

**Rebalancing Long-Term Care Systems in Florida:  
Case Study as of December 2007**

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## Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of all products with web links for completed documents is found on the CMS New Freedom website, at [http://www.cms.hhs.gov/NewFreedomInitiative/035\\_Rebalancing.asp#TopOfPage](http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage), and at [http://www.hpm.umn.edu/ltrresourcecenter/on\\_going\\_research/Rebalancing\\_state\\_ltc\\_systems.htm](http://www.hpm.umn.edu/ltrresourcecenter/on_going_research/Rebalancing_state_ltc_systems.htm).

For the final case studies—in this instance for the State of Florida, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visit conducted by Rosalie Kane and Dann Milne on November 6 and November 7, supplemented by telephone interviews before and after the site visit as needed.

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## Executive Summary

The State of Florida with its high proportion of elderly residents and its ethnic diversity is a harbinger for the challenges other States will eventually encounter. Florida houses many innovative programs to meet LTSS challenges, and has made substantial strides in efforts to achieve a full range of choice and inclusion for people with mental retardation and developmental disability (MR/DD), including providing incentives for competitive employment. Those efforts have become stagnated at present because of general budget problems (due to the housing slump, a failing economy, Hurricane-related expenses, and a strong aversion to increasing taxes) and a specific crisis of financial management in the MR/DD programs.

Several other major efforts have become stalled in the last year. Programs for older people needing LTSS have been bogged down in a multi-year struggle about the extent to which the LTSS strategy should rely on capitation of acute and LTSS services to management by Managed Care Organizations. This was a favored solution in both the Lawton Chiles and Jeb Bush administrations, endorsed by successive secretaries of the Department of Elder Affairs and typically opposed by most Area Agencies on Aging and many advocates. It appears that this solution was, in part, designed to compensate for structural problems in the delivery of services that led to lack of clear accountability or firm commitment to increasing community care for seniors. Instead of addressing those problems by structural change in the system, there was a reliance on managed care organizations with the right incentives to solve the problems. At this writing, the mandatory Senior Care program that would have applied managed acute care and LTSS has been severely curtailed, and it is uncertain what strategy will take its place. In the case of Senior Care, a mandatory managed care plan for seniors dually eligible for Medicaid, the program's momentum also flagged because of stakeholder opposition. Florida's development of consumer-directed options has been similarly slowed by budgetary limitations.

Promising recent developments in Florida include the development of a statewide network Aging Resource Centers (housed in the AAAs), some success in streamlining the eligibility process, serious attention to housing and transportation issues, and several creative efforts to bring government, and private philanthropy together around disability and aging topics, including employment of people with disability, assistive devices, and (in the Communities for a Lifetime Initiative) creation of elder- and disability-friendly communities.

Florida has given concerted attention to improving nursing homes and to increasing staffing standards for nursing departments in nursing homes, and has achieved some success in measurable quality indicators and reduction in law suits. Expenditures in this area make it harder to shift the balance of Medicaid expenditures towards HCBS.

The structure of the new Governor's Commission on Disability may encourage high-level inter-agency cooperation on LTSS issues; its history is too recent to make a judgment. The actual structure of State agencies discourages cross-disability planning, program development, and accountability.

## **Rebalancing Long-Term Care Systems in Florida Case Study as of December 2007**

### **Introduction**

#### Background

Florida continues to be a magnet State for older individuals, including those who are still working and retirees. In 2006, an estimated 16.8 % of its population was over age 65 in 2006, making Florida a bellwether State for aging issues. It is also a populous and ethnically diverse state with a higher proportion than the national average of Hispanic American residents and residents who are foreign-born. Putting long-term supportive services (LTSS) in an historical context, Florida began its state-funded program, Continuing Care for the Elderly (CCE) in the 1970's; administered through Florida's 11 Area Agencies on Aging and lead agencies in each county, it was an early model for services to older people.

In the 1980s and 1990s, Florida adopted a wide array of Medicaid waiver programs for various target populations. Many programs started as Demonstration projects and remained after the demonstration period; at this point Florida has a great variety of co-existing LTSS programs (some state-wide and some limited to selected counties, some based on fee-for-service and some on managed care models.) These programs are administered by multiple governmental agencies, including the Agency for Health Care Administration (AHCA), the Department of Elder Affairs (DOEA), the Department of Health, the Agency for Persons with Disabilities (APD), and the Department of Families and Children. (Florida even has a single waiver for Aging and Disabled Adults (ADA) where about 4/5ths of the slots allocated for older people are managed by the DOEA and the 1/5 allocated for people under age 65 with disabilities are managed by the Department of Health.) Regardless of the agency that manages the operations of the waiver, all

HCBS waivers are overseen fiscally by AHCA, which pays the bills. This organizational system requires a counterpart staff at AHCA for each waiver managed elsewhere and arguably creates some confusion, inefficiency, and divided accountability.

Florida historically has a low supply of nursing homes and a low rate of nursing home use as a proportion of the elderly population, but it has a large supply of licensed assisted living facilities, some of which are institutional in nature. Around the turn of the current century, the Florida legislature responded to a burgeoning crisis in LTSS (including high insurance costs for providers, large liability awards against nursing homes and assisted living facilities, and a perceived crisis in quality) with a Task Force that examined all these issues plus the need for more community care options. Resultant legislation included tort reform limiting awards against LTC facilities, mandated higher staffing ratios in nursing homes, requirements for staff training and credentialing across multiple settings, and new regulatory and quality initiatives, particularly for nursing homes. The costs of these reforms increased the State's investment in nursing homes compared to its investment in HCBS at about the time that the Rebalancing Research began. Simultaneously, the State was increasing its funding for HCBS for persons with mental retardation and/or developmental disabilities (MR/DD), a priority interest for then-governor Jeb Bush. Most LTSS community programs for seniors or persons with physical disabilities remained flat in their funding with the exception of the Long-Term Care Community Diversion Pilot Project (colloquially called the Nursing Home Diversion waiver), which is administered through Managed Care Organization in most legislative sessions. For the last decade, capitated managed care has been a favored solution in Florida not only for LTSS, but also for acute care and behavioral health.

To put this final case study in context, Florida has experienced a budget crisis in the last several years, worsened by the national housing financing crisis, weather-related crop failures reducing State revenue, and hurricane-related expenses incurred by the State. The present and previous State governments have ruled out raising any additional revenue through increased taxes and instead have required State funding programs to undergo deep budget cuts.

### Summary of Early Rebalancing Case Studies

The baseline rebalancing study highlighted the expansion of HCBS services for persons with mental retardation and/or developmental disability (MR/DD)<sup>1</sup>; growing consumer-direction opportunities in HCBS programs; managed care initiatives for older people including the evolution of the Nursing Home Diversion Waiver and planning for Senior Care, a proposed integrated managed care program for Medicaid acute care and LTSS for older people; the creation of a state-funded program of Aging Resource Center and a modified vision for the role of Area Agencies on Aging; an innovative LTSS program for persons with brain and spinal cord injuries administered in the Department of Health; and a wide range of quality initiatives for nursing homes and assisted living. The initial case study for Florida Short and long baseline case studies on rebalancing in Florida were released in 2005, and an update of activities in all 8 states including Florida between July 2006 and July 2007 was released in April 2007.<sup>2</sup>

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<sup>1</sup> In recent months, some State agencies and some advocacy reports have used the term Intellectual Disability/Developmental Disability (abbreviated ID/DD) rather than MR/DD. In this document, we use the older term MR/DD to be consistent with earlier Rebalancing Research documents. These terms may be used interchangeably, as may the term recognized by Medicaid, Mental Retardation and Related Conditions (MR/RC).

<sup>2</sup> Links to the short case study *Rebalancing Long-Term Care Systems in Florida: Experience up to July 31<sup>st</sup>, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 are on the CMS New Freedom website, last visited on April 8, 2008 at [http://www.cms.hhs.gov/NewFreedomInitiative/035\\_Rebalancing.asp#TopOfPage](http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage). A long baseline case study on Florida is on the website of the Long-Term Care Resource Center at University of Minnesota, at [http://www.hpm.umn.edu/ltrsourcecenter/on\\_going\\_research/Rebalancing\\_state\\_ltc\\_systems\\_case\\_studies.htm](http://www.hpm.umn.edu/ltrsourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm).

## **State Initiatives**

### Update on Previously Identified State Initiatives

MR/DD programs. Since 2004, programs for persons with MR/DD over age 3 have been administered by a newly created Agency for Persons with Disabilities rather than by the Department of Children and Families. The appropriations for HCBS waivers increased dramatically, the use of Consumer-Directed Care models increased, and a goal was articulated to drastically curtail or eliminate the use of state-run institutions, which was also the subject of a legal suit. Besides operating the original large Developmental Services (DS waiver), APD administered a new Family and Supportive Living (FSL) waiver, which had lower levels of benefit. Some participants were enrolled in the FLS waiver while on the waiting list for the DS waiver.

A strong emphasis was put on creating employment opportunities for people with MR/DD in the competitive employment sector. A Blue Ribbon Task Force on Inclusive Community Living, Transition and Employment of Persons with Developmental Disabilities was created by the Governor in 2004 and charged with coordinating statewide services for students with developmental disabilities to transition from school to gainful employment, the task force also aims to expand and improve competitive, integrated employment opportunities for individuals with developmental disabilities. To develop public-private partnerships and engage business in this effort, Florida established the Able Trust, also known as the Florida Governor's Alliance for the Employment of Citizens with Disabilities, a public-private partnership foundation. Since its establishment, the Able Trust has awarded more than \$16 million to individuals with disabilities and nonprofit agencies and helps close to 2,000 individuals with disabilities annually to enter the

workforce, and it also awards grants to agencies for on-the-job coaching, job skills-training, job development and employer outreach. It established dozens of Florida/High Tech programs throughout the state, with plans to implement ten new sites by the end of 2005. The program encourages students to set their sites on college and a career in the fields of science, technology, engineering or math. Students with disabilities enrolled in High School/High Tech sites take field trips to science and technology-related businesses and attractions and receive on-the-job experiences through job shadowing and internships.<sup>3</sup>

By 2006, however, the APD had experienced large budget deficits, the effects of which on the State were exacerbated by the general revenue shortages. With a \$150 million dollar deficit in the largest DD waiver, the ID/DS programs were frozen. Though APD now serves about 35,000 people with MR/DD, 25,000 of whom are in the DD waiver, the caseloads have stopped expanding and recent APD emphases have been on utilization controls through prior authorization, fraud detection efforts, and reducing rates for providers, including group homes and other HCBS providers. The APD has had substantial turnover in leadership in its short life. Its first director resigned in January 2006 before the Crist administration took office amid criticisms of her efforts to fulfill the cost-cutting agenda. (APD's denial of a claim to pay for special thermal blankets for a child with cerebral palsy at the cost of \$350 a year despite several appeals for coverage became publicized in the press and led to a personal check for the expense from the Governor and many donations from the general public. This incident caught the public imagination but begged the issue of how the APD leadership should apply their mandates to cut costs. Her successor, who had previously been the Executive Director of the Florida Alliance for Assistive Services and Technology (FAAST) was widely recognized for leadership in the

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<sup>3</sup> For more information about the activities of the Able Trust, see Website, last visited June 15, 2008, at <http://www.abletrust.org/>

development of assistive technology and forging alliances with the private sector, was in office for about a year before she resigned in February 2008, also amid criticisms about how she pursued the requirements to cut costs.

APD is presently planning to assess all current clients by July 2009 and subsequently develop individual client budgets rather than to utilize maximum caps within levels as a guide. According to a Florida legislative auditing body, to effectively implement individualized budgets, APD needs to develop a plan that outlines major activities, milestones, and needed resources and establish an anticipated target date for completion within six months after it has finished assessing all clients using the new needs assessment process. The agency will also need to ensure that its new needs assessment tool is valid and reliable.<sup>4</sup> For this report the auditors contacted 26 States to study how their MR/DD programs are structures and found that 19 place their ID/DD waiver programs in a large, multi-program health or human services agency, 3 place the program in an agency that also administers mental health and substance abuse programs, and only 4 use a stand-alone agency to serve people with MR/DD as in Florida.

FAAST. The Florida Alliance for Assisted Services and Technology (FAAST) is a non-profit organization funded by the US Department of Education through the Assistive Technology Act of 2004, Rehabilitation Services Administration (RSA), private foundations and individuals is another effective public private partnership that provides resources across disability and age groups.<sup>5</sup> FAAST is a comprehensive, statewide system of technology-related assistance,

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<sup>4</sup> OPPAGA (2008). APD Should Take Steps to Ensure New Needs Assessment and Individual Budget Process Is Timely and Effective. (Report No. 08-15, Florida Office of Program Policy Analysis and Government Accountability, March. On web, last visited 6/14/2008, at <http://www.oppaga.state.fl.us/reports/health/r08-15s.html>.

<sup>5</sup> FAAST provides a great deal of useful material about a wide range of equipment, devices, and modifications related to a full range of mobility, communication, and cognitive disability, including specific information about

outreach, and assistive technology purchase loans programs. The program has been in place since 1992, but which has expanded rapidly since 2000 and maintains a high profile. FFAST programs include: hands on assistive technology demonstrations and training; financing for assistive technology purchases, assistive device lending programs; community outreach to rural and underserved group; promotion of accessible, affordable housing; and advocacy and education on consumer choice. A public-private partnership, FFAST functions through 6 regional demonstration centers, each established through annual contracts. Its board of directors must be comprised of at least 51% persons with disabilities or caregivers for them. To illustrate its advocacy function, FFAST helped institute policy changes through state government during the 2005 Legislative Session, when the Florida Senate and House unanimously passed legislation that requires the establishment of interagency agreements to ensure that assistive technology remains with a student as he/she progresses through the education to work continuum.

Managed LTSS for Seniors. The previously mentioned Florida Nursing Home Diversion (NHD) Waiver, administered by the Department of Elderly Affairs (DOEA), is the only waiver serving older people to experience substantial growth over the last five years, and it is a managed care initiative. The NHD expenditures were \$22 million in 1999 and \$250 million in 2006. It received capitation for 2000 new slots in June 2007. As of August 2007, there were 11, 014 participants in the NHD, and the program had expanded to 28 counties (the NHD program has federal authorization to expand to 49 of Florida's 67 counties). The other two statewide waiver programs for seniors administered statewide by the DOEA, the much older statewide Aging and Disabled Adults (ADA) waiver and the Assisted Living for the Elderly (ALE) had 10, 494 and 3, 273 participants respectively, got no increases in slots, and have waiting lists.

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accessible housing and transportation on its website, last visited June 13, 2008, at <http://www.faat.org/Housing.cfm>.

A substantial part of the strategy of the Managed Care Organizations (MCOs) for the NDP is substitution of assisted living for nursing homes. The NHD plans pay assisted living a better rate than the State pays under ALE, a waiver program that directly substitutes AL for nursing homes. There is controversy about the effectiveness of the NHD waiver compared to the fee-for-service waivers that serve older people. Separate evaluations done by the Office of Program Policy Analysis and Program Accountability (OPPAGA) and by the University of South Florida under contract with DOEA differed slightly in method and findings. Both studies showed a decrease in nursing home use for the NHD waiver and concluded that with the capitation rates then in effect the program did not achieve savings for the State.<sup>6</sup> The capitation rate for the NHD waiver has subsequently been lowered.

For at least five years, the major policy initiative for older people in Florida has been Senior Care, originally conceived as a mandatory program under a 1915 (b/c) waiver to integrate Medicaid acute and long-term care for dually eligible seniors. In Senior Care participating Managed Care Organizations (MCOs) would provide under their capitation all the services in the Medicaid State, the waivers, and the state-funded Community Care for the Elderly program. Some key informants suggested that the model would have the advantage of avoiding rigidities and inefficiencies in the existing Aging Network system of service allocation and delivery.

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The University of Florida evaluation was published in Mitchell III, G, Salmon JR, Polivka L, & Soberon-Ferrer H. (2006) The relative benefits and cost of Medicaid home- and community-based services in Florida. *The Gerontologist*, 46 (4):483-494. The reference for the OPPAGA report is OPPAGA (2006). [The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry](http://www.oppaga.state.fl.us/reports/health/r06-45s.html), (Report No. 06-45, May 2006). Tallahassee, FL, OPPAGA. On web, last visited June 13, 2008, at <http://www.oppaga.state.fl.us/reports/health/r06-45s.html>.

Initially Senior Care was to be tested in an urban (Orlando) and more rural (Pensacola) county for a short period and then implemented State-wide.

Despite the strong endorsement by the then-Secretary of DOEA, a former State Legislator who was highly supportive of HMOs, Senior Care was opposed by many AAAs and lead provider agencies in the Aging Network. Already concerned about the potential of the NHD waiver to erode the publicly subsidized aging network, critics in the Aging Network, joined by AARP, argued strongly against Senior Care and particularly its mandatory features. Some existing NHD providers were also opposed to the new model, which would have restricted providers to selected HMOs in each county. In a later evolution, the program was made voluntary for the Orlando demonstration site and mandatory only in Pensacola, where the service structure was less evolved. Further changes were made in 2007 legislative session so that at the time of our site visit in November 2007, the program was voluntary in both pilot counties, it was expanded to younger dually eligible participants, and the Pensacola site was changed to a Miami site. The State would no longer contract via a competitive process with selected HMOs in each county, but instead would contract with “any qualified provider” These qualified providers could be commercial HMOs or NHD waiver program providers.<sup>7</sup> This new permissiveness was argued for by potential providers, particularly in Miami-Dade County, where contenders to participate were plentiful. Senior Care has no new funding, and can only incorporate existing waiver clients who volunteer to which to the new program.

An RFP has now been issued for providers, but clearly, Senior Care has been altered in its original intent to test efficiencies and improved quality that might come from integrated managed Medicaid services. Key informants suggested that the argument that the aging network

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<sup>7</sup> House Bill No. 7065 was enacted in 2007 to alter the design of Senior Care. On the web, last visited July 20, 2008 at <http://www.flsenate.gov/data/session/2005/House/bills/analysis/pdf/h1525.ELT.pdf> CHAPTER 2007-82.

infrastructure was worth preserving was bolstered because the AAAs and lead agencies stepped up to the plate to assist during the Hurricanes that unsettled so many older people whereas the HMOs were not visible in the effort. Also the change of governor led to a group of staffers who were not quite so ideologically in favor of HMOs.

Aging Resource Centers (ARCs). Concomitant with the planning for Senior Care, policy-makers envisaged a different role Area Agencies on Aging (AAAs). When Senior Care became mandatory, AAAs would no longer have responsibilities for direct management of the ADA, or ALE, or the state-funded CCE program for seniors who were dually eligible for Medicare and Medicaid, and the lead provider agencies in each county would participate (as they now do for NHD), only if subcontracted to a participated HMO. A Florida statute was introduced in 2005 that would have changed and sharply curtailed the roles of the AAAs and lead provider agencies, but intensive lobbying against the measure led to its withdrawal.

Another vision for AAAs—making them a fulcrum for information and referral—turned out much more positively. It was planned that each AAA would house an Aging Resource Center to perform multiple functions such as information and referral; financial and functional eligibility assessment; triaging; budget authorization; health and wellness consulting; employment assistance; processing of food stamp and Medicaid applications; and counseling on long-term care options. The ARCs would collaborate with other organizations in the region. Consumers would contact the ARC in multiple ways, including through other agencies or by internet whereas the ARC also could provide intensive personal contact. Legislation was enacted for the state-funded ARC program in 2004.

The Florida ARC program interfaced nicely with the federal Aging and Disability Resource Center (ADRC) program sponsored by the Administration on Aging and CMS. In 2005 Florida

received a federal grant to implement an Aging and Disability Resource Center (ADRC) program. ADRCs were piloted in three AAA areas—the Senior Resource Alliance (which is the Central Florida AAAA serving multiple counties near Orlando), the Broward County AAA (in the Fort Lauderdale area) and the AAA in Pasco and Pinellas County (which includes St. Petersburg). For the ADRC program the population with Serious Mental Illness was also served, but the ADRCs also became a model for the planned ARCs, which were to be central to the aging services system. The Central Florida ADRC, then directed by Douglas Beach, who was appointed by Governor Crist in January 2007 as Secretary of the DOEA, gained considerable acclaim for its effective use of information technology. Documenting extensive use of its website, and a high volume of activity, the Alliance demonstrated that an AAA could become an influential, effective, and well funded leader in the community as a result of developing an ARC.

The further development of the ARC program illustrates how Medicaid became a driver for the program's expansion and success, at the same time that the State planfully took advantage of Medicaid funding for components of its ARC initiative. The statute authorizing ARCs required that OPPAGA (the accountability arm for the legislature mentioned earlier) review the program. In 2006 OPPAGA reported that the State had not yet expanded the Resource Centers beyond the first three pilots and first were working to revise and complete its readiness tool and improve the website protocols.<sup>8</sup> In September 2007, however, OPPAGA reported that the program was aggressively moving toward completion and that, to be maximally effective, ARC's needed to work closely on Medicaid enrollment and should seek to recover Medicaid administrative funds for any ARC personnel who work exclusively on Medicaid enrollment. By that time the DOEA and AAAs were creating a common information and referral data system for the initiative. In

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<sup>8</sup> See OPPAGA (2006) *Aging Resource Center Initiative Has Not Moved Beyond the Pilot Sites*, (Report No. 06-62, September 2006). On web at, last visited June 14, 2008 at <http://www.oppaga.state.fl.us/reports/health/r06-62s.html>.

March 2008 OPPAGA reported that the statewide implementation would be complete in April 2008.<sup>9</sup> In October 2007, the DOEA has begun to use federal Medicaid funds for Aging Resource Center staff positions that spend all of their time on Medicaid-related activities, and it was developing a process for using federal funds to partially fund staff positions that spend a portion of their time on Medicaid-related activities. Moreover interviews with AAAs found positive results that they attributed to the ARC activity, including wider recognition as seniors' gateway to services, more control over access to services, improved communication among agencies responsible for Medicaid eligibility determination, and more statewide uniformity in the information collected about information and referral services. The national technical assistance program for the ADRC's cites Florida's ability to draw Medicaid funds to this effort as a possible national model. Also the page for Florida on that website lists the many memoranda of understanding needed for the ARC's to develop a central role in speeding up access.<sup>10</sup>

The Brain Injury/Spinal Cord (BI/SC) program. This program, located in the Department of Health, was begun with traffic fine revenues. It now also draws on a waiver and state plan services. From the beginning, program leaders took pains to identify each person in the target population, developing a particularly good registry of people with spinal cord injuries. The HCBS waiver took effect 2000. It now has 328 clients, with over 400 on the waiting list. A staff member assessed all waiting list members in 2007, and assigned a priority score to each of the 85 individuals qualified for waivers and wanted to leave a nursing home. State Plan services are inadequate for this group, and to access the waiver participants currently must have a skilled

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<sup>9</sup> See OPPAGA (2007) An Aggressive Schedule Set to Complete Implementation of Aging Resource Centers (Report No. 07-38, September 2007), on web at <http://www.oppaga.state.fl.us/reports/health/r07-38s.html> and OPPAGA (2008). Statewide Implementation of Aging Resource Center Initiative is Substantially Complete (Report No 08-14 March 2008) on web at <http://www.oppaga.state.fl.us/reports/health/r08-14s.html>, both last visited June 13, 2008.

<sup>10</sup> See website, last visited June 15, 2005, at <http://www.adrc-tae.org/tiki-index.php?page=FloridaPagePublic>.

nursing need. Disability Management Specialists (8 across the state for the Waiver program) process enrollment and oversee the care plans of waiver clients; the program emphasizes the importance of using case managers who really understand disability. The case managers also do also do provider recruitment and training.

Quality and training initiatives. In the baseline case study we noted a range of efforts to improve provider capacity, especially those of nursing homes and assisted living facilities. Florida mandated that providers develop dementia training programs using a curriculum approved by a contractor at the University of South Florida. It funded a Teaching Nursing Home (Jewish Home and Hospitals in Miami) to develop a range of web courses and other materials to improve care in the State. It mandated that each nursing home had a risk management program in place. It developed a quality monitoring program with a consultative component to complement the assessment and enforcement side of the Survey and Certification process, which reviews care against as many State-specific regulations as Federal regulations. To encourage positive change over and above regulatory minimums, the State utilizes civil monetary penalty funds for projects in culture change. All these initiatives continue.

The State of Florida had enacted a stringent nursing-staff-to-resident ratio, which planned to implement in 3 increments. However, because of Florida's budget crisis, the 3<sup>rd</sup> phase of implementation has been postponed.

### New State Initiatives

Governor's Disability Commission. At the time of the baseline study, Florida had no strong stakeholder group with formal links to relevant government agencies to work on applying the Olmstead decision. The closest analogue was the ADA Work Group, established by Republican Governor Jeb Bush, which itself was a sequel to a similar group established by Democratic

Governor Lawton Chiles (D) during his prior term. The ADA Work Group was initially charged to provide information and technical assistance to state agencies on complying with the ADA's employment provisions. Applicants for state jobs and state employees can use the Working Group's services to clarify their rights and responsibilities under the ADA. A subsequent executive order added the responsibility to serve as a Clearinghouse on Disability Information to the Working Group's mandate, including providing information on employment with state agencies and in other sectors. The Work Group also undertook projects related to housing and towards the end of its tenure commissioned a study of all HCBS waivers. The ADA Work expired at the end of Jeb Bush's term, and in the previous period was not particularly well situated to organizationally to lead State initiatives.

In July 2007, on the 15<sup>th</sup> anniversary of the Americans with Disability Act, Governor Crist issued Executive Order 07-148 to create the Governor's Commission on Disability, a 19-person Commission with a broad mandate to advance public policy on behalf of persons with disabilities. Its mission included: identifying and recommending methods to remove barriers to the delivery of, and access to, services for people with disabilities; identifying and recommending methods to maximize the freedom and independence of Floridians with disabilities, with a focus on employment, transportation, education, and independent living; providing a forum for communication between individuals with disabilities throughout the State of Florida and the various arms of state government, particularly the Governor and the Legislature; and partnering with other agencies and organizations serving the disabilities community to facilitate collaborative efforts consistent with the purposes of the Commission. With the help of the Florida Council on Advocacy, the Commission was charged with assuming the Clearinghouse functions of the ADA Work Group.

The Commission's 19 members must represent individuals with visual impairments; individuals with hearing impairments; individuals with developmental disabilities; individuals

with spinal cord or brain injuries; individuals with mental illnesses; elderly individuals; disabled veterans of the United States; Centers for Independent Living; the Division of Vocational Rehabilitation; the Florida Department of Health; the Florida Department of Education; the Florida Department of Children and Families; the Florida Agency for Persons with Disabilities; the Florida Department of Elder Affairs; The Florida Agency for Health Care Administration; the Florida Department of Veterans Affairs; the Florida Agency for Workforce Administration; and the Florida Commission for the Transportation Disadvantaged, and it must include the Executive Director of the Statewide Advocacy Council.<sup>11</sup> The Executive Order requires that the Commission receive support from all the relevant State agencies.

Communities for a Lifetime. Communities for a Lifetime is a statewide initiative to assist Florida cities, towns and counties in planning and implementing improvements benefiting the lives of all residents of all ages. The goal is to create elder friendly, inclusive communities and to assist the participating Communities for a Lifetime to use existing resources and state technical assistance to make civic improvements in such areas as housing, health care, transportation, accessibility, business partnerships, community education, efficient use of natural resources and volunteer opportunities to the betterment of their communities.<sup>12</sup> The initiative is housed in the DOEA. It began in 1999 but had a rather low profile and we did not highlight in earlier reports. Governor Crist and Secretary Beach of the DOEA both enthusiastically support

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<sup>11</sup> The Council on Advocacy was established by Florida statute in the 1970's to advocate for the interests of vulnerable individuals served by the State, particularly clientele with mental retardation and developmental. With State funding for local units, the Council has been an effective vehicle for building an advocacy constituency and is discussed in detail in Topic Paper # 1 of the Rebalancing Research Initiative, Priester, J, Hewett, A., & Kane, R.A.. State Strategies to Build and Sustain Consumer Advocacy. Minneapolis, Division of Policy and Management, University of Minnesota School of Public Health, on web, last visited June 15, 2008 at [http://www.hpm.umn.edu/ltresourcecenter/rebalancing\\_attachments/Advocacy%20paper%20Final%20October%2030%202006.pdf](http://www.hpm.umn.edu/ltresourcecenter/rebalancing_attachments/Advocacy%20paper%20Final%20October%2030%202006.pdf).

<sup>12</sup> The Communities for a Lifetime Website, accessible through the DOEA website or through a separate search, last visited June 15, 2008, is on the web at <http://www.communitiesforalifetime.org/index.php>. It includes sections for local community governments desiring to participate, for business participants, and information about resources. The technical assistance components is described and community readiness self-assessment materials at <http://www.communitiesforalifetime.org/docs/blueprint/blueprint2007001plain%206and7.pdf>.

the initiative. The Communities for a Lifetime Bureau within DOEA developed a Blueprint that describes the initiative and the necessary steps that local government officials need to take in order to help their communities become Communities for a Lifetime. A DEOA Unit for Housing is located within the Initiative (see section on Housing below in this report).

As of the end of 2007, 160 communities (towns, cities, or counties) participated, each creating an organization of volunteers in the government, business, and philanthropic local communities to develop local solutions. The Florida AARP chapter is an active partner in the initiative. One of its hallmarks, particularly appropriate for Florida demographics, is that it draws upon the energies and skills of Florida's active seniors to work across age groups for community betterment. Secretary of Elder Affairs, Beach, describes the vision on the website as follows:

In addition, participating *Communities for a Lifetime* are best positioned to develop a strategy to address some of the most critical issues facing today's leaders. Whether it is economic development, growth management or the need for more affordable housing, the *Communities for a Lifetime* initiative can help develop the partnerships needed to address these complex challenges. In the same way, partnerships among a wide variety of community organizations are necessary to ensure that no resident is isolated and at risk. As collaboration takes place, the community also becomes more aware of the ways that seniors in the community enrich our schools, parks and service organizations through leadership and hours of volunteer service. These volunteer efforts enhance intergenerational relationships, as well. *Communities for a Lifetime* are inclusive communities – inclusive of people of all ages and abilities. When a community comes together and honors this service and addresses the needs of older residents, the entire community gains a sense of wellbeing.<sup>13</sup>

### **Goals, Objectives, and Accomplishments**

Florida has not specifically articulated an overall goal for rebalancing resources to serve more people with severe disability in the community and to reduce investment in institutions. Nor is there a strong sense of unified vision centered around reducing reliance on nursing homes.

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<sup>13</sup> The full comments of Secretary Beach and those of Governor Crist are on web at: <http://www.communitiesforalifetime.org/docs/blueprint/blueprint2007001plain%203.pdf>

In contract, during our site visit, we heard considerable skepticism from key informants about whether it would be possible to serve many of Florida's nursing home residents in the community. Florida applied for the first round of Money Follows the Person Demonstrations, but did not revise its proposal for the second funding round. Part of the thinking was that few people would qualify for the transitions, particularly because most of Florida's assisted living facilities (ALs) would not have qualified as community settings under the demonstration. AL rules specifically prohibit residents who 24-hour oversight by a nurse and those accepting Medicaid would mostly not meet the size criterion or have private apartments that might be argued to have independent leases.

The Agency for Persons with Disability articulated a mission to encourage full community integration for people with disabilities and, driven by a lawsuit but also by the convictions of its leaders, has identified all persons with MR/DD in nursing homes and set a target of transitioning 60 a year for 3 years, and it had embarked on a program to gradually close the state-run institutions (which has been slowed down by the current fiscal problems). The Brain Injury/Spinal Cord Injury program is also strongly driven by goals of participant autonomy, community integration, and inclusiveness. But generally, the goals stated by Florida agencies that have a role in LTSS emphasize quality of care, responsible management, and public-private partnerships. It is possible that the fragmented management of LTSS services at the State level may discourage articulation of strong vision statements or numerical goals (see Organization section below). Further, the legislature does not budget globally for all LTSS (i. e. a budget for HCBS plus institutions), and it would be difficult to implement goals for reducing the institutional sector without structural change.

Although Florida has developed many creative programs, it fares poorly by the markers typically used to compare rebalancing by State. Table 1 provides data from the MedStat tracking HCBS versus institutional LTSS expenditures between 2004 and 2006. Using these data, Florida ranks 42<sup>nd</sup> in proportion of Medicaid expenditures on HCBS for seniors and persons with disabilities (12.7%), and 24<sup>th</sup> for persons with MR/DD (28.5%), and overall spent 74% of its Medicaid money institutions. These results may understate Florida’s community care emphasis slightly for two reasons: substantial HCBS and institutional expenditures in Florida Medicaid are channeled through managed care and cannot easily be included in the data, and the State spends substantial State revenues on HCBS through Community Care for the Elderly and other programs. These data are consistent with data published by the Rebalancing Research project in our 2005 and 2006 case studies where we made an effort to include all State expenditures in the two columns rather than just Medicaid expenditures. Between 2000 and 2006, Florida’s expenditures on HCBS were dwarfed by those in institutions. Moreover, of the 8 States, Florida was the one where the expenditures on nursing homes grew during the period. We attribute this growth to the higher staffing ratios and the concomitant increase in nursing home rates.<sup>14</sup>

Table 1. Expenditures on LTSS in Florida in 2004 and 2006.

	Distribution of Medicaid Expenditures in 2004			Distribution of Medicaid Expenditures in 2006		
	HCBS	Institutions	US Rank	HCBS	Institutions	US Rank
Aged/Disabled	11.2 %	88.8 %	42	12.7 %	87.3 %	42
MR/DD	65.9 %	34.1 %	23	28.5 %	71.5 %	24
All	26.0 %	74.0 %	40	29.8%	70.2 %	37

<sup>14</sup>The Executive Summary for Year 1 of the Rebalancing Research and the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 provide comparisons of expenditures by subgroup in the 8 participating States. They are on the CMS New Freedom website, last visited on April 8, 2008 at [http://www.cms.hhs.gov/NewFreedomInitiative/035\\_Rebalancing.asp#TopOfPage](http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage).

## **State Organization**

The organizational structure for LTSS in Florida is, to say the least, complex, and this has not changed appreciably in the four years of the Rebalancing Research project. In the State of Florida, many departments and independent agencies in State government have responsibilities for LTSS. Policy-making authorities are multiple, and policy-making and planning is divided from operations. There are divisions by program and target group also as well as divisions by function. The Department of Elder Affairs (DOEA) operates the Older Americans Act programs, several State-funded programs for the elderly (such as CCE and Home Care for the elderly, a cash payment program), and several waiver programs (the aging part of the ADA waiver, the ALE waiver, access to the Nursing Home Diversion waiver). Some smaller waiver programs that are not State-wide, such as the Channeling Waiver (the original long-term care channeling demonstration of the 1980's, the Alzheimer's program, and the Adult Day Care Waiver) are also operated by DEOA. The Department of Health operates the Brain Injury/Spinal Cord Waiver, the HIV-AIDS waiver, the Disabled part of the ADA waiver), and some other waiver or State plan programs for small populations. The DD waiver and the FSL waiver are operated by the Agency for Persons with Disabilities (APD), which has responsibility for ID/MR programs for persons over age 3. Programs for persons with MR/DD under age 3 are operated by the Department of Education. The Department of Families and Children is responsible for eligibility and also operates some LTSS programs for children. The Florida Agency for Health Care Administration (AHCA) operates some waivers and managed care programs directly, is responsible for many quality assurance programs including licensure and certification, houses the Medicaid program, and pays the bills for all Medicaid programs. There are staff in the operating agencies for each waiver, and additional waiver-specific staff at AHCA for each waiver. One of

the results of this system is that programs cannot manage their expenditures closely, and often experience a 6 months delay in knowing the financial health of the programs for which they are expected to achieve budget neutrality. Arguably the problem of the deficit within the APD was exacerbated by this system of accountability.

The Comprehensive Assessment and Review for Long Term Care Services (CARES) is operated out of the DEOA; it performs the federally mandated function of conducting nursing home pre-admission screening and assessment for Medicaid long term care programs. The CARES data base and the Client Information Registration and Tracking System (CIRTS) data base are maintained at DEOA, which also contracts with the University of South Florida to conduct analyses using these data bases. Other data, such as data on payment come from AHCA.

By Statute, Florida has an unusual structure for its Aging Network. The State is divided into 11 multi-county Area Agency on Aging catchment areas. Each county has a designated non-profit Lead Agency for service delivery. After the initial determination of eligibility for services by CARES, the lead agency oversees care plans, provides services, and may purchase services from other community agencies. Budgetary allocations flow from AAAs to lead agencies to deliver services for specific programs under AAA control such as the state-funded CCE. Lead agencies also provide services through waivers, contracts with other governmental program, and purchasing entities such as HMOs, and through direct fees to privately paying consumers. They may also be certified as Medicare home health agencies. Some lead agencies in populous counties are extremely powerful and sophisticated entities and some have the financial resources to consider risk-bearing roles in capitated programs.

## Access

Access to services is made difficult by fragmentation in the eligibility process, and, in some instances, delays in physician authorizations for Medicaid Services. Some improvements have occurred in this area. The ADRC pilots, and the state-wide ARC program, discussed earlier as a state initiative, have increased information about services and ease of access to services. Some key informants were concerned that as the ARC's have been able to successfully draw Medicaid match as an administrative expense for ARC personnel who work with Medicaid waiver applicants, the program will become "medicalized" and focus on assisting individuals to become Medicaid-eligible to the detriment of meeting the needs of privately paying individuals who need advice about services. The data bases developed by the ARCs and made available on the web improve information about services.

Concern about delays in eligibility processing (both financial and functional) has led to an OPPAGA report on the subject in February 2007.<sup>15</sup> The report concluded that delays in receiving physician forms, regional workload issues, and client unavailability lengthens the time it takes the CARES Program to determine medical eligibility for long-term care services and that "to a large extent these factors remain outside the program's control. The greatest contributor to the elapsed time before an applicant can be enrolled in the Nursing Home Diversion program, according to the report, were delays in receiving physician forms, the financial eligibility determination process, and the Medicaid managed care payment system. The Legislature and the agencies were encouraged to consider options such as improving inter-agency electronic

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<sup>15</sup> Oppaga (2007). Several Factors Can Delay Eligibility Determination for Medicaid Long-Term Care, (Report No. 07-12, February 2007). On web, last visited June 13, 2008, at <http://www.oppaga.state.fl.us/reports/health/r07-12s.html>.

communication or reducing the CARES Program's workload, but each has barriers to implementation. Changes developed by the ARCs are helping reduce the elapsed time. In addition some local offices of Department of Children and families, who do Medicaid financial eligibility, and CARES staff, who do functional eligibility, have co-located. This streamlining has reduced the time needed for developing completed application. It seems, however, that there are structural barriers to speedy processing of applications that go back to the divisions among agencies and the policies for physician's roles in certifying medical necessity.

The other element of access concerns the availability of sufficient services. Freezes in programs diminish access. All senior waiver programs have waiting lists. We have already have already discussed the freezing of MR/DD waivers and the cutbacks in some MR/DD programs. The State budget crisis makes access to services more difficult.

### **Array of Services**

Florida waivers tend to offer a wide range of HCBS services. The State plan also has a relatively good mix of services. For instance, hospice services are more available under Medicaid than in many States. Once consumers get on waiver services in Florida, they typically have a wide array of services they can select. In some localities consumers have a choice of several different approaches to LTSS. For instance, in the Miami area an older consumer could potentially be part of the ADA waiver, the Diversion waiver, or the PACE program. We have already commented on the richness of employment programs in Florida. The assistive technology that is available is another strong point.

Florida was one of the original Cash and Counseling Demonstration states. That program has now become the Consumer-Directed Care Plus waiver. Although DOEA is the lead agency, the idea was that people with MR/DD and other disabilities would use the program and that the

use of consumer directed options would expand in the State. Florida experienced problems, however, that have curtailed the speed of growth. The State had to contend with a fraudulent fiscal employer agency contractor, and it took over the fiscal agency function itself in 2007. The DD program has been frozen because it couldn't meet the cost-effectiveness test. Also some informants believed that consumer-direction in the MR/DD program attracted family members who wanted incomes and that the controls on DD service plan costs were insufficient.

The State appears to be well covered with Adult Family Homes and Assisted Living Facilities (ALFs), and a number of programs have been developed to subsidize the rent component while Medicaid and Medicaid waivers can reimburse for services. However, it is built into the regulations for ALFs that they must not serve people who need continuous nursing care or reach various thresholds of disability, and this means that these congregate facilities are technically only available under waivers to the subgroup of nursing-home certifiable participants who have the lightest care needs.

Florida is missing some of the elements that are often present in State that is intent on Rebalancing. Most LTSS participants have no access to a transition program or relocation specialists. The exception is for participants in the Brain Injury/Spinal Cord program, which hired an Institutional Transitions Coordinator to consult with CARES case managers and facility referrals to Centers for Independent Living. Also missing is any “upstream” information and choice counseling in hospitals or rehabilitation programs.

### **Quality Assurance**

Quality initiatives in Florida, especially those related to nursing homes and assisted living, are extensive. Also built in are training mandates of various kinds—e.g. for Alzheimer's training

for a variety of professionals with certain roles, for risk management training for facilities.

These initiatives were discussed in an earlier section in the first part of this Case Study.

Quality assurance and improvement in the Developmental Disability area is partly managed through contract with the Delmarva Foundation, Florida's QIO. The State of Florida participates in both the Core Indicator Program and the Participant Experience Survey to elicit direct feedback from participants in services. A critical incident reporting system has been developed for participants in APD programs.

## **Housing**

In September 2005 DOEA established an Elder Housing Unit within the Communities for a Lifetime Initiative. Its mission is to provide information and technical assistance to elders and community leaders to create affordable senior housing choices and assisted living. Its tasks include:

- **Public Outreach.** (Maintaining consistent outreach to make the public aware of supportive housing and affordable assisted living and that uses Medicaid and other public assistance programs and services; and educating housing financiers and developers on the importance of supportive housing and related resources that facilitate aging in place, living at optimal level of functioning and diversion from higher, more expensive levels of care).
- **I & R.** (Facilitating access to assisted living and services and provide individuals with information to meet their housing needs and preferences.)
- **Stakeholder development and Technical Assistance.** (Enhancing collaboration among elder housing developers and service providers; facilitating the development of affordable assisted living and supportive housing in underserved areas; providing technical assistance to entities designated as Communities for a Lifetime; and coordinating housing issues among State agencies.

According to the DOEA Housing Unit, the shortage of affordable housing for low-income or frail elders has reached critical levels in Florida. The problem is created by overpriced markets and depletion of affordable housing units. This shortage results in year-long or greater waiting

list for elder an increasing need for emergency housing, fierce competition for affordable privately-owned rental units, and a crucial need for rental assistance for the elderly to defray daily living costs. Elders who live in their own homes face a similar affordability issue due to rising property taxes, doubled and tripled.

### **Future of the Nursing Home**

Florida's supply of nursing homes as a proportion of the elderly population has long been low. We did not identify any concerted effort to downsize the industry. In discussions with key informants in Florida governmental agencies, we developed the impression that Florida has been more worried about maintaining a supply of nursing homes in the face of insurance and liability threats and in maintaining and improving quality than cutting numbers. There is some skepticism that many individuals can be safely moved out of nursing homes without dramatically increasing costs. The "woodwork effect" (i.e., the possibility that improved community programs might increase the overall number of consumers using them and increase overall costs) continues to worry Florida authorities.

Although we did not identify any unified qualitative vision for the kinds of places future nursing homes should be, the Florida Nursing Home Pioneers is an active group and has received encouragement from the Agency for Health Care Administration (AHCA), which regulates the compliance of nursing homes with federal regulations and a large body of state-specific regulations, but also uses Civil Monetary Penalty money to fund selected individual nursing homes that are attempting to individualize case, improve quality of life, or transform their environments.<sup>16</sup>

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<sup>16</sup> At this writing, the quality engineering group at AHCA are considering a rule that would mandate single occupancy in new construction or major renovation. Whether this proposed rule will go forward is unclear (some provider organizations oppose it on the basis of concerns) but even the serious consideration is a remarkable step, and, oddly, one that is not mandated in ALFs in Florida. Personal communications with Lu Marie Polivka-West,

## **Integration of Acute and Long-Term Care**

Above we discussed the Nursing Home Diversion Waiver and the planning for Florida Senior Care, an actual and a proposed capitated program for Medicaid acute and long-term care. The Diversion program does not hold its providers at financial risk for long-stay nursing home care, and arguments have been made that Senior Care will be flawed without inclusion of nursing home stays in the capitation.<sup>17</sup> Two other managed care programs in Florida that integrate acute care and LTSS are much smaller. There are two PACE sites, one at Jewish Home and Gardens in Miami, which is authorized for 150 enrollees and currently has about 70, and a newer one in Fort Myers; these programs, of course, capitate both Medicare and Medicaid services for dually eligible seniors. Florida also has a Frail Elder Option program which capitates all Medicaid services; it is limited geographically to three counties and in 2005 served slightly short of 5000 participants. Advocates for younger people with disabilities including persons with MR/DD are steadfastly opposed to integrating acute care and LTSS under managed care options.

## **Conclusions**

The State of Florida houses many innovative programs to meet LTSS challenges, and has made substantial strides in efforts to achieve a full range of choice and inclusion for people with MR/DD, including providing incentives for competitive employment. Those efforts have become stagnated at present because of general budget problems (due to the housing slump, a failing economy, Hurricane-related expenses, and a strong aversion to increasing taxes) and a specific crisis of financial management in the MR/DD programs. Several major efforts have

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Associate Director for Regulation and Training, Florida Health Care, and Kathy Lieblich, Director, Florida Pioneer Network.

<sup>17</sup> Mercer Government Human Services Consulting provided a document dated February 16, 2006, entitled Florida Senior Care: Inclusion of Funds for Medicaid Nursing Home Services, and arguing for MCOs to be at continuing financial risk for nursing home care. On web, last visited July 20, 2008 at [http://ahca.myflorida.com/medicaid/long\\_term\\_care/pdfs/mercer\\_nh-ltc\\_021606.pdf](http://ahca.myflorida.com/medicaid/long_term_care/pdfs/mercer_nh-ltc_021606.pdf) Feb 16, 2006

become stalled in the last year. In the case of Senior Care, a mandatory managed care plan for seniors dually eligible for Medicaid, the program's momentum also flagged because of stakeholder opposition.

Programs for older people needing LTSS have been bogged down in a multi-year struggle about the extent to which the LTSS strategy should rely on capitation of acute and LTSS services to management by Managed Care Organizations. This was a favored solution in both the Lawton Chiles and Jeb Bush administrations, endorsed by successive secretaries of the Department of Elder Affairs and typically opposed by most Area Agencies on Aging and many advocates. This solution not only was consistency with the policy bent of various State administrations, but was seen as, in part, a compensation for structural problems in the delivery of services. Florida's LTSS programs are extraordinarily complex, and lack clear accountability in that the agencies that authorize services are not responsible for payment, which occurs retroactively. It was hoped that managed care organizations with the right incentives might consolidate accountability, and move cost-effectively to increasing community care for the elderly. At this writing, the mandatory Senior Care program that would have applied managed acute care and LTSS has been severely curtailed, and it is uncertain what strategy will take its place. Florida's development of consumer-directed options has been similarly slowed by budgetary limitations, and the deficit situation for the Agency for Persons with Disabilities, the biggest user of the program. Advocates for seniors have shown some ambivalence about consumer-directed options.

Promising recent developments in Florida include the development of a statewide network Aging Resource Centers (housed in the AAAs), some success in streamlining the eligibility process, serious attention to housing and transportation issues, and several creative efforts to bring government, government, and private philanthropy together around disability and aging

topics, including employment of people with disability, assistive devices, and (in the Communities for a Lifetime Initiative) creation of elder- and disability-friendly communities.

Florida has given concerted attention to improving nursing homes and to increasing staffing standards for nursing departments in nursing homes, and has achieved some success in measurable quality indicators and reduction in law suits. Expenditures in this area make it harder to shift the balance of Medicaid expenditures towards HCBS.

The structure of the new Governor's Commission on Disability may encourage high-level inter-agency cooperation on LTSS issues; its history is too recent to make a judgment. The actual structure of State agencies discourages cross-disability planning, program development, and accountability.