Chapter 9

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

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Section I: Overview of the CCE Program

The purpose of the CCE program is to prevent, reduce, or delay premature or inappropriate placement of older persons in nursing homes and other institutions. Additionally, the program provides the following:

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

Section II: Legal Basis and Specific Legal Authority

A. Legal Basis:

The Florida Legislature passed the CCE Act in 1973 and the Act was amended in 1976. The legislative intent of this statewide program is 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 Department, through the Area Agency on Aging shall fund in each planning and service area, at least one community care service system that provides case management and other in-home and community services as needed to help the older person maintain independence and prevent or delay more costly institutional care.

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 designated 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. Specific Authority:

- Chapter 430.201-207, F.S.
- Chapter 58C-1, F.A.C.

Section III: 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 (AAAs) shall be the only organization conducting CCE intake services unless a waiver is approved by DOEA. The AAA shall not provide any other 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.

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.

C. Other Support Services: Other Support Services expand the array of care options to assist functionally impaired elders and their caregivers.

Section IV: Program Requirements

A. General Eligibility Criteria: To be eligible for CCE the client must meet the following criteria:

1. Age: Be sixty (60) years or older.

2. 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 services through the CCE program.

3. Clients may not be dually enrolled in the CCE program, and a Medicaid capitated long-term care program.

B. Eligibility Process: Functional impairment shall be determined through a functional assessment as determined by the 701S screening used to prioritize applicants for the program who have not begun to receive CCE services.

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 to determine functional impairment activities. Applicants can be prioritized by greatest need and risk of institutionalization without CCE services. A priority score and rank are produced when the assessment is entered in eCIRTS. The Comprehensive Assessment (701B) is used for enrollment into the program prior to the initiation of services, at reassessment, and to assess and update the significant change in the client’s situation. A risk score is produced from the 701B and a priority score and rank from either assessment form type.

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.

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.

Note: *A 701B must be completed annually for each client receiving CCE services to ensure ongoing eligibility.*

C. 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.

1. **Assessment and Prioritization of Service Delivery for New Clients:** Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core 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 to serve new clients being assessed and prioritized for service delivery.

   a. 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 protective investigations to be vulnerable adults in need of services or 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 priority consideration for receiving CCE services. As used in this subsection, "priority 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. Every AAA, DCF Region, and Lead Agency is responsible for jointly creating and signing a memorandum of understanding that defines:
      - The APS referral process;
      - Method for tracking referrals in eCIRTS and the APS Tracking Tool (ARTT); and
      - Service delivery guidelines.

Designated as a “high risk referral,” the referral will be staffed by APS and the Lead Agency to determine the specific services needed. Such services may be time limited and designed to resolve the emergency or crisis situation that could place the person at risk of further harm. For referrals received during business hours, the Lead Agency must initiate the emergency or crisis resolving service(s) within 72 hours of receipt of the referral from APS. Case management alone does not meet this requirement. For high-risk referrals that are currently receiving services funded by DOEA, the 72-hour time frame includes not only existing services, but also any additional emergency or crisis resolving services.

Upon receipt of the referral, the Lead Agency must communicate to the consumer that services put in place may be limited to 31 days. The provision services(s) may exceed 31 days if:

- The emergency or crisis still exists, and continuation of the services is needed for resolution; or
- The crisis is likely to return without the provision of services.

A 701B must be completed in person within 72 hours of receipt of the APS Referral Tracking Tool (ARTT) referral packet for high-risk referrals received during business hours. For high-risk referrals received after business hours, the CCE Lead Agency must initiate the emergency or crisis resolving service(s) within 72 hours of the phone call from APS. A 701S, 701A, or 701B assessment must be completed within 14 calendar days for intermediate and low-risk referrals.

NOTE: Crisis-resolving services may begin before the 701B is completed for clients with high-risk referrals.

Before services are terminated after 31 days, the client will be seen face-to-face by a Lead Agency case manager. If it is determined that services can be safely terminated, APS will be contacted (using contact information in the ARTT). APS staff will participate in a discussion with the client regardless of the status of the case.

CCE co-payments for services will be waived for high-risk referrals during the first 31 days of service or until the vulnerable adult’s crisis has been resolved as determined by the Lead Agency and APS staff.

If both parties agree that crisis-resolving services can safely be terminated, the client may be placed on a pre-enrollment list for additional services if appropriate. The case manager will complete and enter the new 701B Form in eCIRTS.

If both parties do not agree that services can safely be terminated, the lead agency case manager will assess the client's needs, and the assessment will be entered in eCIRTS. An APS investigator supervisor and a case manager supervisor at the Lead Agency will jointly review the case to resolve the issue(s), identified at staffing.

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

b. Imminent Risk: 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 very likely within three (3) months.

Regarding question 19 on the 701S or 21 on the 701A and 701B, the certified staff completing the tool should mark "N" because individuals in nursing homes are not considered IR according to the definition. It is the responsibility of the certified staff to screen and assess only individuals who are residing in a private residence, assisted living facility, or adult family care home.

Regarding question 20 (on the 701S) or 22 (on the 701A and 701B), certified staff should only respond "Y" if, during the completion of the tool, the individual or their representative provides information that meet the following:

- The individual or his/her caregiver expressed the individual's mental or physical health condition has deteriorated by answering "worse" or "much worse" (question 31 on the 701S, question 38 on the 701A and question 49 on the 701B);
- The individual or his/her caregiver expressed the individual's inability to perform self-care by needing" assistance (but not total help)" or" assistance (cannot do at all)" with at least one or more ADL(s)(question 38 on the 701S, question 46 on the 701A and question 68 on the 701B);
- The individual or his/her caregiver expressed that nursing facility placement is imminent due to the fact that the individual may no longer reside at home without services in place or that services cannot continue to be provided through the ALF due to pending eviction; and
- The individual or his/her caregiver expressed there is no capable caregiver, and the ability to continue receiving needed services is threatened (actual or anticipated and permanent i.e. more than 30 days). This IR situation applies if (1) an individual's caregiver was providing services but is no longer or will no longer be designated

as the caregiver and able to provide services, or (2) an individual or his/her caregiver is arranging and paying for services through a paid service provider and the services have or will be ending with no alternative means for service provision.

The provider, AAA, or ADRC must document the above information in as much detail as possible in the notes section of the DOEA 701S Screening Form, 701A Condensed Assessment and 701B Assessment. The screener must then request supervisor review and approval of the IR designation. The ultimate IR designation will be at the supervisor's discretion but must demonstrate in the notes section that the client meets the definition for IR.

All individuals designated IR in CIRTS must have supervisor approval documented in the form, including the date of review and approval and the supervisor's first and last name. The screener's supervisor is their direct supervisor at the agency or provider.

c. Aging Out: Individuals receiving Community Care for Disabled Adults (CCDA) and Home Care for Disabled Adults (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.

NOTE: Aging Out clients may receive Intake (INSC) and Case Management/Aide prior to turning 60 to ensure smooth transition of services.

d. Service priority for individuals not included in (a), (b), or (c) above, regardless of referral source, will be determined through the Department's 701A, 701B, or 701S assessment or screening administered to each applicant, to the extent funding is available.

D. Referrals for Medicaid Services:

The contractor shall require subcontractors to identify potential Medicaid eligible CCE clients through the assessment instrument and refer them to apply for Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) Program.

Individuals identified as being potentially Medicaid eligible are required to apply for waiver services to receive CCE services and can only receive CCE services while the SMMC LTC Program eligibility determination is pending. If the individual is found ineligible for Medicaid services for any reason other than failure to provide required documentation, the individual may continue to receive CCE services.

Medicaid probable is defined as current CCE active clients whose self-reported income

and assets fall below limits of established standards per the SSI-Related Programs Financial Eligibility Standards. Individuals who have been identified as being potentially Medicaid eligible must be advised of their responsibility to apply for SMMC LTC services as a condition of receiving CCE services during the eligibility determination process.

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.

E. Service Provision

1. Co-payment: 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. No co-payments with be assessed on any client whose income is at, or below, the federal poverty level (FPL) as established each year by the U.S. Department of Health and Human Services. The co-payment fee schedule will commence at $1 above the established FPL each year.

   No client may have their services terminated for inability to pay their assessed co-payment. Area Agencies on Aging, in conjunction with provider agencies, must establish procedures to remedy financial hardships associated with co-payments and ensure there is no interruption in service(s) for inability to pay. If a client's co-payment is reduced or waived entirely, a written explanation for the change must be placed in the client file. See Appendix B for instructions for assessing co-payments.

2. Services to Persons in 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.

Section V: Agency and Stakeholder Responsibilities

A. DOEA Responsibilities:

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 staff development and training.

   k. Review the required area plan annual update and all revisions, as necessary.

   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. Assess the availability of a 10 percent match for the AAA’s budget.

s. Develop co-payment guidelines.

B. AAA RESPONSBILITIES:

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.

   f. Conduct CCE intake services.

   g. Provide technical assistance to Lead Agencies and vendors to ensure provision of quality services.

   h. Require annual submission of CCE applications or updates, for funding of current Lead Agencies using minimum guidelines provided by DOEA.

   i. Notify applicants of acceptability of applications and any further action.

   j. 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.

   k. Assess Lead Agency fiscal management capabilities.

   l. Monitor and evaluate Lead Agency case management capabilities.

   m. Assess the availability of a 10 percent match for Lead Agency budget.

   n. Establish agreements for Lead Agency and CCE services according to manuals, rules, and agreement procedures of DOEA. Establish vendor agreements, when applicable.

   o. Monitor and evaluate contracts, subcontracts, and vendor agreements for programmatic and fiscal compliance.

p. Submit timely payments to contractors in accordance with Section 287.0585, F.S.

q. Provide a preservice training for CCE service providers and staff.

r. Provide an annual in-service training program for CCE service providers and staff.

s. Establish appeal procedures for handling disputes involving Lead Agency, CCE services and vendor agreements.

t. Establish procedures for handling recipient complaints concerning such adverse actions as service termination, suspension, or reduction in services.

u. Lead Agency case management capabilities.

v. Ensure compliance with Enterprise Client Information and Registration Tracking System (eCIRTS) regulations.

w. Monitor performance objective achievements in accordance with targets set by the Department.

x. Ensure implementation of co-payment guidelines.

y. Conduct client satisfaction surveys to evaluate and improve service delivery.

z. May only directly provide core services if the designated lead agency is unable to perform its duties and the department approves.

C. Lead Agency Responsibilities:

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. If the Lead Agency subcontracts with an entity to provide direct services, the entity must be selected as the result of a procurement decision using competitive or non-competitive method (i.e., sole source) to provide services pursuant to a legally executed agreement.

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.

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 staff and 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.

NOTE: *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.*