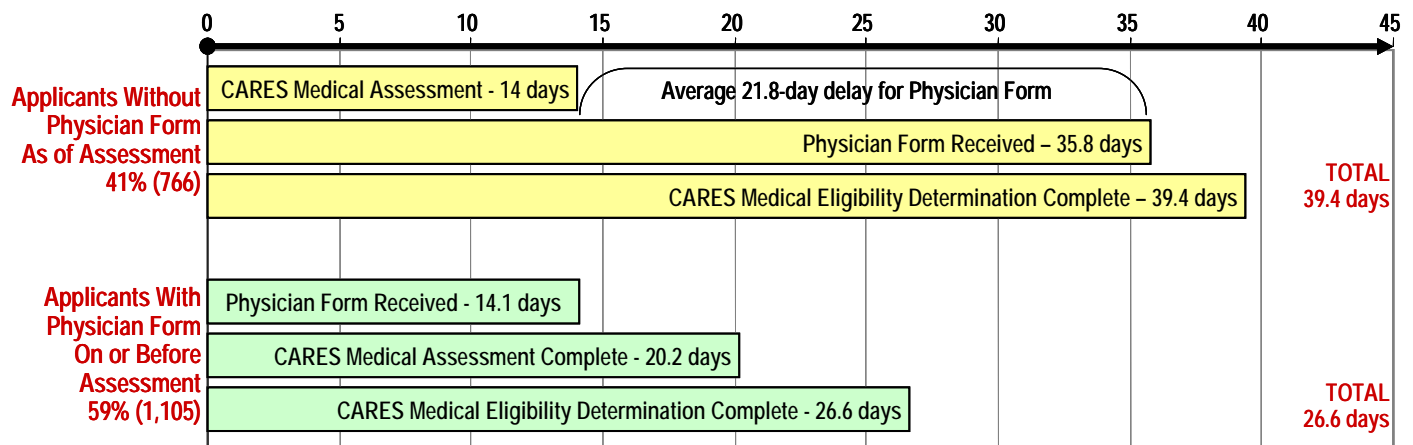
Source: Rules 59G-4.180 and 59G-4.290, *Florida Administrative Code*.

Appendix C

Length of Time to Enroll Nursing Home Diversion Applicants Averages 10 to 14 Weeks

We examined DOEA medical eligibility determination and DCF financial eligibility and enrollment information for Fiscal Year 2005-06 Nursing Home Diversion applicants. As shown in Table C-1, we found that 59% (1,105) of applicants had a physician form at the time they applied or prior to the CARES assessment, while 41% (766) did not. The length of time taken to determine medical eligibility for clients who had a completed physician form at the time of the assessment was an average of 12.8 days shorter than for those applicants who lacked a completed form at the time of the assessment.

Table C-1
Medical Eligibility Determination Time Is Shorter When Applicants Have a Physician Form Early in the Process

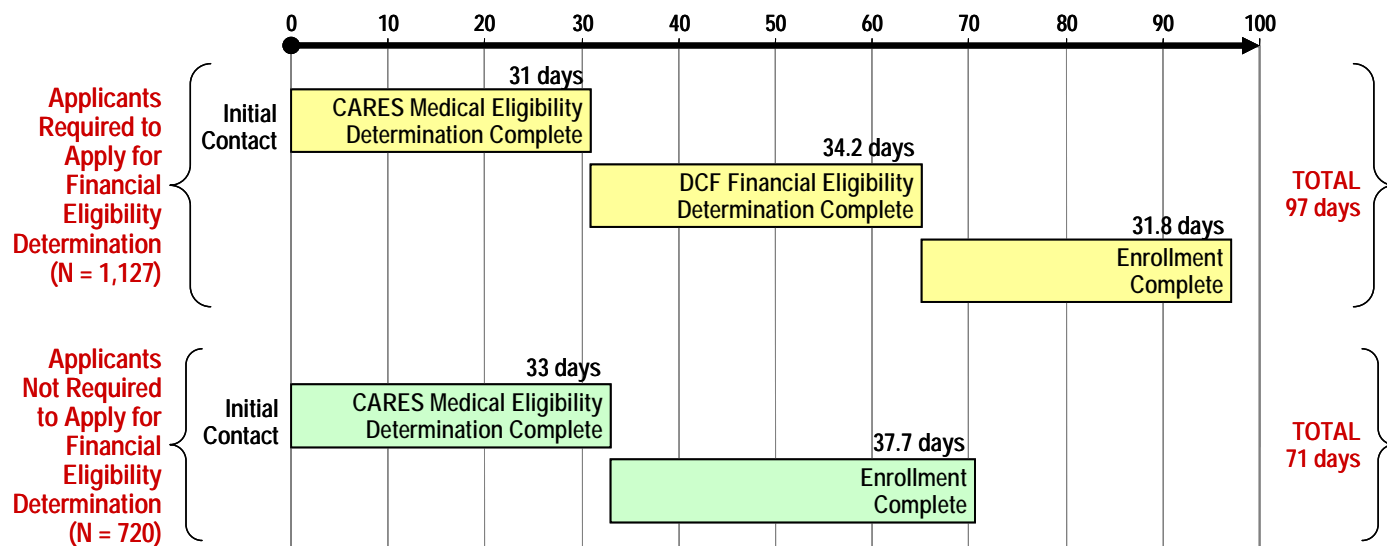


Source: OPPAGA analysis of Department of Elder Affairs data.

As shown in Table C-2 it took an average of 97 days (about 14 weeks or three months) for applicants to complete the medical and financial eligibility determination processes and be enrolled in the Nursing Home Diversion Program. The average time for applicants who did not have to apply for a full financial eligibility determination was 71 days (10 weeks).²⁹

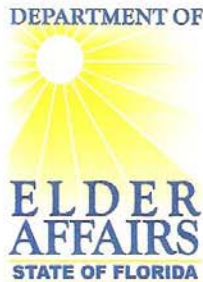
²⁹ Applicants who are Supplemental Security Income (SSI) recipients and others who are already receiving other Medicaid waiver services do not have to go through the full financial eligibility determination process.

Table C-2
Average Time to Enrollment for Nursing Home Diversion Is Three Months If Not Already Financially Eligible for Medicaid



Source: OPPAGA analysis of Department of Children and Families data and Department of Elder Affairs data.

Appendix D



CHARLIE CRIST
GOVERNOR

CHARLES T. CORLEY
INTERIM SECRETARY

February 14, 2007

Mr. Gary R. VanLandingham, Director
The Florida Legislature
Office of Program Policy Analysis
And Government Accountability
111 W. Madison Street, Suite 312
Tallahassee, Florida 32399-1475

Dear Mr. VanLandingham:

Thank you for sending the report titled "Several Factors Can Delay Eligibility Determination for Medicaid Long-Term Care" dated February 2007. The Florida Senate directed the Office of Program Policy Analysis and Government Accountability to perform this study of the Department of Elder Affairs (DOEA), Comprehensive Assessment and Review for Long Term Care Services (CARES) program activities last legislative session. More specifically, OPPAGA was mandated to examine the time frames and barriers associated with enrollment in the Long-Term Care Community Diversion program (Nursing Home Diversion program).

I want to take this opportunity to commend Mary Alice Nye, Justin Graham and Becky Vickers of your staff for analyzing these complex processes and producing a detailed and objective report. This team conducted many interviews with CARES field offices staff in Orlando, Largo and Miami as well as management staff in Tallahassee. It appears that the multiple barriers that staff face in enrolling frail, elder Floridians into this program have been fairly represented.

The Department of Elder Affairs staff reviewed the six options for improving the state's eligibility determination and enrollment processes outlined in this report. Several of the options described deserve further consideration. The option of outsourcing client assistance and related activities to the area agencies on aging or to private case management agencies has been previously analyzed by DOEA and determined to be financially prohibitive given current budget resources.

In closing, the Department of Elder Affairs, in conjunction with the Agency for Health Care Administration and the Department of Children and Family Services, will continue to examine and refine the Nursing Home Diversion eligibility and enrollment processes with the goal of delivering services to more frail elders in less time.

Sincerely,

Chuck Corley
Interim Secretary
CTC/sf

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