

**Rebalancing Long-Term Care Systems in Florida:  
Experience up to July 31, 2005**

**Abbreviated Report**

submitted to the

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The overall project is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. This baseline case study covers a period through July 31, 2005; updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was discussed at a CMS Open Door Forum, February 22, 2006. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the Florida Liaison to the study, Beth Kidder, Chief, Bureau of Medicaid Services, Florida Agency for Health Care Administration.

## Table of Contents

<b>Highlights</b> .....	<b>1</b>
<b>Context</b> .....	<b>2</b>
<b>Real Choice System Change (RCSC) Grants</b> .....	<b>3</b>
<b>Programs and Services</b> .....	<b>4</b>
<b>Featured Management Approaches</b> .....	<b>5</b>
Control of nursing home supply .....	5
Assisted Living Development.....	5
Developmental Disabilities Programs.....	5
Expansion of Consumer-Directed Services .....	5
Managed Long-Term Care for Older People .....	6
Spinal Cord Injury Program.....	6
Quality and Labor Force Initiatives for Nursing Homes and Licensed Providers.....	7
Aging Resource Centers in all 11 Area Agencies on Aging.....	7
<b>Quantitative Markers of Rebalancing</b> .....	<b>7</b>
Changing Patterns of Nursing Home Use as Marker of Rebalancing .....	7
Table 1: Change in Nursing Home Acuity at Admission and .....	8
3 Months Post Admission in Florida, 2002 - 2004 .....	8
Balance between Institutional and Community Care.....	8
<b>Conclusion</b> .....	<b>11</b>
Issues for Further Observation.....	11

## **Rebalancing Long-Term Care Systems in Florida: Abbreviated Report**

### **Highlights**

The State of Florida is a populous, highly urbanized state with a racially and ethnically diverse population; almost 35% of Floridians are either from minority groups of color or are of Hispanic origin.<sup>1</sup> Long a retirement Mecca, Florida has the oldest population of any state (17.8 % of the populace over age 65) and is thus a bellwether state for the rest of the United State's rapidly aging society. Florida has historically been innovative in long-term care and long-term support services, and the State now has an array of services and waiver programs in place, some statewide and some in developmental phases in specific counties.

Among the highlighted management approaches are:

- A multi-faceted approach to the nursing home sector including control of the growth of nursing home beds and use, tort reform, and a phased-in increase of nurse staffing ratios for nursing homes that renders Florida's requirements much more stringent than federal requirements.
- Investment in establishing standards for and public support of an expanding Assisting Living sector for older people. In Florida, the assisted living supply exceeds the nursing home supply.
- Expanding Consumer-Directed Care for all populations.
- Expansion of HCBS and community integration for persons with developmental disabilities
- Managed care options under HCBS waivers and a planned pilot of mandatory managed long-term care for seniors in 2 areas of the state (8 counties).
- An effective, individualized program for persons with Spinal Cord injury, begun with funding from traffic fines but now partly funded by the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) HCBS waiver.
- Re-considering functions of aging network, and developing an aging resource capacity in every Area Agency on Aging.

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<sup>1</sup> This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Florida, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, will appear over the next few months on the website [HCBS.org](http://www.hcbs.org) and on the University of Minnesota's Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. The report covers a period up to July 31, 2005; subsequent reports will update the case study as of July 2006 and July 2007.

- Substantial investment in training and quality improvement efforts in all licensed care settings, particularly nursing homes. This includes a state-funded teaching nursing home, which develops and disseminates training materials, a state-sponsored risk-management program for nursing homes, and state-wide training on Alzheimer's disease.

### **Context**

- A fiscally conservative state government, with goals of minimizing tax burdens. The State is also interested in reducing the size of direct government and contracting with the private sector for a wide array of program operations.
- Governor Jeb Bush has emphasized services for persons with developmental disabilities from the beginning of his administration, creating a climate conducive for expansion of HCBS and opportunities for community integration for persons with developmental disabilities.
- Florida has not consolidated state agencies for long-term care in the manner noted in other states, but rather has created new higher profile agencies for specific populations over the years. The Florida Agency for Health Care Administration (AHCA) carries overall responsibility for Medicaid. At one point, a large the Department of Health and Rehabilitative Services was the major operating agency: the Health Department was split off into a separate department in the 1980s, leaving the Department of Children and Family Services (DCF) in the former HRS. In 1991, the Department of Elder Affairs was created as the cabinet-level focal point for Aging Services. In 2004 the Agency for Persons with Disabilities was removed from DCF to form a separate agency, serving individuals with developmental disabilities.
- Local level entry to services is somewhat complex and differs for various populations. Among the features:
  - Financial eligibility is processed through the Department of Children & Family Services. Some commentators believe the process is too protracted to be optimal for consumers with emergency needs.
  - The Aging Network in Florida operates through 11 Area Agencies on Aging, each of which further contracts with lead agencies that provide case management and services for a geographic area. The Aging Network operates a large state-funded program, Community Care for the Elderly (CCE), which predates HCBS waivers. CCE is now in part used to provide waiver match, and it also operates a program of small cash allowances, called Home Care for the Elderly.
  - Florida has had a longstanding process of state-wide assessment for waiver programs through its CARES program (Comprehensive Assessment Review and Evaluation of Services), which is performed by regional CARES teams employed by the Department of Elder Affairs, serves as a preadmission screening function, and generates priority scores for services. Florida also has invested in a related CIRTS (Client Information Registration and Tracking System) process

administered by lead agencies, which includes certification and recertification for a wider array of services. The CARES and CIRTS data bases (built on an almost identical assessment) can be and are combined with billing data to allow the State to commission studies to inform itself about the characteristics and outcomes of consumers using a variety of services.

- Developmental Services (DS) are managed through contracted support counselors who provide a coordination service and a very large array of contracted agencies. The front-end assessment for DS is distinctive from the CARES system, and thus the analyses that can be performed for Seniors. Individual-level characteristics of consumers with DD are not readily available in the CARES and CIRTS systems.
- By the end of the 20<sup>th</sup> century, Florida nursing homes and ALFs had experienced a high rate of successful tort litigation and/or large out-of-court liability settlements. This litigation, in turn, affected the ability of Florida providers to obtain liability insurance. The State was forced to consider the extent to which its problems with litigation were the result of poor quality of care or the result of marketing by trial attorneys combined with state rules for coverage of attorney fees. The State formed a high level task force to study these issues, and the Task Force itself had to grapple explicitly with the issue that moneys used to improve staffing levels in nursing homes would reduce moneys available to expand the HCBS side. New Florida policies address these issues in a balanced way by creating new and higher nurse staff ratios for nursing homes, tort reforms reducing incentives for suits, and making new money available for HCBS (but the high costs of nursing home increases also made a demand on State budgets).

### **Real Choice System Change (RCSC) Grants**

Florida has received a total of \$3,776,746 in RCSC funding from 2001 to 2004, somewhat less per capita than the awards received by many other, usually less populous states. The largest grant was a Real Choice award of \$2.0 million in 2001. This grant funded a Partnership Project organized around four objectives: create operational linkages among State agencies and service providers; streamline the delivery of services to consumers; create a comprehensive single point of contact and inquiry for individuals, and develop community support networks. The effort is managed by the ADA Working Group, the State's Olmstead Planning Group. Florida also received a 2003 grant for an Independence Plus Initiative, which went to the Department of Children and Family Services to fund the Florida Freedom Initiative, and a 2004 grant for a Quality Assurance and Quality Improvement Initiative for the Agency for Persons with Disabilities to create a customer approach to quality management. In 2004, the Department of Elder Affairs received \$799,945 for Aging and Disability Resource Center development, which will be an important plank in Florida's current planned development.

## **Programs and Services**

Florida operates 12 section 1915 (c) HCBS waivers for the elderly and persons with disabilities. The State's largest HCBS waiver is the Developmental Services (DS) Waiver operating since 1982 for persons with developmental disabilities, which in FY 2001 accounted for nearly half of the state's HCBS waiver enrollees and 72% of the state's HCBS waiver expenditures. Recently, a second waiver, Family Supportive Living (FSL), was developed for people with developmental disabilities. FSL offers a less rich mix of services and is open to those on waiting lists for the DS waiver, as well as for those whose needs can be met through FSL. The Aged and Disabled Adult (A/DA) waiver was also established in 1982 (initially including DD until the latter split off in 1985); about 4/5 of the A/DA waiver slots are operated by the Department of Elder Affairs and the remainder by the Department of Children & Family Services (DCF) for younger adults. Other waivers of varying sizes and coverage include the Channeling Waiver for Frail Elders (in 2 counties); Project AIDS Care, Assisted Living for the Elderly (ALE), Traumatic Brain Injury/Spinal Cord Injury, Adult Cystic Fibrosis, Adult Day Health Care (in 2 counties), the Model Waiver (formerly, the Katie Becket waiver), and the Alzheimer's Disease waiver (in 4 counties). Finally the Nursing Home Diversion (known as the Diversion Waiver) provides Medicaid waiver and all other Medicaid long-term care services to seniors through managed care organizations. The Diversion waiver now operates in 26 counties and forms the basis for the Florida Senior Care plan, a pilot to be operated in 2 areas of the state (8 counties).

Other services in Florida under the State Medicaid Plan include a large home health and hospice benefit. Personal care is largely not available under the State Plan with some exceptions for children and for the Assisted Services benefit, which supports services in assisted living to people not on the ALE waiver. Targeted case management and case management under children's health services are also in the state plan. Florida also operates state-funded services for older people, most notably the Community Care for the Elderly (CCE) program operated through the Aging Network, and Home Care for the Elderly (HCE), a cash program also operated through the Aging Network.

Under the Medicaid State Plan, Florida operates a PACE site in Miami/Dade County. Under a 1915(b) waiver, Florida operates a Medicaid managed care program including long-term care for frail elderly persons in 2 counties. It also used an 1115 waiver for the state's Cash & Counseling demonstration program, which is continuing under a Consumer Direction + Plus Waiver that is open to individuals who are first enrolled in one of the other HCBS waivers (A/DA, DD, TBI/SCI).

## **Featured Management Approaches**

### **Control of nursing home supply**

Florida successfully controls the growth of its nursing homes through a Certificate-of-Need process combined with periods of moratorium. In 2003, Florida had 28 nursing home beds per 1000 person over age 65, compared to 49 beds for the United States. The occupancy rate for nursing homes in 2003 was 87.2%, higher than in 1998 due to the lowered overall supply of beds as a result of the moratorium.

### **Assisted Living Development**

Florida has developed a capacity for long-term support services within its large residential care sector, formerly known as Adult Congregate Living Facilities (ACLFs) and now known as Assisted Living Facilities (ALFs). In 2004, the state had 2,250 assisted living facilities (ALFs) with 74,763 units, a capacity greater than Florida's nursing home capacity. Florida has introduced 3 add-on licenses for ALFs wishing to provide a higher than standard level of care: Extended Congregate Care (ECC); Limited Nursing Care; and Limited Mental Health. ALF services are covered under an HCBS waiver for tenants over age 60 who qualify on the basis of need (somewhat higher than the nursing home certifiability criteria) in ALFs that also meet the requirement. In 2004, 581 ALFs provided waiver services to 4,167 participants. Another financing mechanism to help low-income persons afford ALFs is through an optional State supplement to the federal SSI payment. Finally as of 2001, Assisted Care Services (ACS) was implemented under the Medicaid State plan for supportive services to eligible residents in ALFs who might either not be eligible for the waiver or for whom no waiver slot is available. In 2004, 1,527 ALFs participated in the ACS program and provided state plan services to 14,188 consumers.

### **Developmental Disabilities Programs**

Florida is dramatically expanding HCBS services for persons with developmental disabilities while also introducing more accountability into the program. Under court order but also in keeping with State goals and the Governor's expressed priorities, planned downsizing and closure of remaining state institutions is underway. Building blocks for the changes include: creation of the Agency for Persons with Disability (APD), formerly a unit within the Department of Children & Family Services; development of an additional waiver, Supportive/Family Living, which has a very wide array of services but applies more stringent monetary caps than does the large Developmental Disability waiver; vigorous efforts to reduce the waiting list for waiver services; emphasis on employment in the Florida Freedom Initiative; and piloting of a customer-focused quality monitoring approach.

### **Expansion of Consumer-Directed Services**

Florida is expanding consumer directed services for all populations including seniors, people with disabilities under age 65, and people with developmental disabilities of all ages. The State became one of 3 States participating in the Cash and Counseling National Demonstration. Florida included 3 waivers in this demonstration and was the only State to include children. After the successful demonstration period, Florida expanded the program under a waiver called Consumer Directed Care+, which is open to persons enrolled in the Aging and Disabled Adult Waiver, the Developmental Services Waiver, or the Traumatic Brain Injury/Spinal Cord Injury

Waiver. As of July 2005, however, only 128 people over 65 participated in the consumer directed waiver.

### **Managed Long-Term Care for Older People**

Florida has considerable experience with testing managed long-term care mechanisms through contracts with private managed care organizations, and is planning further expansion of that modality. The State operates a Frail Elders program of managed Medicaid services in two counties under an 1915(b) waiver and one PACE program under the Medicaid State Plan in Miami. The State's largest experience with managed long-term care is through the Nursing Home Diversion Waiver (known simply as the Diversion Waiver), which operates through managed care organizations in 26 counties and, during the time period of this case study, bore complete financial risk for nursing home care. Notably, in its management of the Diversion Waiver and other managed care initiatives for long-term care, Florida requires that the MCOs keep encounter records, which enables the state to understand and compare services received under the waivers to those received under fee-for-service. This allows the State to monitor an unusual level of detail in its managed care programs, and gave Florida the necessary information to adjust the capitation rate for the Diversion program in 2005, based on a new rate methodology that was certified by the Agency for Health Care Administration's contracted actuary.

In May 2005 the Legislature enacted a Bill authorizing the Agency for Health Care Administration and the Department of Elder Affairs to implement a managed, integrated long term care program (Florida Senior Care) in two areas of the State. The hallmarks expected from this demonstration will be better management of health conditions, while maintaining flexibility of service options. The Florida Senior Care program will be piloted on a mandatory basis in the Pensacola area, where the contracted managed care organizations (MCOs) will receive capitation to cover all long-term care services for persons age 60 or more, including services usually covered under waivers, the Medicaid state plan, and the state-funded programs such as CCE; Florida Senior Care will be piloted as a voluntary program in the Orlando area. At the time of this writing, the MCOs were to be at full (not time-limited) risk for Medicaid services for enrollees. Details of Florida Senior Care were still being planned at the end of the baseline study time period with the expectation that a request for a 1915(b) and 1915(c) waiver would be submitted in early 2006. At present planning, Florida Senior Care would include all persons age 60 and over except seniors on the Developmental Disabilities or TBI/Spinal Cord Injury waivers, seniors already in managed long-term care such as PACE, seniors in the consumer-directed waiver, Project AIDS Care, and seniors on Florida Assertive Community Treatment (FACT) teams.

### **Spinal Cord Injury Program**

The Spinal Cord Injury program operated in Florida is unusually vigorous in its epidemiological and rehabilitative approach. The program has flexibility of resources because of its use of funds from traffic fines. A data base was developed for all persons with spinal cord injuries, including newly injured individuals and people in nursing homes, and a vigorous and successful effort was undertaken to help almost all persons with spinal cord injuries return to the community.

### **Quality and Labor Force Initiatives for Nursing Homes and Licensed Providers**

Florida has given major attention to the quality of its nursing homes and has implemented several strategies to improve service: 1) a phased-in requirement for increased nurse staffing ratios in nursing homes; 2) a mandatory risk management program; 3) a state-supported teaching nursing home program. These initiatives grew out of a bipartisan Task Force convened in 2000 to study and address several inter-related problems in Florida that added up to a mounting crisis: 1) the perception that quality nursing home care was poor; 2) the high rate of successful malpractice suits against nursing homes and ALFs in Florida with large damage awards or large out-of-court settlements; 3) the difficulty that NFs and ALFs in Florida were experiencing in getting insurances; and 4) concerns about insufficient HCBS services. These issues were examined together, with awareness that increased investment in nursing homes would draw resources away from HCBS. Ultimately some tort reform was achieved related to attorney's fees and caps on punitive settlements, the increased staffing ratios were mandated along with the risk management program, and new resources were applied to HCBS services. More generally, Florida mandates training requirements throughout all its licensed programs, including home care and hospice. Alzheimer's training is one of the required elements. The State funds a Teaching Nursing Home through the University of Miami and Jewish Home and Hospitals Douglas Garden, which in turn develops, tests, and disseminates state-wide educational programs for all nursing homes. Modules are typically available on DVD and are sophisticated in their design for particular learning objectives and audience—including professional and paraprofessional personnel. Examples of topics addressed include: falls prevention, conducting a mini-mental status exam, and assessing and treating depression.

### **Aging Resource Centers in all 11 Area Agencies on Aging**

The Aging Network has evolved uniquely in Florida, through a system of multi-county Area Agencies on Aging, which in turn contract with geographically based lead agencies (with a few exceptions, one per county). As the State plans for new ways of providing long-term care to seniors, largely through capitated MCOs, it also envisages that the Area Agencies on Aging will develop a stronger capacity to assist consumers in decision-making. Lead agencies will be free to provide services in arrangements with MCOs or, if they have the capacity, to compete for risk-bearing contracts. It is hoped that the Area Agencies on Aging can develop excellence as a resource for information about the full array of services and service providers.

## **Quantitative Markers of Rebalancing**

### **Changing Patterns of Nursing Home Use as Marker of Rebalancing**

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Florida nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in Florida deteriorated slightly from the average ADL score of 14.74 in 2002 to an average ADL score of 15.29 in 2004 (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). Moreover, the proportion of residents admitted with no ADL dependencies, or very few, decreased. During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.65 in 2002 to 1.55 in 2004 (the possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). The rate of persons with no cognitive impairment or mild impairment increased.

**Table 1: Change in Nursing Home Acuity at Admission and 3 Months Post Admission in Florida, 2002 - 2004**

	2002	2003	2004
<b>At Admission</b>			
Mean ADL	14.74	14.94	15.29
Mean CPS	1.65	1.60	1.55
<b>3 Months Post Admission</b>			
Mean ADL	13.98	13.99	14.41
Mean CPS	2.57	2.50	2.48

The ADL functioning at 3 months after admission deteriorated slightly over the 3 year period. The average ADL scores in 2002, 2003, and 2004 were 13.98, 13.99, and 14.41, respectively, suggesting more disability over time. Moreover, the proportion of persons with no and few ADL dependencies decreased. For cognitive functioning, the CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 was 2.57, dropped to 2.50 in 2003 and further dropped to 2.48 in 2004. However the proportion with no cognitive impairment changed little.

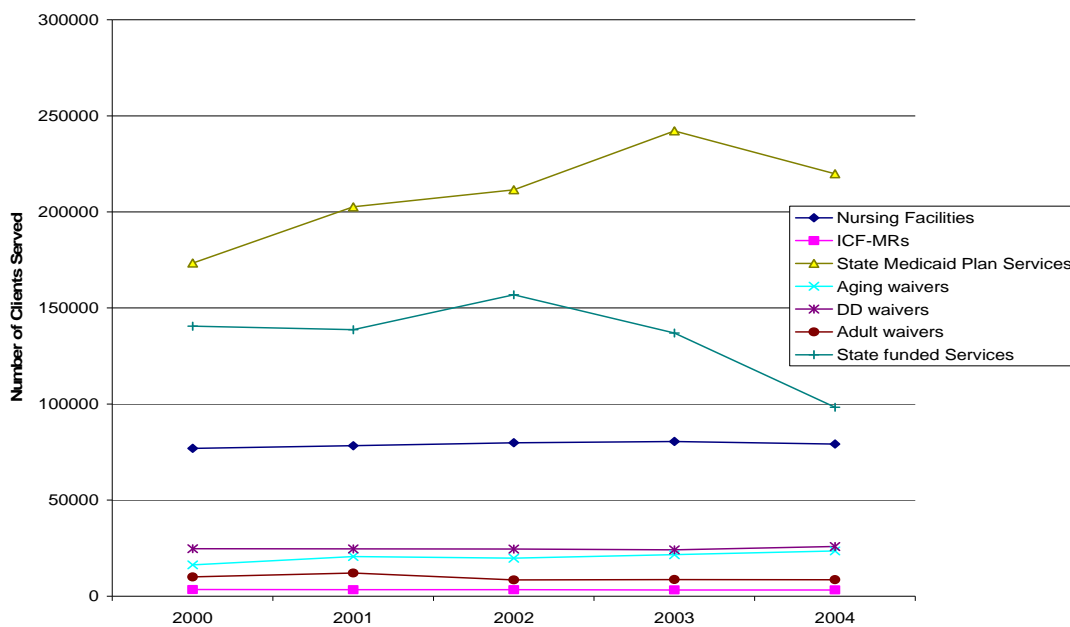
This pattern suggest that HCBS may have achieved that part of its goals of deflecting the clients with lower ADL needs to other sources, but the same effect was not seen for cognition.

**Balance between Institutional and Community Care**

Florida has a wide array of HCBS services, making possible many different kinds of comparisons. Results would vary depending on how programs are grouped. Figure 1 illustrates one such comparison of the number of participants in a variety of programs from 2000 through 2004. The State Plan Services (which for this analysis includes home health, hospice, and assistive services, and case management) served the largest number of participants, followed by the state funded services (Community Care for the Elderly, Home Care for the Elderly, Older Americans Act programs, and nursing homes). Despite the low supply of nursing homes, substantially more clients are served in nursing facilities than are served by HCBS waivers. In this analysis waivers were grouped to combine 3 waivers largely serving older people (the bulk of the Aged and Disabled Adult Waiver, the Channeling Waiver, and the Diversion Waiver), waivers serving developmental disabilities (the DS waiver and the Family Supportive Services Waiver), and waivers serving younger adults (the TBI/Spinal Cord Waiver, the Disability part of

the A/DA waiver, the AIDS waiver). Some of the smaller and/or newer waivers (Model Waiver, Cystic Fibrosis, Adult Day Health Care, and Alzheimer’s disease Waiver are not included.)

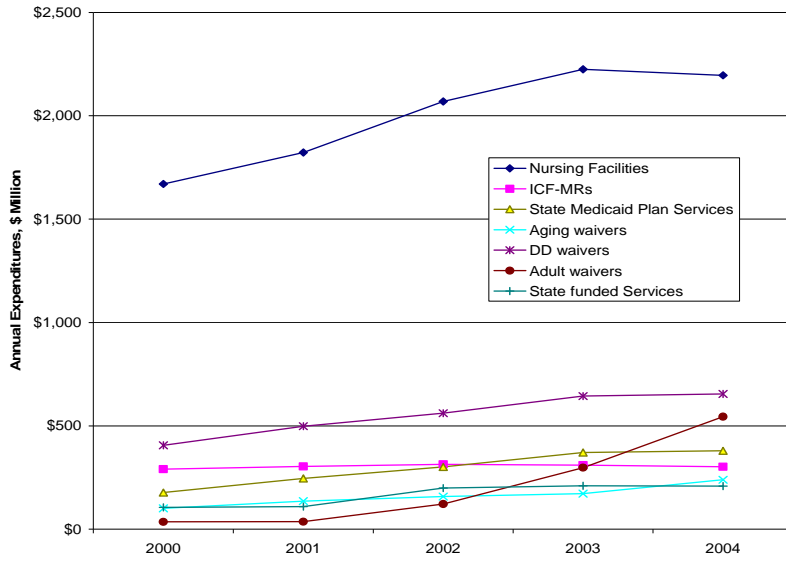
Mental retardation institutions in this analysis includes 3 types of ICFDDs: 1) state-run ICF-DDS developed within the 3 remaining state-operated DD institutions, which serve about 1100 people; 2) Cluster ICF-DDs, which are each comprised of 24 people in 3 separate 8-person buildings, and which were purpose-built on state land but are operated by private contractors; and 3) private ICF-MRs, which include a small number of older facilities with 64 or more people, and a larger number of small ICFs with 6 or fewer people. Taking all these institutions together, the number of people serviced in DD institutions is comparatively few.



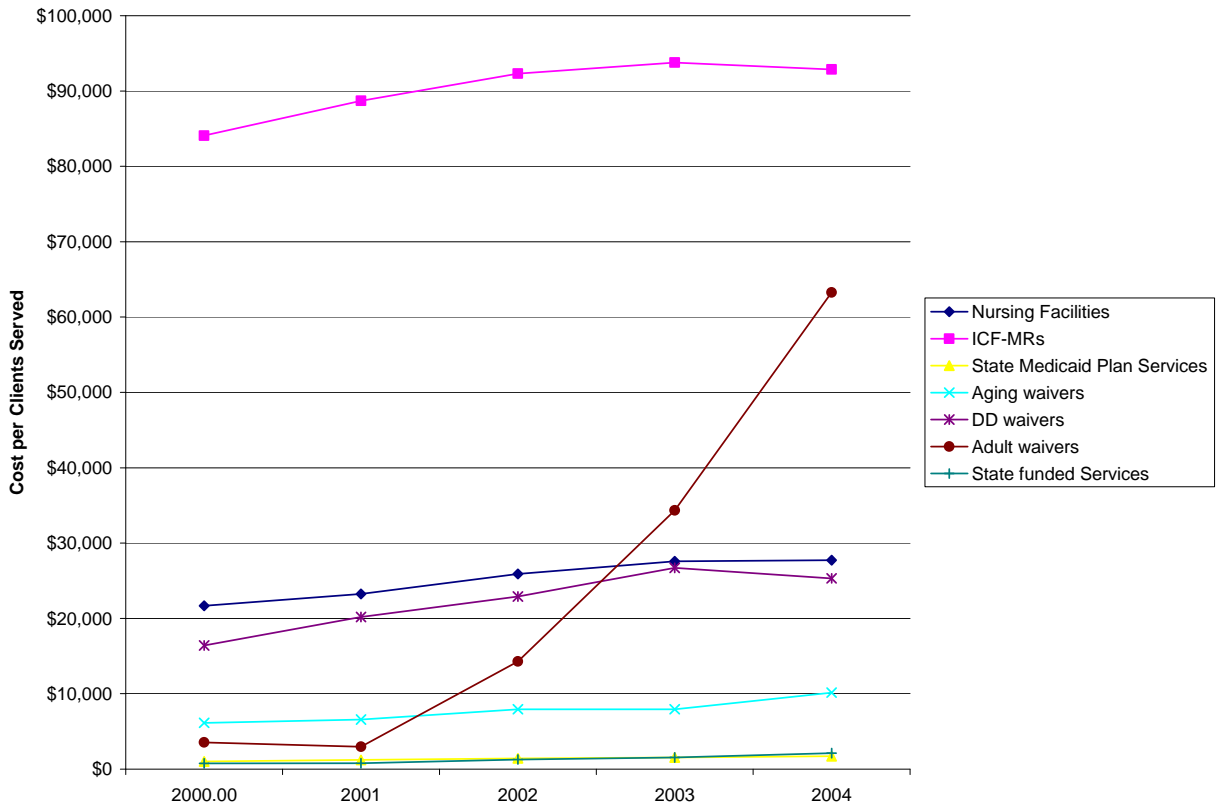
**Figure 1. Clients Served in Selected Florida Programs, 2000-2004**

Figure 2 traces the annual Medicaid expenditures for the same programs. The most money is spent on nursing home care, and those costs have continued to rise until 2004, partly as a result of the mandated increases in staff ratios. Considerably less, but next in order, were expenditures on DD waivers. The cost of adult waivers is increasing, while the rest of the expenditure categories are stable.

# Rebalancing Long-Term Care Services in Florida



**Figure 2. Expenditures for Selected Florida Programs, 2000 to 2004**



**Figure 3. Costs per Consumer Served in Selected Florida Programs, 2000-4004**

Figure 3 examines the Medicaid costs per client served. These costs may be affected by the fact that not all clients are served for a full year. The costs per MR/DD client served are consistently higher than those for elderly clients. The costs per elderly client served in a nursing facility are higher than those served in the community. The costs of adult waivers are escalating.

### **Conclusion**

Long-term care in Florida reflects an effort to balance expenditures designed to enhance the quality of nursing homes with the expenditures on HCBS services. The trend towards consolidating state agencies for long-term care, which was noted in some states, was not noted in Florida, and a plethora of waiver programs that emerged to meet historically perceived needs now co-exist. On the other hand, Florida is moving towards consumer-directed care models in many of its waiver programs, the State is expanding HCBS options for people with developmental disabilities, and the State is testing models for long-term care for seniors that rely on capitated payments to Managed Care Organizations. (The latter policies are occasioning some concerns among aging advocates about preserving the infrastructure for public programs and anxieties among provider agencies uncertain about their own futures under the new approach.) The State of Florida intends to develop a data system that allows it to “manage” the managed care efforts to ensure accountability and determine optimal capitation payments.

### **Issues for Further Observation**

Numerous initiatives recently undertaken or about to begin in Florida have potential to generate information of interest nationally. Among these:

- At the time of this baseline study, Florida was embarking on a plan for general Medicaid reform that would entail acceptance of a federal block grant for the Medicaid program. As this Medicaid initiative proceeds, it will surely influence Medicaid long-term care programs, which will also operate under the general budget.
- Now that higher nurse staff ratios and tort reforms have been in place for more than 5 years, it is of interest to observe the effects of those strategies on quality in nursing homes?
- Of great interest is the experience of the 2-area (8 county) demonstration of Florida Senior Care? We will want to observe, among other things, the ability to develop competitive Managed Care capacity; the nature and flexibility of the long-term support services generated in counties without the previous strong history of managed care such as in Southern Florida; the participation of lead agencies and other aging network providers; the use of assisted living facilities versus community providers; the infusion of consumer direction; the costs of the program; and the contrast between the county with a mandatory Florida Senior Care program compared to the one with a voluntary program. What Florida learns from these efforts will of great interest to the rest of the country.

- Given the plan to invest in managed long-term care, we will be able to observe how the Area Agencies on Aging and the lead service agencies in each county evolve in conjunction with the evolution of managed long-term care programs? In that regard, the experience of the Area Agencies in creating viable aging and disability resource centers in catchment area will be followed.
- Florida also affords an opportunity to examine the further evolution of consumer-directed care, and the take-up rates for that model in each of the waivers?
- Finally, we have an opportunity to observe the continuing experience in reducing use of ICF-MRs and moving towards more integrated community options for MR/DD?