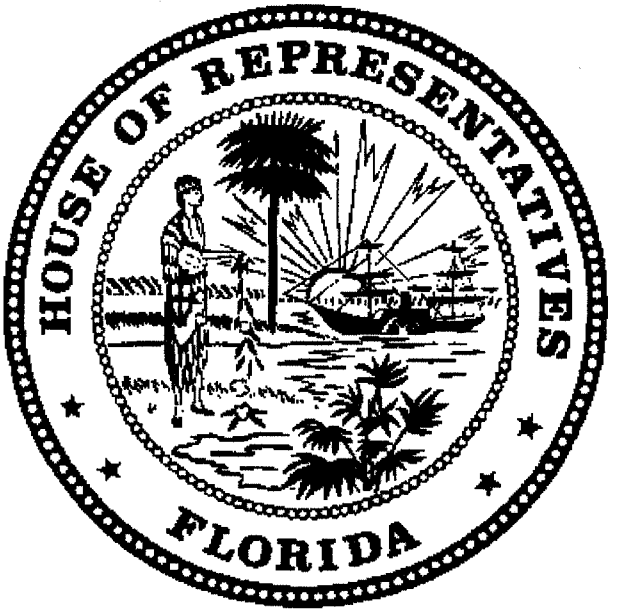

Health & Human Services Quality Subcommittee

Tuesday, November 1, 2011
1:30 PM – 4:00 PM
306 HOB

Dean Cannon
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Quality Subcommittee

Start Date and Time:	Tuesday, November 01, 2011 01:30 pm
End Date and Time:	Tuesday, November 01, 2011 04:00 pm
Location:	306 HOB
Duration:	2.50 hrs

Panel discussion on long term care certificate of need and licensure

Appearance forms can be found on myfloridahouse.gov. Please bring 2 copies of the form to the meeting and give them to the administrative assistant.

NOTICE FINALIZED on 10/25/2011 16:10 by Iseminger.Bobbye

Beth Kidder

Long-term Care Managed Care Program

Why are changes being made to Florida's Medicaid program? In 2011, the Florida Legislature created a new program called Statewide Medicaid Managed Care (SMMC). Because of it, the Agency for Health Care Administration (AHCA) will need to change how some individuals receive their health care from the Florida Medicaid program.

These changes to Florida Medicaid are **not** being made because of National Health Care Reform or the Affordable Care Act passed by the U.S. Congress.

There will be two different programs that make up Medicaid Managed Care:

(i) the Florida Long-term Care Managed Care program and
(ii) the Florida Managed Medical Assistance program.

Medicaid recipients who qualify and become enrolled in the Florida Long-term Care Managed Care program will receive long-term care services from a long-term care managed care plan. Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance program will receive all health care services other than long-term care from a managed care plan.

What is managed care? Managed care is when health care organizations manage how their enrollees receive health care services. Managed Care Organizations work with different health care providers to offer quality health care services. Managed Care Organizations also work to make sure enrollees have access to all needed doctors and other health care providers for covered services.

When will these changes to Florida Medicaid occur? It is anticipated that the Long-term Care Managed Care program will be available in certain areas of the state in the first quarter of 2013 and will be statewide by October 1, 2013.

Who is eligible to enroll in Long-term Care Managed Care? Florida Medicaid will send recipients a letter notifying them as to whether or not they are required to enroll in the Long-term Care Managed Care program. In general, the criteria outlined below will determine whether a recipient is (1) required to enroll, (2) not required but may choose to enroll, or (3) is not allowed to enroll in the Long-term Care Managed Care program.

1. The following Medicaid recipients are **required** to enroll in the Long-term Care Managed Care program:
    - Medicaid recipients living in nursing facilities or enrolled in one of the following programs when the Long-term Care Managed Care program begins:
        - the Assisted Living Waiver;
        - the Aged and Disabled Adult Waiver or the Consumer-Directed Care Plus part of this waiver;
        - the Adult Day Health Care Waiver;
        - the Program of All-inclusive Care for the Elderly (PACE);
        - the Nursing Home Diversion Waiver; and
        - the Channeling Services Waiver for Frail Elders.
    - Medicaid recipients who are 18 years of age or older who enter a nursing facility after the Long-term Care Managed Care program begins.
    - Medicaid recipients age 18 and older who meet nursing facility level of care, but who wish to receive long-term care services in their home or a community setting will be enrolled as space becomes available.

2. The following Medicaid recipients are **not required**, but **may choose to enroll** if they meet nursing facility level of care and all other enrollment requirements:
    - Medicaid recipients enrolled in the following home and community-based services waiver programs: Adult Cystic Fibrosis, Familial Dysautonomia, Project AIDS Care, Traumatic Brain Injury/Spinal Cord Injury

3. The following Medicaid recipients **may not** enroll:
    - Women who are eligible only for family planning services
    - Women who are eligible through breast and cervical cancer services program
    - Persons who are eligible for emergency Medicaid for aliens
    - Children receiving services in a prescribed pediatric extended care center
    - Medicaid recipients who do not need or do not meet the criteria for Long-term Care services
    - Medicaid recipients under age 18.

Will the Long-term Care Managed Care program affect Medicare benefits? No, the Long-term Care Managed Care program will not change Medicare benefits.

What services will Long-term Care Managed Care plans provide? All long-term care managed care plans must provide the services listed below. Long-term care managed care plans may choose to provide additional services; however, all additional services must first be approved.

Adult day care
Attendant care
Behavior management
Caregiver training
Case management
Companion
Home accessibility adaptation
Home-delivered meals
Homemaker
Hospice
Intermittent and skilled nursing
Medication administration
Medical equipment and supplies, including incontinence supplies
Medication management
Nursing facility care
Nutritional assessment and risk reduction
Occupational therapy
Personal care
Personal emergency response system
Physical therapy
Respiratory therapy
Respite care
Services provided in assisted living facilities
Speech therapy

Will there still be a wait list for home and community based (HCBS) services? Yes, the SMMC program does not provide additional funding or create additional "slots" for recipients to receive home and community based services. The SMMC program provides that the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before making enrollment offers, the Department is required to determine that sufficient funds exist to support additional enrollment into plans. Once a recipient enrolls in a Long-term Care Managed Care plan, the plan is responsible for providing appropriate services, whether in a nursing facility setting or in a home or community based setting.

Will plans be able to force a recipient to move out of their nursing home? No, a recipient residing in a nursing facility can choose to remain in that facility, if this is the least restrictive setting that can provide the appropriate level of care for that individual.

Will Medicaid funding for nursing home services be limited based on available slots and funding? If an individual meets the technical and financial criteria for the Institutional Care Program and meets a nursing home level of care as determined by the CARES unit, can the individual be denied Medicaid funding to pay for nursing facility services based on slots and funding availability? Who will determine what level of care a recipient qualifies for? Will it still be CARES? There will be no wait list for nursing facility services under the Statewide Medicaid Managed Care program. Individuals who meet the financial eligibility criteria for Medicaid as determined by the Department of Children and Families, and who meet nursing home level of care criteria as determined by CARES (Comprehensive Assessment and Review for Long Term Care Services) will be eligible to receive all medically necessary services through a Long-term Care Managed Care plan in their nursing home of choice.

Jeff Gregg

Health Care Certificate of Need in Florida

House Health & Human Services
Quality Subcommittee
October 4, 2011

What Is CON?

- Certificate of Need (CON) is a population based health planning program that tries to direct new development to areas of greatest population need.
- CON began as a required federal program in 1974
- Florida CON became state-only in 1982.
- 36 states have CON

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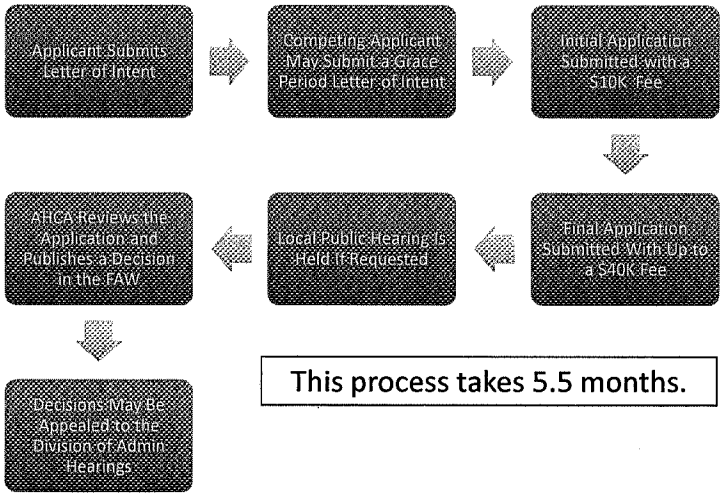
What Is CON?

- CONs are required for new hospitals, nursing homes, hospices and intermediate care facilities for the developmentally disabled.
- CON includes
  - Competitive batched reviews
  - Expedited reviews
  - Exemptions
  - Annual monitoring of CON conditions

3

Competitive Batched Reviews



This process takes 5.5 months.

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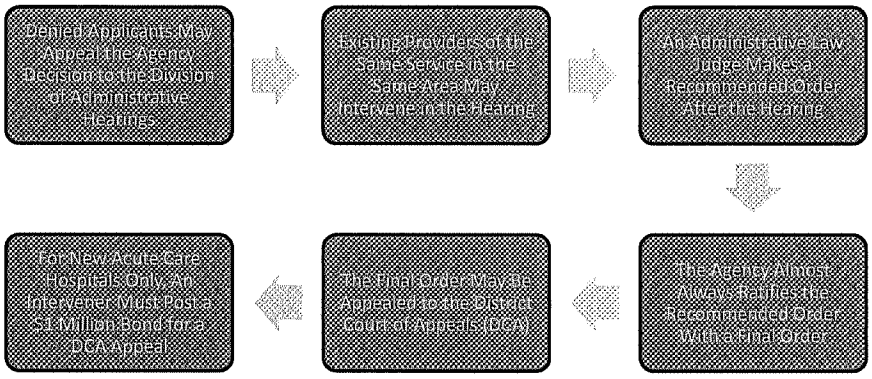
CON Appeals



This process takes 1 to 2 years.

5

Other CON Processes

- Expedited reviews
  - Expedited reviews follow the same process as batched reviews except the applicant chooses when the process starts.
  - Examples of expedited reviews:
    - Transferring a CON for a nursing home or a hospice that is not yet licensed to a new organization,
    - Adding sheltered nursing home beds in continuing care retirement communities,
    - Moving existing community nursing home beds short distances under certain circumstances.

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Other CON Processes

- CON exemptions
  - Exemption applications receive a brief review for a $250 fee.
  - Examples of projects that need CON exemptions:
    - Adding mental health beds in acute care hospitals
    - Adding NICUs in hospitals with relatively large numbers of births
    - Authorizing emergency-only angioplasty programs in hospitals that do not have open heart surgery programs
    - Adding inpatient rehab beds in hospitals with highly utilized rehab units
    - Replacing a nursing home within 3 miles of its existing site

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Other CON Processes

- Condition monitoring
  - CON holders commit to providing certain services or certain levels of a service.
  - The most common CON condition is an agreement by a nursing home to serve a certain level of Medicaid residents.
    - Penalties for failure to meet nursing home Medicaid conditions were eliminated last session in CS/HB 7109.
  - CON holders report annually.
  - Failure to meet a CON condition can result in an annual fine of up to $365,000.

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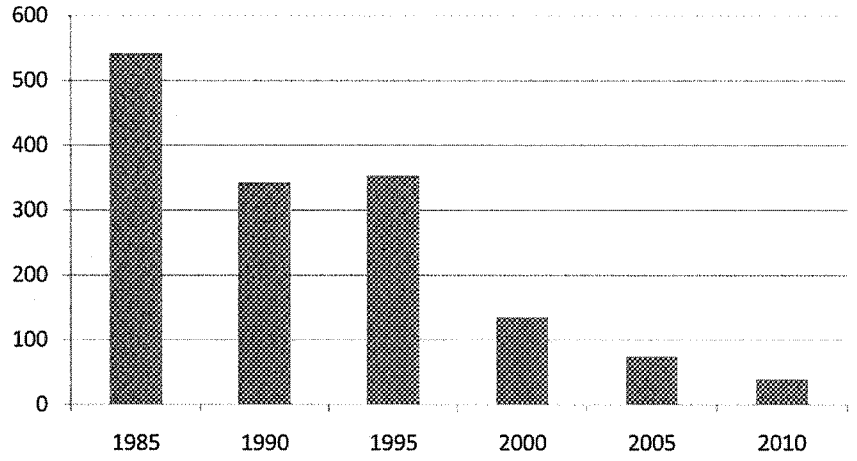
Number of Applications Reviewed



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CON Reforms Timeline

Year	Reform
1974	Federal program established. Required for all states.
1982	Federal program eliminated. Federal health systems agencies eliminated and replaced by Florida's local health councils. Local role in CON becomes voluntary.
1987	Capital expenditure thresholds for hospitals eliminated for outpatient services and modified for major medical equipment. Review of hospital-based obstetrical programs eliminated. Fining authority added for failure to meet CON conditions.
1997	Review of major medical equipment eliminated.
2000	Small bed additions at hospitals and nursing homes were eliminated from batched review and converted to CON exemptions. Review of Medicare certified home health agencies eliminated.
2001	5-year moratorium on the addition of community nursing home beds.
2003	CON requirements eliminated for rural hospitals.

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CON Reforms Timeline

Year	Reform
2004	Eliminated review of most kinds of hospital bed additions or conversions from one type of bed to another.
2006	Moratorium on the addition of community nursing home beds extended until 2011.
2007	Established a process to replace the CON review of adult open heart surgery programs and burn units with hospital licensure programs.
2008	Streamlined the process for the review and appeal of new general hospitals.
2011	Moratorium on the addition of community nursing home beds extended until 2016 or when the statewide implementation of Medicaid long term care managed care is complete.

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Which Facilities and Services Are Subject to CON Review in 2011?

- New hospitals (general and specialty)
- Hospital tertiary services
  - Organ transplant programs
  - New inpatient rehab units
  - Neonatal intensive care units (NICUs)
  - Pediatric organ transplant and cardiovascular programs
- New nursing homes (moratorium since 2001)
  - Nursing home bed additions
- New hospice programs
  - New hospice inpatient facilities
- New ICF-DDs

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Tony Marshall

Long Term Care Certificate of Need and Licensure

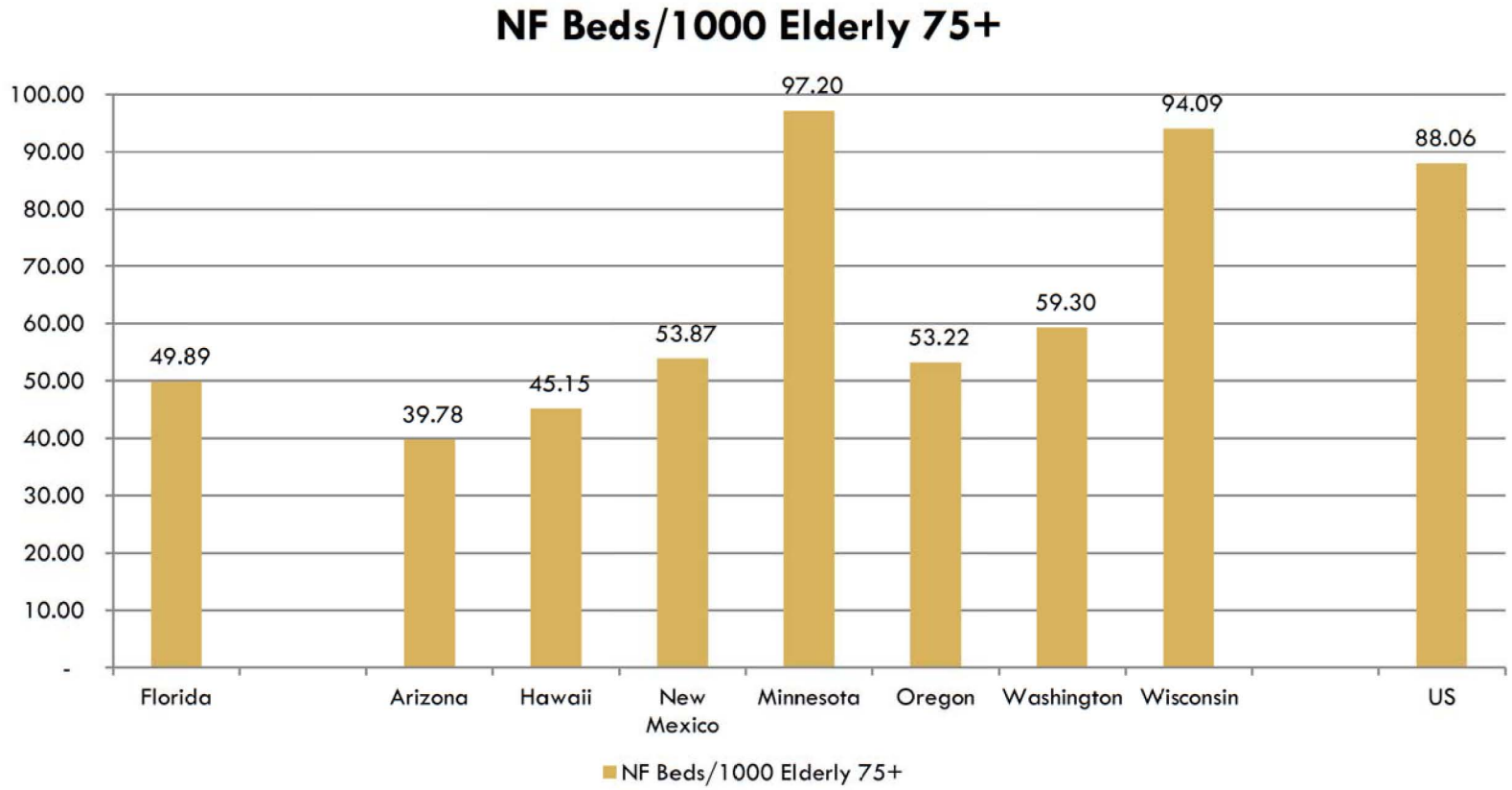
Florida House
Health & Human Services Quality Subcommittee
November 1, 2011

Tony Marshall
Senior Director of Reimbursement
Florida Health Care Association

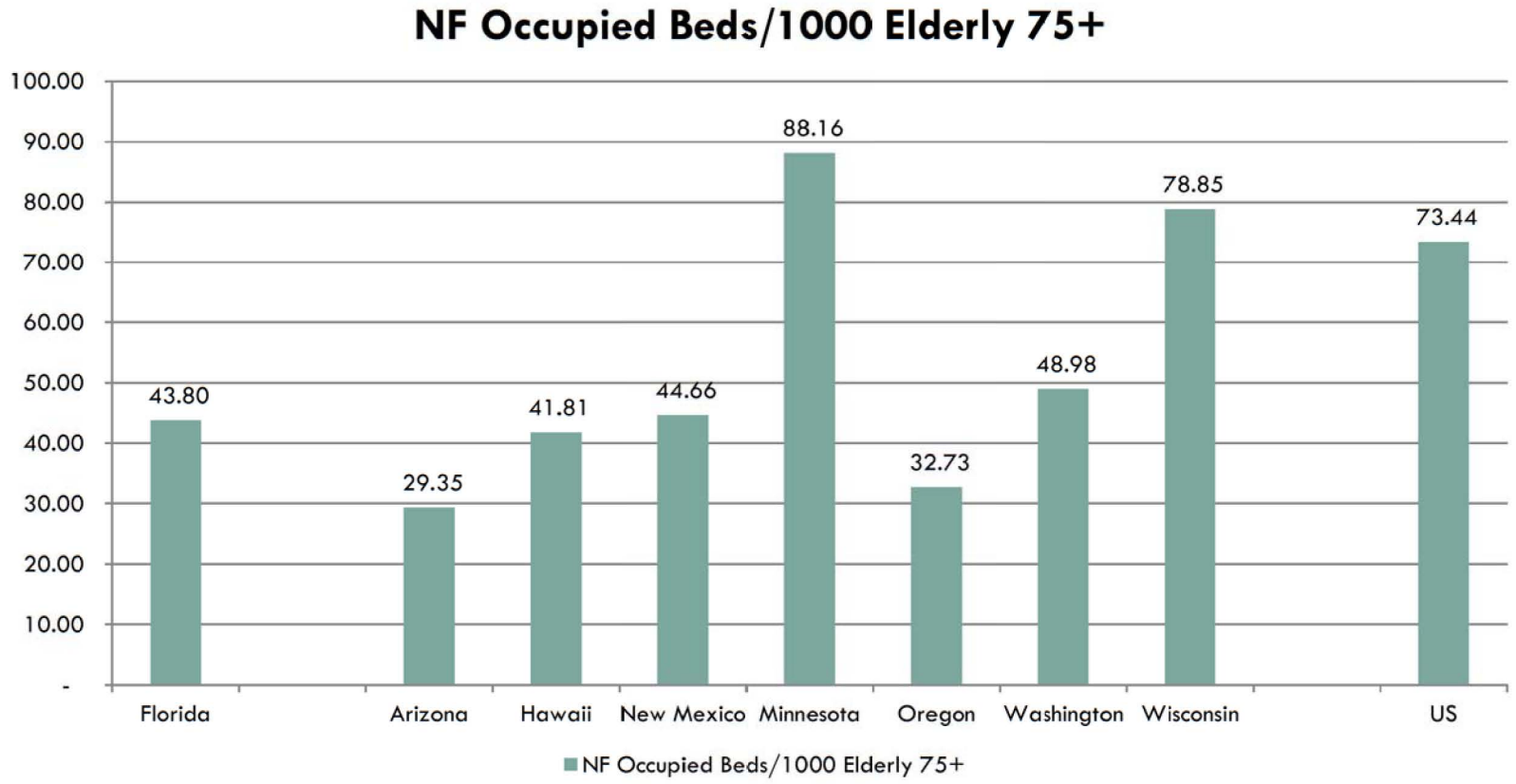
Licensed Nursing Facilities/Beds

Year	Licensed Ch. 400 Beds	CON Approved Ch. 400 Beds	Licensed Ch. 400 Facilities	Licensed Sheltered Beds
01/01/2002	80,933	2,089	668	14
01/01/2003	80,258	1,447	682	14
01/01/2004	80,125	972	659	12
01/01/2005	80,052	704	657	12
01/01/2006	79,753	824	651	16
01/01/2007	79,525	1,156	653	16
01/01/2008	79,389	1,192	650	17
01/01/2009	79,238	1,165	651	17
01/01/2010	79,377	1,064	651	18
01/01/2011	79,429	952	650	18

Nursing Home Beds Per 1000 Elderly 75+ in 2010



Occupied Nursing Home Beds Per 1000 Elderly 75+ in 2010



Population Demographics 2010

	US	Florida	Arizona	New Mexico	Wisconsin
Total Population 65+	40,243,713	3,418,697	922,010	278,967	771,993
% of Overall Population	13.0%	17.8%	13.9%	14.1%	13.5%
Total Population 85+	6,123,458	537,846	120,875	38,326	128,800
% of Overall Population	2.0%	2.8%	1.8%	1.9%	2.2%
Nursing Facility Residents	1,396,448	71,909	11,878	5,562	30,654

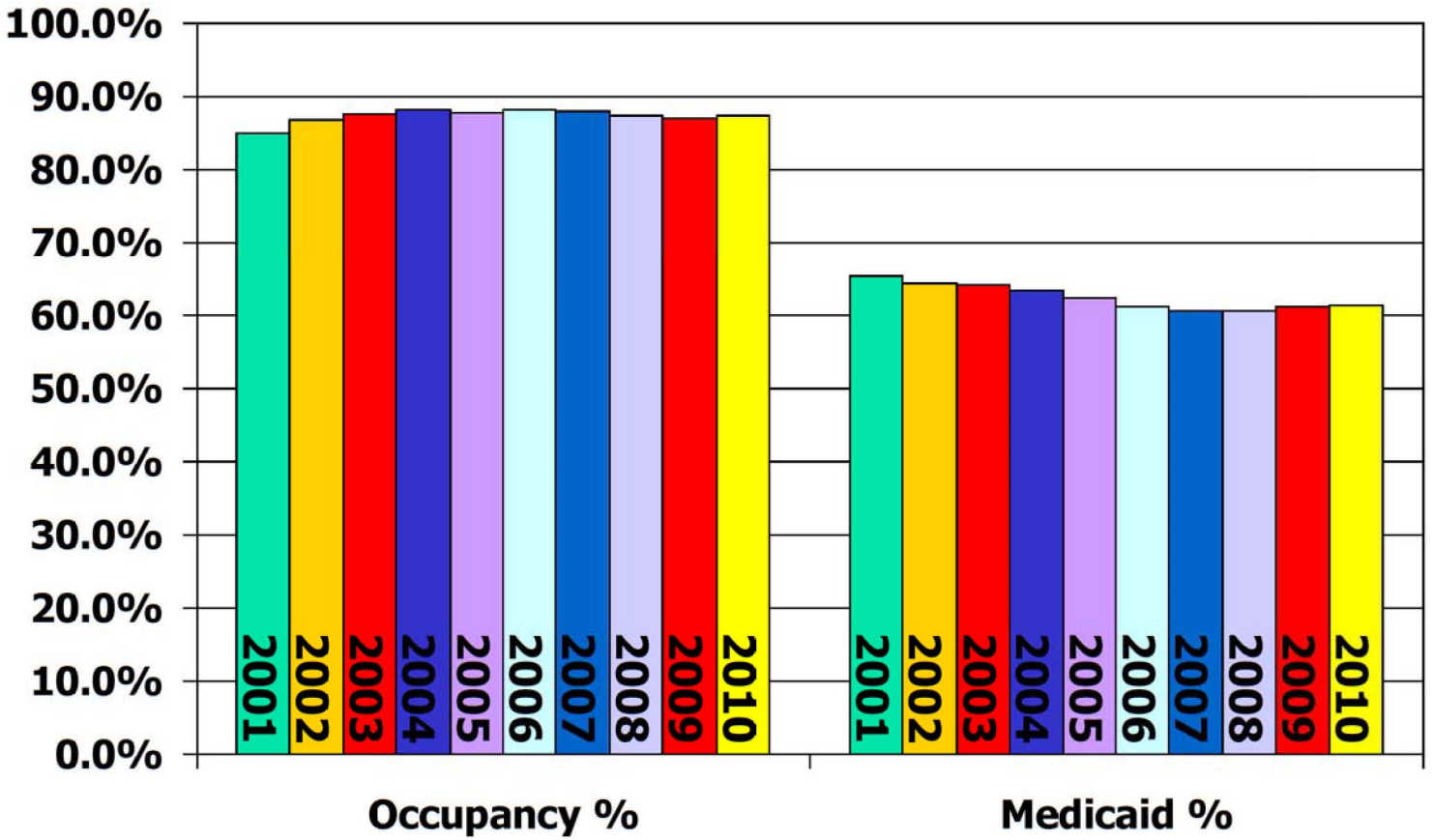
Population Demographics 2030 Projected

	US	Florida	Arizona	New Mexico	Wisconsin
Total Population 65+	71,453,471	7,769,452	2,371,354	555,184	1,312,225
% of Overall Population	19.7%	27.1%	22.1%	26.4%	21.3%
Total Population 85+	9,603,034	943,675	265,274	75,629	182,654
% of Overall Population	2.6%	3.3%	2.5%	3.6%	3.0%

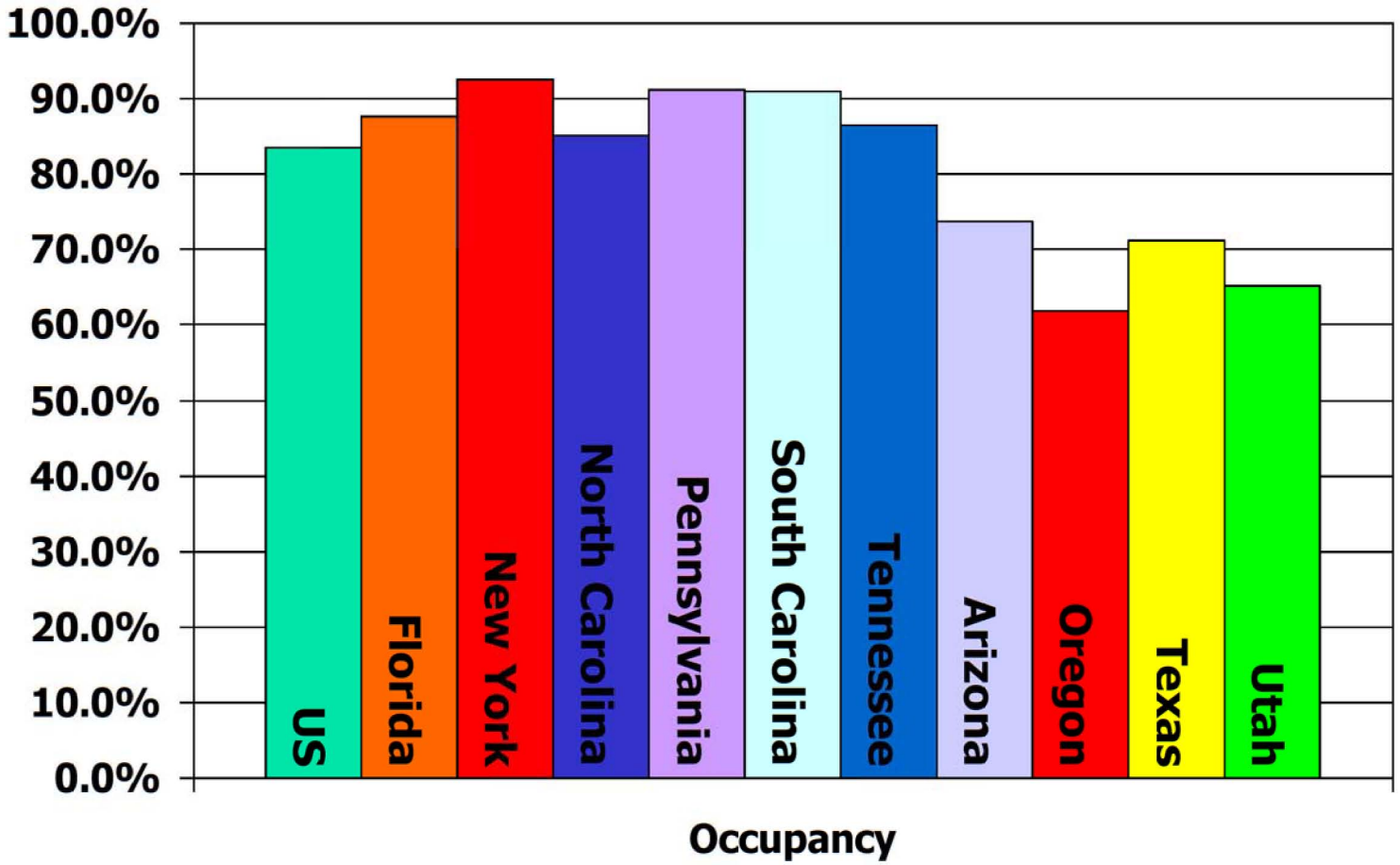
Medicaid Patient Days

Rate Semester	Annual Medicaid Patient Days	Change	Cumulative Change
Jul-04	17,219,501	-	-
Jan-05	16,649,225	(570,276)	(570,276)
Jul-05	16,622,479	(26,746)	(597,022)
Jan-06	16,528,609	(93,870)	(690,892)
Jul-06	16,433,909	(94,700)	(785,592)
Jan-07	16,285,630	(148,279)	(933,871)
Jul-07	16,043,881	(241,749)	(1,175,620)
Jan-08	15,873,209	(170,672)	(1,346,292)
Jul-08	15,727,701	(145,508)	(1,491,800)
Jan-09	15,662,880	(64,821)	(1,556,621)
Jul-09	15,530,994	(131,886)	(1,688,507)
Jan-10	15,555,960	24,966	(1,663,541)
Jul-10	15,557,043	1,083	(1,662,458)
Jan-11	15,540,893	(16,150)	(1,678,608)
Jul-11	15,612,083	71,190	(1,607,418)

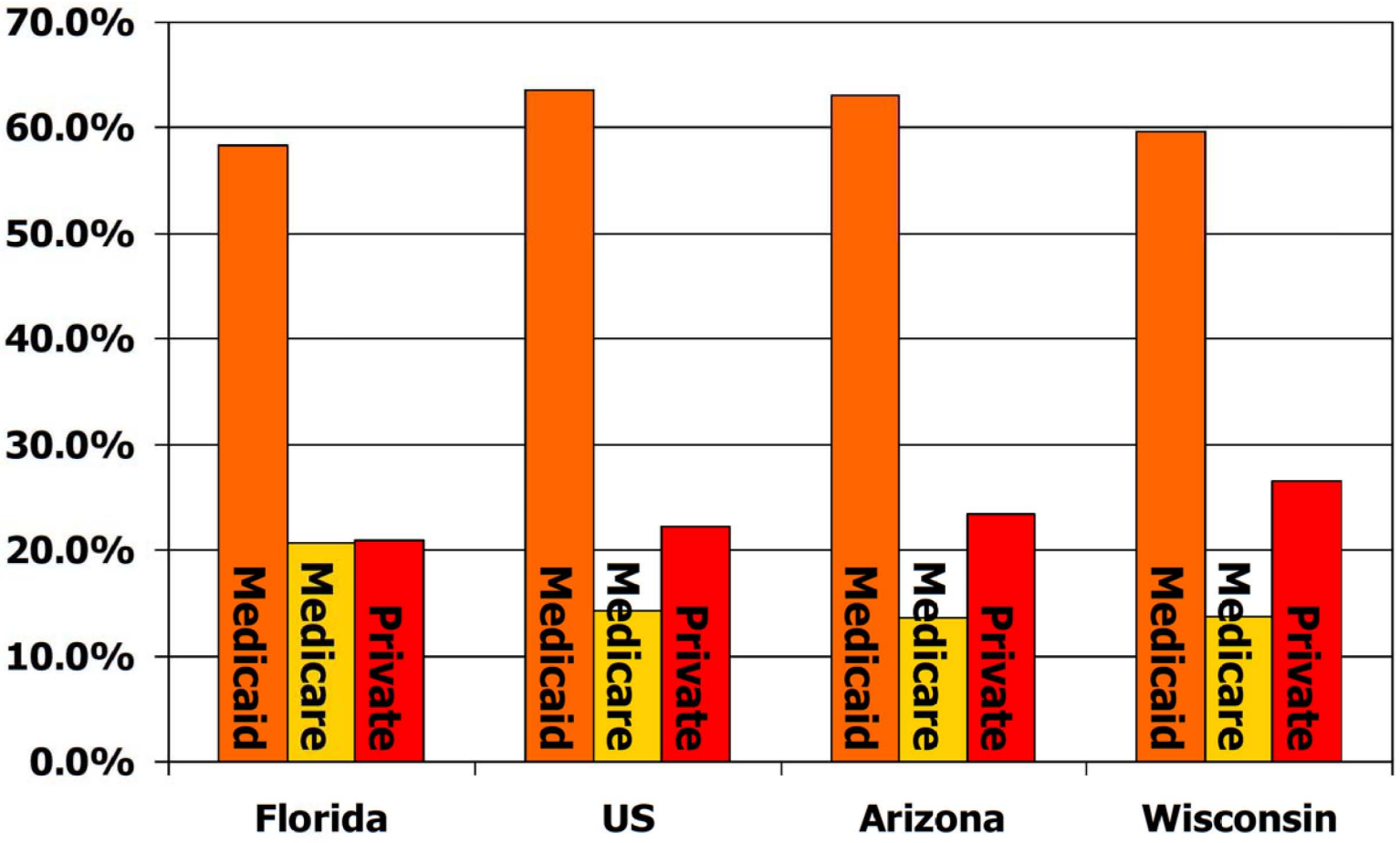
Florida Occupancy and Medicaid Caseload



Nursing Home State Occupancy Rates



Percentage of Nursing Home Patients (Payer)



Medicaid Reform
Major Financial Risks

- Delayed/reduced nursing home placement – declining NH occupancy
- Major emphasis and incentives for HCBS services and infrastructure development to achieve it
- Slower claims processing
- Passive Medicare managed care enrollment – impact on Medicare stays and rates

Medicaid Reform Opportunities

- Reward (Gain) sharing for achieving certain objectives (reduced hospitalizations and re-hospitalizations)
- Increased short term stay admissions
- Higher rates and margins on difficult patients - medically complex/behaviorally complex
- Expanded NH participation/engagement in home- and community-based care

Options for Consideration

- Continue certificate of need moratorium on nursing home beds without additional exemptions through 2016
  - Control Medicaid Costs
  - Insure Access
- Evaluate impact of change in sanctions for not meeting certificate of need conditions requiring minimum Medicaid participation on access
- Establish a workgroup to develop a plan for licensure flexibility to assist nursing homes in developing comprehensive long-term care service capabilities (2010 House PCB contained this provision)

CONTACT INFORMATION

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