FLORIDA ASSISTED LIVING ASSOCIATION (FALA)
2024 LEGISLATIVE SESSION PRIORITIES

FALA legislative priorities for the January 2024 legislative Session

Low income, frail elderly, and disabled Floridians deserve an acceptable quality of life and access to necessary care and services. FALA, its members, partners in care, and other stakeholders have identified three key items to improve quality of life, utilization of resources, and access to much needed care for Florida's most vulnerable population.

Therefore, FALA is proposing the following three key changes for the 2024 Legislative Session.

1) Increase **Personal Needs Allowance** ("PNA") for Eligible ALF Residents – See page 4
2) Increase Medicaid **Assistive Care Services** (ACS) Daily Fee Amount for ALFs – See page 12
3) Remedy Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) Wait List Issues Negatively Impacting ALF Residents – See page 14

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INTRODUCTORY OVERVIEW

Who is FALA:

The Florida Assisted Living Association (FALA) is Florida's largest and longest established trade association dedicated to the assisted living industry.

FALA has:

- nearly 500 assisted living provider members comprised of state licensed Assisted Living Facilities (ALFs) and Adult Family Care Homes (AHCHs)

- nearly 300 Associate Members comprised of various organizations who provide products and/or services to assisted living providers and/or their residents.

- provided advocacy, education, and regulatory support to members and the other providers for over 30 years.

Assisted Living Summary:

Assisted Living Facilities (ALFs) are regulated on the state level. Florida's model for assisted living was carefully constructed to allow for care to be provided in the least restrictive, most homelike environment possible. This promotes resident independence and an enhanced quality of life to allow Floridians to age in place in a community setting for as long as possible with dignity and respect.

ALFs range in size from two residents to several hundred residents offering resident-centered care. Personal care staff are employed to respond to scheduled and unscheduled needs. Amenities usually include three meals a day, housekeeping services, laundry service, transportation, security, and social and recreational activities.

Care services based on individual needs include: ADL Assistance (assistance with eating, bathing, dressing, toileting, transferring, and walking), medication management and help with self-administration of medication, memory care and care for residents with other cognitive impairments, oversight and coordination of necessary health care services (including primary care services, physician specialists, physical therapy, dental, podiatry, skilled nursing, home healthcare, hospice, and assistance with navigating payor challenges).

NOTE: Skilled nursing services may also be provided by appropriately licensed ALF staff, but only as permitted based on the ALF license type and the individually identified and contracted needs of residents.

These vital services provided by ALF staff help to promote quality of life and effectively reduce hospitalizations and other high-cost medical interventions.

Assisted Living Facility (ALF) vs. Skilled Nursing Facility (SNF or "Nursing Home")

Assisted Living Facilities (ALFs) and the type and level of care provided therein are distinct from Skilled Nursing Facilities (SNFs or "Nursing Homes"). While ALFs are viewed as being a "Residential or Community Setting", SNFs which are regulated on both the state and federal levels, are considered "Institutional Settings". Care provided by an ALF is viewed as "Custodial Care" vs. the (24-hour) "Skilled Care" provided by a SNF.

Pursuant to Chapter 429, Part I, Florida Statutes, The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities."

NOTE: Whereas Skilled Nursing care is recognized as a state and federal "Entitlement" (the right to a particular privilege granted by law to those who qualify), Assisted Living care is not. Access to reimbursement for assisted living care for low-income individuals (eligible for Medicaid) exists only on a state level, is "Privileged," and only available through Medicaid Waiver Programs.

Due to frequent misunderstanding of assisted living services and the significant differences between SNFs and ALFs, benefits, improvements, and funds approved and allocated for SNFs and their residents are often assumed to also apply to ALFs and their residents. In fact, most often they do not.

Florida's Current Long-Term Care Crisis:

Florida ranks # 1 in the nation for its percentage of residents age 65+ and is second only to California for the total number of residents age 65+. Not only are our elderly the fastest growing segment of our population, but people are living longer than ever, causing them to outlive their resources and become reliant on Medicaid as their care needs continue to increase with advanced age and disability.

Assisted living providers are rising to meet these challenges by offering critically important and notably cost-effective care to Florida's most vulnerable population. Unfortunately, assisted living and its important role in the healthcare continuum is often misunderstood and has been largely overlooked, causing assisted living services to be undervalued and, in many ways, historically excluded from both private and government funding sources allocated for long-term care needs. This has put a strain on assisted living providers and restricted access to much needed care and services for a great number of low-income Floridians.

Due to insufficient funding, there are fewer and fewer Assisted Living facilities willing and able to accept low-income/Medicaid dependent Floridians and provide them with the quality care and services they need. Each year the demand for care and services increases in Florida, and so the supply and access to care must follow suit.

Increase Personal Needs Allowance for Eligible ALF Residents

Current Situation:

Currently, ALF residents who are eligible for Medicaid and Optional State Supplement (OSS) receive a monthly Personal Needs Allowance (PNA) that is set at a rate of $54 per month. This amount (a minimum monthly sum that an individual may retain from his/her own income to cover personal expenses not covered by Medicaid) was established in 2001 and has not been revisited since. In contrast, the PNA for a Medicaid recipient residing in a SNF is currently $160 per month. The PNA for individuals residing in SNFs has been raised several times over the years to account for cost-of-living increases, while no such increase has been given to individuals residing in ALFs.

Access to funds for personal needs promotes a sense of independence and enhances the quality of life of individuals. Significant increases in cost of living from 2001 to 2023 have rendered the $54 PNA received by ALF residents insufficient.

As a result, many ALF providers caring for low-income residents who are reliant on a PNA for their personal needs are often confronted with having to allow their residents to go without or having to compensate for the deficit using their own operating funds. This causes financial strain and jeopardizes the ALF's ability to continue operating and providing quality care and services to our most vulnerable.

Additionally, the difference in PNA between SNFs and ALFs often contributes to decisions by individuals who are eligible to transition from an institutional care setting (SNF) to a community setting (ALF) to remain within the institutional setting at a significantly greater expense to the Medicaid system.

Background on Personal Needs Allowance (PNA):

The Personal Needs Allowance (PNA) establishes a minimum monthly sum of money that low-income individuals receiving Medicaid may retain for personal expenses from their personal income. Any income above the PNA is applied toward the cost of their care.

Federal law requires that Medicaid beneficiaries residing in long-term care Skilled Nursing Facilities (SNFs/Nursing Homes) receive a PNA. The PNA is intended to cover the personal expenses of individuals residing in long-term care SNFs which are not covered by Medicaid. This may include but is not limited to haircuts, vitamins, clothing, shoes, magazines, and snacks.

The PNA for individuals residing in SNFs (classified as "institutional" settings) is referenced in **42 CFR § 435.725 - Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care**, which states: "The agency must reduce its payment to an institution for service provided to an individual by the PNA owed to the individual and the remaining amount stays with the institution."

NOTE: The PNA is focused and defined to retain monies to patients in SNFs which are defined as institutional care settings. There does not exist a definitive PNA definition that includes Assisted Living Facilities (ALFs).

2023 Increase in Personal Needs Allowance (PNA) for Skilled Nursing Facilities (SNFs/Nursing Homes):

As passed by the Legislature during the 2023 Legislative Session and approved by the Governor, the FY 2023-24 General Appropriations Act (SB 2500) includes the following proviso language as directive from the Legislature:

> *From the funds in Specific Appropriations 218, 219, 220, 221, and 222, $7,147,436 in recurring funds from the General Revenue Fund and $10,569,437 in recurring funds from the Medical Care Trust Fund are provided to the Agency for Health Care Administration to increase the personal needs allowance from $130 to $160 per month for residents in institutional settings.*

NOTE: The above proviso language addresses Medicaid residents of "institutional settings" which does not include assisted living facilities.

Personal Needs Allowance (PNA) for Assisted Living Facilities (ALFs):

The PNA for ALF residents exists in **Chapter 65A-2.036, Florida Administrative Code (FAC): Optional State Supplementation (OSS) Base Provider Rates and Program Standards** which provides for funds appropriated by Florida's Legislature for OSS eligible individuals (individuals receiving Supplemental Security Income (SSI) - monthly payments to individuals with disabilities and older adults who have little or no income) to receive a PNA. **Rule 65A-2.036, FAC,** establishes the personal needs allowance for eligible ALF residents at a rate of $54.

NOTE: The ALF residents' PNA does not vary according to the type of license of the ALF where the individual resides.

The PNA for eligible ALF residents was set at $54 in 2001 and has not been revisited since. However, **Rule 65A-2.036, FAC, Section (7)** states that PNA "shall be increased by the annual cost-of-living adjustment."

Proposed Solution:

Add budget proviso language to the FY 2024-25 budget similar to what was included for Medicaid residents of "institutional settings" that would provide a needed and long overdue increase to eligible Medicaid recipients in ALFs.

> *From the funds in Specific Appropriations _____, $_____ in recurring funds from the General Revenue Fund and $_____ in recurring funds from the Medical Care Trust Fund are provided to the Agency for Health Care Administration to increase the personal needs allowance for from $54 to $160 per month for residents in assisted living facilities.*

Applicable Statutes and Rules

s. 435.725, F.S. Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

(a) Basic rules.

(1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) Required deductions. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) Maintenance needs of family. For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) Continued SSI and SSP benefits. The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income—(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses—(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

Rule 65A-2.036, FAC - Optional State Supplementation Base Provider Rates and Program Standards.

(1) The Department establishes the base provider rates for specialized living arrangements (the amount the individual is to pay the facility) specified in subsection (4), below, within funds appropriated by the Legislature. Base provider rates may vary depending upon type of specialized living facility and covered services in such facilities.

(2) Within the funds appropriated by the Legislature, Optional State Supplementation (OSS) eligible individuals receive a standard personal needs allowance (PNA), the amount the individual keeps for personal needs. The PNA is established by Legislative proviso language. The individual’s PNA does not vary due to type of specialized living facility and covered services in such facilities.

(3) Optional State Supplementation Program Financial Standards. Optional State Supplementation Program financial standards are subject to Florida legislative appropriations and federal cost-of-living adjustments.

(a) The monthly income eligibility standard for residents of Assisted Living Facilities (ALFs), Adult Family Care Homes (AFCHs) and, except as specified in paragraph (b), below, Mental Health Residential Treatment Facilities (MHRTFs) is $872.40.

(b) The monthly income eligibility standard for residents of MHRTFs that do not meet the criteria for enrollment as qualified Medicaid providers of Assistive Care Services (ACS), and for individuals with coverage under subsections 65A-2.033(3) and (4), F.A.C., is $979.00.

(c) The personal needs allowance is $54.

(4) Optional State Supplementation Base Provider Rates. Optional State Supplementation base provider rates are subject to Florida legislative appropriations and federal cost-of-living adjustments.

(a) For ALFs, AFCHs and**,** except as specified in paragraph (b), below, MHRTFs, the monthly base provider rate is $872.40 and is inclusive of room and board only.

(b) For MHRTFs that do not meet the criteria for enrollment as qualified Medicaid providers of ACS, and for the individuals covered under subsections 65A-2.033(3) and (4), F.A.C., the monthly base provider rate is $979.00 and is inclusive of room, board and personal care.

(5) To calculate the amount of the OSS payment, the base provider rate is added to the standard PNA to determine the individual's total needs. From this sum, the individual's gross income, minus the allowable exclusions at rule 65A-2.035, F.A.C., is subtracted, resulting in the amount of the OSS payment.

(6) Payment for the month of admission to the special living arrangement shall be prorated if the month of admission is the month of application or later. For months other than the month of admission, payment begins the first day of the month.

(7) The monthly income eligibility standards of paragraphs (3)(a) and (b), above, and the base provider rates established at subsection (4) above, shall be increased by the annual cost-of-living adjustment to the federal benefit rate, provided the average state optional supplementation contribution does not increase as a result.

(8) The payment is issued monthly through an automated delivery system.

(9) This rule will be reviewed and repealed, modified, or renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 409.212(7) FS. Law Implemented 409.212 FS. History–New 1-1-77, Amended 9-27-79, 10-7-80, 9-29-81, 9-29-82, 10-31-83, 11-28-83, 9-30-84, 10-1-85, Formerly 10C-2.36, Amended 1-1-87, 2-9-88, 11-6-88, 2-16-89, 3-1-90, 1-27-91, 2-19-95, Formerly 10C-2.036, Amended 1-27-99, 12-16-01, 5-14-02, 11-26-18, 6-30-19, 6-11-20, 10-26-21.

Rule 65A-2.035 - Income Calculation.

(1) To be determined eligible for Optional State Supplementation, an individual must not have gross monthly income, after the following exclusions, in excess of Department standards, as found in subsection 65A-2.036(3), F.A.C.:

(a) Gross income, less an earned income exclusion of $65 plus one-half of the remaining earned income;

(b) Other federal exclusions to the individual's income; and,

(c) Additional exclusions provided by Section 409.212(5), F.S.

Rulemaking Authority 409.212(7) FS. Law Implemented 409.212 FS. History–New 1-1-77, Amended 9-29-82, Formerly 10C-2.35, Amended 1-27-91, Formerly 10C-2.035, Amended 12-16-2001.

Universal Citation: FL Admin Code R 65A-2.032

Current through Reg. 49, No. 124; June 27, 2023
(1) An eligible individual must be age 65 or older, or age 18 or older and blind or disabled as defined by Title XVI of the Social Security Act (SSA). Federal disability criteria are found at 20 C.F.R. §§ 416 et seq.

(2) An eligible individual must be living in the state of Florida with the intent to remain.

(3) An eligible individual must be a United States citizen or a qualified noncitizen as defined in 8 U.S.C. § 1641(b).

(4) An eligible individual must have income within standards established by the Department in subsection 65A-2.036(3), F.A.C.

(5) An eligible individual must have assets within SSA Title XVI standards for Supplemental Security Income (SSI).

(6) An individual must apply for and seek a determination of eligibility for all other monetary benefits for which they may be entitled or otherwise potentially eligible as required by 20 C.F.R. § 416.210 for the SSI Program and by 42 C.F.R. § 435.608 for the Medicaid Program.

(7) An eligible individual must be living in a licensed Assisted Living Facility as defined in Section 429.02(5), F.S.; a licensed Adult Family Care Home as defined in Section 429.65(2), F.S.; or a licensed Mental Health Residential Treatment Facility as defined in Section 394.67(23), F.S. Additionally, the facility must meet the individual's needs based on objective medical and social evaluations and care plans, in accordance with Chapter 59A-36, 59A-37 or 65E-4, F.A.C., respectively.

(8) Pursuant to Section 429.67(8), F.S., the Department of Children and Families will refer residents who receive Optional State Supplementation (OSS) to adult family care homes by providing the resident with the Adult Family Care Home Referral Notice, CF-ES 2202, 08/2009, incorporated by reference and available athttp://www.flrules.org/Gateway/reference.asp?No=Ref-13625. The following non-English versions of the Adult Family Care Home Referral Notice are incorporated by reference: CF-ES 2202H (Creole), 08/2009, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-13625, and CF-ES 2202S (Spanish), 08/2009,http://www.flrules.org/Gateway/reference.asp?No=Ref-13626.

(9) When appropriated OSS funding is insufficient to meet fiscal demands, a proportional reduction will be applied to OSS payments, but shall not affect maintenance of effort required per 42 U.S.C. § 1382g.

(10) This rule will be reviewed and repealed, modified, or renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 409.212(7), 429.67(8) FS. Law Implemented 409.212, 429.67(8) FS. New 1-1-77, Amended 9-29-81, 10-31-83, Formerly 10C-2.32, Amended 9-30-86, Formerly 10C-2.032, Amended 12-16-01, 2-25-10, Amended by Florida Register Volume 47, Number 198, October 12, 2021 effective 10/26/2021.

FLORIDA ASSISTED LIVING ASSOCIATION
2024 LEGISLATIVE SESSION PRIORITIES

Increase Medicaid Assistive Care Services Daily Fee for ALFs

Current Situation

Low income, frail elderly and disabled Floridians deserve an acceptable quality of life and access to necessary care and services. Due to insufficient funding, there are fewer and fewer Assisted Living Facilities willing and able to accept low-income Medicaid recipients and provide them with the quality care and services they deserve.

The current rate of reimbursement ($13.37 per day) to Assisted Living Facilities (ALFs) for Medicaid residents under Florida's Medicaid Assistive Care Services (ACS) Program is not only restricting access to care for our most vulnerable population but is also contributing to an increased need for placement of low-income frail elderly and disabled Floridians in institutional care settings.

Florida's Medicaid Assistive Care Services (ACS) Program

Funding and access to reimbursement for assisted living care for low-income individuals (eligible for Medicaid based on a maximum total monthly income of $1,215 per month) exists only on the state level, is "Privileged" (not an "Entitlement"), and is only available through Medicaid Waiver Programs.

For low-income Medicaid eligible individuals with functional or cognitive deficits, the **Florida Medicaid Assistive Care Services (ACS) Program** under the **Home and Community Based Services Waiver** provides additional funding for individuals residing in Medicaid enrolled Assisted Living Facilities (ALFs), Adult Family Care Homes (AFCHs), or Residential Treatment Facilities (RTFs).

The purpose of Florida's ACS Program is:

- To promote and maintain the health of eligible Medicaid recipients who require an integrated set of services;

- Minimize the effects of illness and disabilities to delay or prevent institutionalization, and allow the individual to continue to reside in the community

Assistive Care Services Provided by Facility Staff:

Services must include scheduled and unscheduled care by facility staff on a 24-hour per day basis when needed by the qualifying Medicaid resident.

Assistive Care Services provided by facility staff include:

- Health Support Services – oversight and coordination of necessary health care services including but not limited to: primary care services, physician specialists, physical therapy,

mental health services, dental care, podiatry, skilled nursing, home healthcare, and hospice care.

- Medication Assistance – including Assistance with self-administration of medication.

- Assistance with ADLs – including eating, bathing, dressing, toileting, transferring and walking.

- Assistance with Instrumental ADLs – including shopping for personal items, making telephone calls, managing money, scheduling appointments etc.

The current (2023) daily reimbursement rate for Medicaid Assistive Care Services (ACS) under the Home and Community Based Services Waiver is **$13.37 per day** under **Rule 59G-4.002, FAC – Assistive Care Services Fee Schedule.**

Effective Year	Maximum Fees	Maximum Allowable Unit
2011-2022	$12.25	1 per day
2023	$13.37	1 per day

The current rate of reimbursement to Assisted Living Facilities (ALFs) through Florida's Medicaid Assistive Care Services (ACS) Program is insufficient to cover the costs associated with providing all the care and services needed by frail elderly and disabled Medicaid residents and achieve the purpose of the program which is to prevent or delay institutionalization allowing individuals to remain aging in place within in a community setting for as long as possible.

As a result of insufficient funding, many ALF providers have stopped accepting Medicaid dependent residents. Others must make the difficult decision to send residents to a higher level of care as resident needs and the cost of care continue to rise. Although these individuals are frequently still within the scope of care that can be provided by the ALF, the number of staff hours required far exceed ACS reimbursement rates.

Medicaid eligible residents who are discharged from an ALF are frequently sent to long-term care Skilled Nursing Facilities (SNF/Nursing Home/Institutional Setting) because options within a community setting are limited due to lack of funding and this higher level of care (which costs significantly more than ALF care) is an "Entitlement" which allows for access to additional Medicaid funding. Some of these individuals will reside in the institutional setting (SNF) for the required minimum of 60 days, allowing them to apply for "priority enrollment" for Home and Community-based Services through the Long-term Care Managed Care Program in hopes of gaining access to additional funding so they may transition back to an ALF. Others will remain in the SNF for the rest of their days.

Proposed Solution

Support increased reimbursement rates for Medicaid ACS under the Home and Community Based Services Waiver to an amount that aligns with the cost of care and cost of living in conjunction with the increases in hourly wages.

FLORIDA ASSISTED LIVING ASSOCIATION
2024 LEGISLATIVE SESSION PRIORITIES

Remedy The Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) Wait List Issues Negatively Impacting ALF Residents

Current Situation

Florida ranks # 1 in the nation for its percentage of residents age 65+ and is second only to California for the total number of residents age 65+. Not only are our elderly the fastest growing segment of our population, but people are living longer than ever, causing them to outlive their resources and become reliant on Medicaid as their care needs continue to increase with advanced age and disability.

Florida's Statewide Medicaid Managed Care (SMMC) Long-Term Care Program provides home and community-based services to help low-income individuals receive the care and support services they need to age in place in a community setting to delay or prevent institutionalization. Florida's SMMC Long-Term Care program is not an entitlement program like the Medicaid state plan ("regular Medicaid"). Individuals who apply must be "screened" or assessed to find out if they are eligible to receive services. Individuals determined eligible are then placed on a waitlist and released from the waitlist as enrollment becomes available.

The Florida Department of Elder Affairs (DOEA) works with Aging and Disability Resource Centers (ADRCs) to manage the Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) wait list. Information about the LTC waitlist can be found at: https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/long-term-care-program/smmc-ltc-program-waitlist-release

Response on October 2, 2023, to a public records request by FALA from the Agency for Health Care Administration (AHCA) revealed **43,335 low-income individuals on Florida's Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) wait list**. The information below further demonstrates that with advanced age, there exists more need for care and supportive resources. The greatest number of Medicaid eligible individuals on the wait list are those 85 years of age or older.

Age of Individuals	60-64	65-69	70-74	75-79	80-84	85+
# of Individuals	3,251	4,965	6,354	7,906	8,348	12,511

SMMC LTC Waitlist – 10/02/2023

Florida's LTC waitlist is not based on a first come first served basis. The LTC waitlist is a triage system intended to help the sickest and neediest first. Prioritization occurs by assessing the immediate needs of the Medicaid eligible individual who has applied.

When individuals residing in Assisted Living Facilities (ALFs) deplete their personal funds apply and are assessed while living in the ALF, they are at a disadvantage compared to individuals

residing in private residences. Although they have extensive care needs, (often far exceeding those of individuals still living in private residences) they are ranked at low priority since care needs are being met in the ALF setting. This does not take into consideration the fact that continued residence within the ALF is dependent on access to additional funds.

In order for the care needs of ALF residents to be fully recognized, they must either be made homeless – putting them at immediate risk, or be admitted to and reside in a Skilled Nursing Facility (SNF/Nursing Home) for 60 days, at which point they may apply for "priority enrollment" for Home and Community-based Services through the Long-term Care Managed Care Program in hopes of gaining access to additional funding so they may transition back to their original ALF. Others may be sent to another ALF because there are no available beds. For some individuals who are especially frail and elderly, they may remain in the SNF for the rest of their days because the transition from ALF to SNF is often taxing and destabilizing, causing mental disorientation and physical decline.

Regulatory Authority

Chapter 409.979, Florida Statutes, defines eligibility for Long-Term Care Services. (f) speaks to individuals that are afforded priority enrollment for home and community-based services through the long-term care managed care program that do not have to complete the screening or wait-list process if all other long-term care managed care program eligibility requirements are met.

Proposed Solution

Amend Chapter 409.979(f), Florida Statutes, to include a new Item ("4.") under Section 5, Paragraph (f), to read:

4. An individual who has resided in a state licensed assisted living facility for at least six months or for thirty days following referral by the Department of Children and Families and requires assistance with two or more activities of daily living.

such that the statute in its entirety would read as follows:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:

1. Nursing facility care as defined in s. 409.985(3); or
2. Hospital level of care, for individuals diagnosed with cystic fibrosis.

(2) ENROLLMENT OFFERS.—Subject to the availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization. Before making enrollment offers, the agency and the Department of Elderly Affairs shall determine that sufficient funds exist to support additional enrollment into plans.

(a) A Medicaid recipient enrolled in one of the following Medicaid home and community-based services waiver programs who meets the eligibility criteria established in subsection (1) is eligible to participate in the long-term care managed care program and must be transitioned into the long-term care managed care program by January 1, 2018:

1. Traumatic Brain and Spinal Cord Injury Waiver.
2. Adult Cystic Fibrosis Waiver.
3. Project AIDS Care Waiver.

(b) The agency shall seek federal approval to terminate the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver once all eligible Medicaid recipients have transitioned into the long-term care managed care program.

(3) WAIT LIST, RELEASE, AND OFFER PROCESS.—The Department of Elderly Affairs shall maintain a statewide wait list for enrollment for home and community-based services through the long-term care managed care program.

(a) The Department of Elderly Affairs shall prioritize individuals for potential enrollment for home and community-based services through the long-term care managed care program using a frailty-based screening tool that results in a priority score. The priority score is used to set an order for releasing individuals from the wait list for potential enrollment in the long-term care managed care program. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list shall receive priority for release.

1. Pursuant to s. 430.2053, aging resource center personnel certified by the Department of Elderly Affairs shall perform the screening for each individual requesting enrollment for home and community-based services through the long-term care managed care program. The Department of Elderly Affairs shall request that the individual or the individual's authorized representative provide alternate contact names and contact information.
2. The individual requesting the long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening for placement on the wait list. The screening or rescreening must be completed in its entirety before placement on the wait list.
3. Pursuant to s. 430.2053, aging resource center personnel shall administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a high priority score. Aging resource center personnel may administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a low priority score.
4. The Department of Elderly Affairs shall adopt by rule a screening tool that generates the priority score and shall make publicly available on its website the specific methodology used to calculate an individual's priority score.

(b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual's authorized representative that the individual has been placed on the wait list, unless the individual has a low priority score. The Department of Elderly Affairs must maintain contact information for each individual with a low priority score for purposes of any future rescreening. Aging resource center personnel shall inform individuals with low priority scores of community resources available to assist them and inform them that they may contact the aging resource center for a new assessment at any time if they experience a change in circumstances.

(c) If the Department of Elderly Affairs is unable to contact the individual or the individual's authorized representative to schedule an initial screening or rescreening, and documents the actions taken to make such contact, it shall send a letter to the last documented address of the individual or the individual's authorized representative. The letter must advise the individual or his or her authorized representative that he or she must contact the Department of Elderly Affairs within 30

calendar days after the date of the notice to schedule a screening or rescreening and must notify the individual that failure to complete the screening or rescreening will result in his or her termination from the screening process and the wait list.

(d) After notification by the agency of available capacity, the CARES program shall conduct a prerelease assessment. The Department of Elderly Affairs shall release individuals from the wait list based on the priority scoring process and prerelease assessment results. Upon release, individuals who meet all eligibility criteria may enroll in the long-term care managed care program.

(e) The Department of Elderly Affairs may terminate an individual's inclusion on the wait list if the individual:

1. Does not have a current priority score due to the individual's action or inaction;
2. Requests to be removed from the wait list;
3. Does not keep an appointment to complete the rescreening without scheduling another appointment and has not responded to three documented attempts by the Department of Elderly Affairs to contact the individual;
4. Receives an offer to begin the eligibility determination process for the long-term care managed care program; or
5. Begins receiving services through the long-term care managed care program.

An individual whose inclusion on the wait list is terminated must initiate a new request for placement on the wait list, and any previous priority considerations must be disregarded.

(f) Notwithstanding this subsection, the following individuals are afforded priority enrollment for home and community-based services through the long-term care managed care program and do not have to complete the screening or wait-list process if all other long-term care managed care program eligibility requirements are met:

1. An individual who is 18, 19, or 20 years of age who has a chronic debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
2. A nursing facility resident who requests to transition into the community and who has resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days.
3. An individual who is referred by the Department of Children and Families pursuant to the Adult Protective Services Act, ss. 415.101-415.113, as high risk and who is placed in an assisted living facility temporarily funded by the Department of Children and Families.
4. **An individual who has resided in a state licensed assisted living facility for at least six months or for thirty days following referral by the Department of Children and Families and requires assistance with two or more activities of daily living.**

(g) The Department of Elderly Affairs and the agency may adopt rules to implement this subsection.

History.—s. 20, ch. 2011-134; s. 14, ch. 2012-33; s. 21, ch. 2014-18; s. 2, ch. 2016-147; s. 16, ch. 2017-129; s. 1, ch. 2020-46.