

Chapter 5

Administration of the Community Care for the Elderly (CCE) Program

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 5: Community Care for the Elderly Program

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PURPOSE OF THE CCE PROGRAM:

- A. Chapter Contents:** This chapter provides program policies, standards and procedures for use by the Department and all contractors and subcontractors in administering the Community Care for the Elderly (CCE) program.
- B. Purpose:** The primary purpose of the CCE program is to prevent, reduce or delay premature or inappropriate placement of older persons in nursing homes and other institutions.

Additional purposes of the CCE program are to provide the following:

1. A continuum of service alternatives to meet the diverse needs of older people;
2. Access to services for elders most in need; and
3. A local resource that will coordinate delivery of services for the frail elder/caregiver.

LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

- A. CCE Act:** The Florida Legislature demonstrated its commitment to meeting the special needs of Florida's aging citizens by passing the CCE Act in 1973. This Act was amended in 1976, authorizing the funding and implementation of demonstration projects to determine acceptable and cost-effective ways of keeping elderly persons in their own homes to prevent, postpone or reduce inappropriate or unnecessary institutional placements. The seven demonstration projects established as a result of the Act served seniors with the greatest need who were frail or functionally impaired and required ongoing help. Today, CCE funding is available in all 67 counties.
- B. Specific Authority:**
1. Chapter 430.201-207, F.S.
 2. Chapter 58C-1, F.A.C.

SERVICES PROVIDED UNDER THE CCE PROGRAM:

State funds appropriated for CCE services must be used to fund an array of services that meet the diverse needs of functionally impaired elders. These categories of services are most needed to prevent unnecessary institutionalization. The Area Agencies on Aging (AAA) shall not provide CCE funded services. Refer to Appendix A, "Service Descriptions and Standards," for a description of each service. The services include the following categories:

- A. Core Services:** Core Services include a variety of in-home services, day care services, and other basic services that are most needed to prevent or delay institutionalization.
1. Adult Day Care;
 2. Chore Services;
 3. Companionship;
 4. Escort;
 5. Financial Risk Reduction;
 6. Home Delivered Meals;
 7. Homemaker;
 8. Housing Improvement;
 9. Legal Assistance;
 10. Pest Control Services;
 11. Respite Services;
 12. Shopping Assistance; and
 13. Transportation

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Services Provided under the CCE Program

B. Health Maintenance Services: Health Maintenance Services are routine health services that are necessary to help maintain the health of functionally impaired elders. The services are limited to medical therapeutic services, non-medical prevention services, personal care services, home health aide services, home nursing services, and emergency response systems.

1. Adult Day Health Care;
2. Emergency Alert Response;
3. Gerontological Counseling;
4. Health Support;
5. Home Health Aide;
6. Medication Management;
7. Mental Health Counseling/Screening;
8. Nutrition Counseling;
9. Occupational Therapy;
10. Personal Care;
11. Physical Therapy;
12. Skilled Nursing Services;
13. Specialized Medical Equipment, Services and Supplies; and
14. Speech Therapy.

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Services Provided under the CCE Program

- C. Other Support Services:** Other Support Services expand the array of care options to assist functionally impaired elders and their caregivers.
1. Caregiver Training/Support;
 2. Case Aid;
 3. Case Management;
 4. Intake;
 5. Material Aid; and
 6. Other.

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Program Requirements

Community Care Service System

COMMUNITY CARE SERVICE SYSTEM:

- A. Description:** The CCE law defines the community care service system as a service network comprised of a variety of in-home and other basic services for functionally- impaired elderly persons. Services may be provided by several agencies under the direction of a single Lead Agency. The purpose of the community care service system is to provide a continuum of care encompassing a range of preventive, maintenance and restorative services.

- B. Program Requirements:** The CCE program requirements are listed on the following pages.

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Program Requirements

General Eligibility Requirements

GENERAL ELIGIBILITY CRITERIA:

Listed below are the eligibility criteria for the CCE program:

- A. Age:** Individuals 60 years of age or older.
- B. Functional Impairment:** Functional impairment is characterized by physical or mental limitations, which restrict the ability to perform the normal activities of daily living and which impede the capacity to live independently without the provision of CCE services. Functional impairment shall be determined through a functional assessment administered to each applicant for CCE services.
1. The functional assessment process determines functional impairment and risk of institutionalization, facilitating the identification of the appropriate array of services needed to maintain the independence of the client. Two forms are used for conducting screening and assessment activities. The Screening Form (701S) is used to prioritize applicants for services who have not begun to receive services. Applicants can be prioritized by greatest need to be assessed and to receive needed services. A priority score and rank are produced. The Comprehensive Assessment (701B) is used at initiation of services, at reassessment and to assess and update significant change in the client's situation. A risk score is produced from the 701B and a priority score and rank are produced from either form.

Only after completing the assessment is a determination of an individual's functional impairment made for eligibility determination. If the individual is determined by the case manager to be functionally impaired, he or she is eligible to receive CCE services. The case manager also determines the individual's risk of institutionalization without CCE services. Priority is given to the individual most at risk.

In summary, client eligibility is based on age, need and risk of institutionalization without CCE services.
 2. A client comprehensive assessment must be completed annually for each client receiving CCE services to ensure ongoing eligibility.
- C.** Clients may not be dually enrolled in the CCE program and a Medicaid capitated long-term care program.

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Preliminary Eligibility Determination at Intake

PRELIMINARY ELIGIBILITY DETERMINATION AT INTAKE:

- A.** Approval to begin the eligibility process for Department-funded programs is determined by the availability of funds and the priority ranking of individuals. Priority groups are described in Section D below.

- B.** If the applicant appears to be eligible for CCE services based on the preliminary information received, an appointment should be made for a screening as soon as possible. The person conducting the intake process will explain that a more thorough discussion of the applicant's situation and need for services is required.

- C.** If the person clearly does not appear to meet the CCE eligibility requirements, the person conducting the intake process must explain the eligibility criteria. Referral to other agencies must be made, if appropriate. The referral (if applicable) and determination of ineligibility must be documented.

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Program Requirements

Priority Groups

PRIORITY GROUPS:

Clients in the following subgroups are priority recipients for CCE case management and CCE services. The subgroups are listed in order, beginning with the highest priority.

If two individuals are assessed as the same priority level and are at risk of nursing home placement, priority must be given to the individual with the lesser ability to pay for services. If the ability to pay is the same, the individual with the greatest length of time on the assessed priority consumer list must be given priority.

Clients in the following groups are priority recipients for CCE services, listed in the order of the highest priority:

A. Assessment and Prioritization of Service Delivery for New Clients

Clients in the following subgroups are priority recipients for CCE case management and CCE services. The following are the criteria used to prioritize new clients in the sequence below for service delivery. It is not the intent of the Department to remove current clients from any services in order to serve new clients being assessed and prioritized for service delivery.

1. Department of Children and Families (DCF) Adult Protective Services (APS) High Risk individuals: The Contractor shall ensure that pursuant to Section 430.205(5)(a), Florida Statutes, those elderly persons who are determined by DCF APS to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm, and are referred by APS, will be given primary consideration for receiving CCE services. As used in this subsection, "primary consideration" means that an assessment and services must commence within 72 hours after referral to the Department or as established in accordance with Department contracts by local protocols developed between Department service Contractors and APS.

The Contractor shall follow guidelines for DCF APS High Risk referred individuals established in the APS Referrals Operations Manual, which is incorporated by reference.

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2. Imminent Risk individuals: Individuals in the community whose mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or likely within three (3) months.

Regarding question 19 (on the 701S) or 21 (on the 701A): “The individual is transitioning out of a nursing facility (NF),” certified screeners and assessors/case managers should respond, “N” because individuals in nursing homes are not considered IR according to the definition. It is the responsibility of certified screeners and assessors/case managers to screen and assess only individuals who are residing in the community (private residence, assisted living facility, or adult family care home). Please note that if an individual is currently in an NF and interested in NF services, long-term care program education should be provided, and the individual should be referred to CARES.

Regarding question 20 (on the 701S) or 22 (on the 701A): “Individual is at imminent risk of NF placement,” certified screeners and assessors/case managers should only respond “Y” if during completion of the assessment, the individual or their representative provides information that indicates the individual’s “*mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or very likely within three (3) months.*” The certified screener or assessor/case manager will not ask the individual or their representative the question but will instead check an answer based upon the observations by the screener or assessor. The screener or assessor will document justification for the designation in the appropriate “Notes and Summary” sections of the assessment form, including supervisor approval. Additionally, the Department may request Aging and Disability Resource Centers (ADRCs) to rescreen any individual ranked imminent risk prior to Enrollment Management System (EMS) release to confirm the IR designation.

3. Aging Out individuals: Individuals receiving Community Care for Disabled Adults (CCDA) and Home Care for Disabled Adult (HCDA) services through the Department of Children and Families’ Adult Services transitioning to community-based services provided through the Department when services are not currently available.

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Priority Groups

4. Service priority for individuals not included in (1), (2), and (3) above, regardless of referral source, will be determined through the Department's functional assessment administered to each applicant, to the extent funding is available. The Contractor shall ensure that priority is given to applicants at the higher levels of frailty and risk of nursing home placement. For individuals assessed at the same priority and risk of nursing home placement, priority will be given to applicants with the lesser ability to pay for services.

Referrals for Medicaid Waiver Services:

1. The contractor shall require subcontractors to identify potential Medicaid eligible CCE clients through the assessment instrument and refer them to apply for Medicaid waiver services (hereafter referred to as "waiver services").
2. Individuals identified as being potentially Medicaid waiver eligible are required to apply for waiver services to receive CCE services and can only receive CCE services while the Medicaid waiver eligibility determination is pending. If the individual is found ineligible for waiver services for any reason other than failure to provide required documentation, the individual may continue to receive CCE services.
3. Individuals who have been identified as being potentially Medicaid waiver eligible must be advised of their responsibility to apply for waiver services as a condition of receiving CCE services during the Medicaid waiver eligibility determination process.
4. Individuals enrolled in CCE who have been terminated from the Medicaid waiver eligibility process for not meeting the required timeframes in the currently established Enrollment Management System (EMS), may remain active in CCE for an additional 30 days following termination from the process. If the individual completes the eligibility step associated with termination of the process within the 30 days, the Medicaid eligibility process can resume. However, if the individual does not complete the step associated with termination within the 30 days, CCE enrollment will be terminated with notice in accordance with the grievance procedures outlined in Appendix D of the Programs and Services Handbook.

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Program Requirements

Service Provision

SERVICE PROVISION:

Services may be provided to eligible CCE clients after the completion of the client comprehensive assessment and the development of the care plan. CCE clients are assessed co-payments based upon their ability to pay. A co-payment is assessed for all clients receiving any core services and/or health maintenance services. See Appendix B for instructions for assessing co-payments.

Adult Protective Services (APS) Referrals:

- A.** The Department of Elder Affairs (DOEA) and the Department of Children and Families (DCF) signed a memorandum of agreement to ensure the delivery of timely services to vulnerable elders in need of services or victims of abuse, neglect or exploitation. The agreement called for development of joint local written procedures through a memorandum of understanding for serving Adult Protective Services referrals.

- B.** Every AAA, DCF region and Lead Agency is responsible for jointly creating and signing a memorandum of understanding that defines:
 - 1.** The APS referral process;
 - 2.** Method for tracking referrals in CIRTTS and the APS Referral Tracking Tool (ARTT); and
 - 3.** Service delivery guidelines.

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Program Requirements

Services to Persons in Alternate Care

SERVICES TO PERSONS IN ALTERNATE CARE:

Assisted Living Facilities (ALFs) and Adult Family Care Homes (AFCHs):

Residents of assisted living facilities and adult family care homes may receive such services as home health aide or transportation; however, provision of any service would be a low priority.

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Program Requirements

Responsibilities of Stakeholders

RESPONSIBILITIES OF STAKEHOLDERS:

A. DOEA:

1. **Purpose:** The purpose of DOEA in the community care system is to budget, coordinate and develop policy at the state level necessary to carry out the CCE program.
2. **Responsibilities:** The responsibilities of DOEA are listed below:
 - a. Develop an area plan format, which includes CCE information.
 - b. Develop an allocation formula for distributing CCE funds to Planning and Service Areas (PSAs).
 - c. Allocate CCE funds to service providers through the Area Agencies on Aging (AAAs).
 - d. Prepare CCE service provider application guidelines.
 - e. Serve as a statewide advocate for functionally-impaired older persons.
 - f. Ensure provision of quality services through the monitoring process.
 - g. Establish policies and procedures for AAA, Lead Agency and CCE subcontractors.
 - h. Evaluate the quality and effectiveness of services and client satisfaction with the CCE program, as required.
 - i. Develop program reports.
 - j. Provide for staff development and training.
 - k. Review the required area plan annual update and all revisions as necessary.

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Responsibilities of Stakeholders

- l.** Provide and monitor program policies and procedures for the PSAs.
- m.** Review and make recommendations for improvement on program reports.
- n.** Provide technical assistance to the AAAs in program planning and development and ongoing operations, as needed.
- o.** Assume AAA responsibilities, if necessary, for a period not to exceed 180 days, except as provided for in Section 306 (e)(3)(B) of the Older Americans Act.
- p.** Assist the AAAs and Lead Agencies in determining CCE services to be funded within the PSAs.
- q.** Co-monitor with the AAAs, if feasible.
- r.** Process payments to the contract agencies.
- s.** Develop co-payment guidelines.

B. AREA AGENCIES ON AGING (AAA):

- 1. Purpose:** The purpose of the AAA in the community care system is to monitor and fund Lead Agencies and other agencies.
- 2. Responsibilities:** The AAA's responsibilities are listed below:
 - a.** Develop PSA level allocation formula for distribution of CCE funds.
 - b.** Plan for, advertise, and approve funding for Lead Agencies.
 - c.** Prepare and revise the area plan update.
 - d.** Plan with Lead Agencies to determine CCE services to be funded.
 - e.** Designate Lead Agencies and establish vendor agreements at the AAA level, when applicable.

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Responsibilities of Stakeholders

- f. Provide technical assistance to Lead Agencies and vendors to ensure provision of quality services.
- g. Require annual submission of CCE applications or updates, for funding of current Lead Agencies using minimum guidelines provided by DOEA.
- h. Notify applicants of acceptability of applications and any further action.
- i. Assess the applicant's ability to be a Lead Agency or vendor, as well as its ability to establish subcontracts, if the applicant indicates plans to do so.
- j. Assess Lead Agency fiscal management capabilities.
- k. Monitor and evaluate Lead Agency case management capabilities.
- l. Assess the availability of a 10 percent match for Lead Agency budget.
- m. Establish agreements for Lead Agency and CCE services according to manuals, rules and agreement procedures of DOEA. Establish vendor agreements, when applicable.
- n. Monitor and evaluate contracts, subcontracts and vendor agreements for programmatic and fiscal compliance.
- o. Submit payments to contractors.
- p. Arrange in-service training for Lead Agencies at least annually.
- q. Establish appeal procedures for handling disputes involving Lead Agency, CCE services and vendor agreements.
- r. Establish procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services.

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Responsibilities of Stakeholders

- s. Ensure compliance with Client Information and Registration Tracking System (CIRTS) regulations.
- t. Monitor performance objective achievements in accordance with targets set by the Department.
- u. Ensure implementation of co-payment guidelines.
- v. Conduct client satisfaction surveys to evaluate and improve service delivery.

C. LEAD AGENCY:

1. **Purpose:** The purpose of the Lead Agency in the community care service system is to provide case management to all CCE clients and to ensure service integration and coordination of service providers within the community care service system.
2. **Responsibilities:** The Lead Agency's responsibilities are to:
 - a. Ensure that all other funding sources available have been exhausted before targeting CCE funds.
 - b. Ensure that coordination is established with all community-based health and social services for functionally impaired older persons funded wholly or in part by federal, state and local funds to provide a continuum of care.
 - c. Provide directly or establish subcontracts or vendor agreements, when applicable, for CCE services.
 - d. Provide case management to applicants and ongoing recipients of CCE services.
 - e. Assess and collect co-payments for core services and health maintenance services provided through the CCE program.
 - f. Train and use volunteers as possible to provide services to clients and assist with other Lead Agency activities.

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Responsibilities of Stakeholders

- g.** Compile accurate reports.
- h.** Monitor subcontracts and vendor agreements to ensure quality services and efficient use of funds. Make payments to subcontractors for CCE services.
- i.** Initiate and maintain coordination among agencies.
- j.** Arrange in-service training for staff, including volunteers and CCE service subcontractors, at least once a year. Monthly, or at least quarterly, training is recommended. An in-service training on abuse, neglect, and exploitation of vulnerable adults shall be provided to volunteers annually.
- k.** Accept voluntary contributions, gifts and grants to carry out a community care service system.
- l.** Demonstrate innovative approaches to program management, staff training and service delivery that impact on cost avoidance, cost effectiveness, and program efficiency.
- m.** Establish and follow procedures for handling recipient complaints concerning such adverse actions as service termination, suspension, or reduction in services.
- n.** Conduct client satisfaction surveys to evaluate and improve service delivery.

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Program Requirements

Lines of Communication

LINES OF COMMUNICATION:

Lead Agencies shall request and receive technical assistance from the AAA. When additional interpretation is needed, the AAA should forward the request to DOEA. DOEA will address all requests and provide a timely response.

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Program Requirements

Co-Payment Assessment

CO-PAYMENT ASSESSMENT:

Co-payment assessment information is included in Appendix B of this handbook.

GRIEVANCE PROCEEDINGS:

Please refer to Appendix D, “Minimum Guidelines for Recipient Grievance Procedures,” in this Handbook.