Long-Term Care Community Diversion Pilot Project

2009-2010 Legislative Report

Rick Scott, Governor

Charles T. Corley, Interim Secretary
Table of Contents

Executive Summary ........................................................................................................... 1

Table 1 - Nursing Home Diversion Capitation Rates ..................................................... 2

Project Background ........................................................................................................ 2

Eligibility .......................................................................................................................... 3

Services ............................................................................................................................ 4

Project Funding ................................................................................................................ 5

Table 2 - Appropriation History, FY 1997 – FY 2011 .................................................... 6

Enrollment Trends .......................................................................................................... 6

Chart 1 - Diversion Enrollment Trends 2008-2010 ....................................................... 7

Counties and Providers Approved for Diversion Projects ............................................. 8

Map 1 - Diversion Counties of Operation ...................................................................... 9

Comparison of Diversion to Other Long Term Care Alternatives .............................. 9

Table 3 - Frailty Profile of Active Clients by Program .................................................. 11

Table 4 – Program Cost and Utilization by Program 2009-10 ..................................... 12

Initiatives and Future Direction ..................................................................................... 12

Table 5 – 2009-10 Program Performance Measures ..................................................... 16

Conclusion .......................................................................................................................... 17
Executive Summary

In its twelfth year of operation, the Department of Elder Affairs Long-Term Care Community Diversion Pilot Project (Diversion) represents a model managed-care home- and community-based services (HCBS) alternative to traditional fee-for-service HCBS Medicaid programs for frail elders at risk of permanent nursing home placement. Unlike fee-for-service HCBS programs, the Diversion program incorporates a continuum of Medicaid long-term care services with providers assuming the full financial risk of these services including the cost of nursing home placement, a program feature that incentivizes providers to ensure that clients receive the care necessary to remain in less costly and less restrictive community settings.

The Diversion approach provides significant advantages to both the State and to the elder by helping preserve dignity, maximum possible independence and a sense of continued connection to the community for the elder with the financial predictability, service flexibility, and program accountability associated with a managed care service delivery model. In addition, these advantages are provided at a cost that is typically less than one-third than that of traditional nursing home placement.

The program serves a frail elderly population that is Medicaid-eligible and meets specified medical criteria that would otherwise qualify these elders for full-time nursing home care (see detailed eligibility criteria in Project Background section, below).

Diversion providers contract to provide a comprehensive set of long-term care, acute care, and case management services for a fixed monthly payment (capitated rate), and to assume the financial risk of paying for nursing home care when nursing home placement becomes unavoidable.

Capitation rates are determined and certified annually by independent actuaries based on encounter claims (service utilization data) submitted by the Diversion plans, and rates are adjusted by plan and by county. Over the last three years, the monthly average capitation rate has decreased each year based on this encounter data (see Table 1), while the cost of nursing home care has increased each year. Furthermore, since the program’s inception in 1998, the average payment rate has been reduced by more than 30 percent from approximately $2,300 per enrollee per month in 1999 to the current rate of approximately $1,500 per enrollee per month.

As illustrated in Table 1, the 2010-11 statewide average capitated rate of $1,510.55 per member per month (PMPM) remains well below the comparable Medicaid reimbursement schedule for full-time nursing home care of $6,363.17 per month.
Despite its obvious appeal, the Diversion program continues to offer some challenges that the Department is actively addressing. The obvious struggle to balance cost-control with quality of care for the vulnerable, frail elders served through this program requires enhanced monitoring and a sensitive system of checks and balances.

We also remain cognizant of barriers that limit the availability of the Diversion option for many residents who live in under-served areas. For example, managed care plans have been either unable or unwilling to offer the program in rural counties where it is often difficult to provide potential enrollees with an adequate range of third-party services, or where the relative isolation of elders or lack of service providers presents significant challenges to efficient service delivery. Other geographic areas, particularly the more urban regions, benefit from robust competition and a wealth of choices for potential program participants. The Department is actively working with state and federal officials and its managed-care partners to evaluate ways to incentivize the expansion of Diversion programs into those areas of the state with the greatest need, while re-considering the unlimited expansion of new plans into areas already heavily served.

Although Diversion enrollment is expected to re-open by summer 2011, the program has reached its legislative funding capacity, and the Department anticipates an expanding wait-list and possible future enrollment freezes as enrollment stays near the maximum level that can be supported at current funding levels.

### Project Background

The Long-Term Care Community Diversion Pilot Project (Diversion) was authorized by the 1997 Florida Legislature, and was launched in December of 1998. The Diversion program provides frail elders who are at risk of nursing home placement an individualized package of community-based services designed to help delay or prevent nursing home placement. The Department of Elder Affairs (Department) administers the project in consultation with the Agency for Health Care Administration (AHCA) through a cooperative agreement.

The Diversion project serves very frail elders, who have medical and functional profiles similar to elders who reside in nursing homes, but who can safely be served through alternative home or assisted living settings.

---

### Table 1: Nursing Home Diversion (NHD) Capitated Rates

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Average NHD Capitated Rate (Per Month)</th>
<th>Comparable Nursing Home Cost (Per Month)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>$1,784.71</td>
<td>$4,982.25</td>
</tr>
<tr>
<td>2008-09</td>
<td>$1,624.33</td>
<td>$5,427.85</td>
</tr>
<tr>
<td>2009-10</td>
<td>$1,528.08</td>
<td>$6,273.44</td>
</tr>
<tr>
<td>2010-11</td>
<td>$1,510.55</td>
<td>$6,363.17</td>
</tr>
</tbody>
</table>

*Source: AHCA Medicaid Nursing Home statewide average reimbursement schedules, 2007-10
The Diversion project, referenced in the *Florida Statutes* as a pilot project, is directed to accomplish the following pursuant to the authorizing statute, section 430.705, *Florida Statutes*:

1. Provide services of sufficient quality, type and duration to prevent or delay nursing facility placement.
2. Integrate acute and long-term care services, and the funding sources for such services.
3. Encourage individuals and families to plan for their long-term care needs.

To meet these objectives, the Department requires that potential providers demonstrate the capacity and experience to maximize placement of participants in the least restrictive, most appropriate care settings. Managed care contractors\(^1\) are currently selected through an open application process and those that meet the requirements contract with the Department to provide services. Managed care organizations receive a per-member per-month fixed payment to provide, manage and/or coordinate the enrollee’s full continuum of long-term care and medical care, including nursing home costs if necessary. The Diversion providers’ liability for the cost of all long-term care services, especially expensive nursing facility care, provides a financial incentive for providers to ensure high-quality home- and community-based services.

**Eligibility**

Project enrollees must be age 65 and older, and enrollment is voluntary. Enrollees must also:

- Be enrolled in Medicare Parts A & B;
- Be Medicaid eligible up to the Institutional Care Program (ICP) income and asset levels;
- Reside in the project service area;
- Be determined by the Department of Elder Affairs’ Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff to be a person who, on the effective date of enrollment, can be safely served with home- and community-based services;
- Be determined by CARES to be at risk of nursing home placement; and
- Meet one or more of the following clinical criteria:
  - Require some help with five or more activities of daily living (ADLs); or
  - Require some help with four ADLs plus require supervision or administration of medication; or

---

\(^1\) For the purpose of the Diversion program, managed care contractors are not limited to health maintenance organizations. Other qualified providers (OQP) as defined in 430.703 are also eligible to become Diversion providers. Examples of potential OQPs are nursing homes, home health agencies, hospice providers, adult day care centers, and assisted living facilities.
- Require total help with two or more ADLs; or
- Have a diagnosis of Alzheimer’s disease or another type of dementia and require assistance or supervision with three or more ADLs; or
- Have a diagnosis of a degenerative or chronic condition requiring daily nursing services.

**Services**

Diversion plans coordinate a mandatory array of **acute care services** and are directly responsible for **long-term care** and **case management** support and the delivery of a full spectrum of long-term care services for individuals who are **dually eligible** for Medicaid and Medicare. The typical plan includes professional coordination of services, personal care and/or chore, adult day or assisted living facility care when needed, prescription drugs (the limited Medicaid formulary not covered by Medicare Part D), payment of Medicare coinsurance and deductibles, and skilled nursing home care as needed.

**Acute care services** offered through the Diversion program include community mental health services; dental, vision, and hearing services; home health care; independent lab and x-ray services; inpatient hospital care; outpatient hospital services; emergency medical services; physician services; prescribed drugs; and hospice. Diversion providers have financial responsibility for the portion of these services that are not covered by Medicare or reimbursed by Medicaid pursuant to Medicaid’s cost-sharing polices.

**Long-term care services** available through Diversion providers include the following: adult companion; adult day health; assisted living services; chore services; consumable medical supplies; environmental accessibility adaptation; escort; family training; financial assessment/risk reduction; home-delivered meals; homemaker; nutritional assessment/risk reduction; personal care; personal emergency response systems; respite care; occupational, physical and speech therapies; nursing facility services; and coordination of prescribed drugs and other Medicare funded services. Some plans also offer expanded benefits such as Medicare Advantage coverage, enhanced visual/hearing/dental services, transportation and other services.

**Case management services** ensure coordination and integration of care delivery. Case managers facilitate enrollee access to needed medical, social and educational services from a variety of community resources. In accordance with Federal requirements, Diversion contractors are required to provide case management directly; however, the Department, in consultation with the Medicaid Agency, is exploring the opportunity of permitting this service to be subcontracted in order to help facilitate establishment of Diversion services in rural areas.

In addition to case management, the four most utilized services are assisted living, adult day health, personal care and homemaker services. The range of services offered through Diversion has changed very little since its inception in 1998, with two notable
exceptions. In 2008, Florida Medicaid ceased funding of transportation services for a number of programs including the Diversion project. Another change, also made in 2008, permits clients to be dually-enrolled in Hospice care and Diversion, as long as services are not duplicated, which is a great benefit to many elders.

The Diversion project is statutorily directed to integrate acute and long-term care services and the funding sources for such services. Under the current model, Diversion providers offer coordination of acute (Medicare) and long term care (Medicaid) services and funding is not integrated:

Services: Coordinated, and in some cases integrated. For enrollees who voluntarily choose to enroll with a Diversion provider that also offers a Medicare Advantage product, services may be integrated at the plan level. For example, if Contractor U has a contract with the Department of Elder Affairs to provide services through the Diversion program and Contractor U also has a contract with Medicare to deliver Medicare services, an enrollee could choose to enroll in both of Contractor U’s plans and receive integrated care at the plan level.

In addition to expanding Diversion program contracts with Medicare Advantage or Special Needs Plans, the Department is analyzing several other integration models. The models are discussed later in this report and would require legislative authority and support.

**Project Funding**

The Diversion project was implemented in December 1998 with approximately $22 million in Medicaid funding. In state fiscal year 2003-04, the project received its first significant funding increase, bringing the total funding to approximately $68 million.

Initial funding for 2007-2008 was $217 million, until Special Session C, which added approximately $6.8 million for a total of approximately $224 million. For the 2008-09 state fiscal year, the appropriation totaled $306,373,201 million. For the 2009-2010 state fiscal year, funding totaled $327,899,046, an increase appropriated to serve approximately 2,200 additional clients.

In November 2010, statewide enrollment was approximately 20,500 elders. Based on current capitation rates, the Medicaid program is avoiding nearly $675 million in additional costs that would have to be paid if all current enrollees were served in nursing homes instead of through Diversion. Table 2 displays the Diversion program’s appropriation history. Funding presents combined federal and state appropriations and was transferred from AHCA’s appropriation to the Department effective July 1, 2009.
### TABLE 2: APPROPRIATION HISTORY
**FY 1997 – FY 2011**

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Combined Federal and State Funding (Dollars)</th>
<th>Clients Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-1997</td>
<td>$11,117,454</td>
<td>N/A</td>
</tr>
<tr>
<td>1997-1998*</td>
<td>$22,769,909</td>
<td>N/A</td>
</tr>
<tr>
<td>1998-1999</td>
<td>$22,769,907</td>
<td>118</td>
</tr>
<tr>
<td>1999-2000</td>
<td>$22,769,907</td>
<td>814</td>
</tr>
<tr>
<td>2000-2001</td>
<td>$22,769,907</td>
<td>1,074</td>
</tr>
<tr>
<td>2001-2002</td>
<td>$26,119,143</td>
<td>1,165</td>
</tr>
<tr>
<td>2002-2003</td>
<td>$30,916,013</td>
<td>1,216</td>
</tr>
<tr>
<td>2003-2004</td>
<td>$68,082,110</td>
<td>4,247</td>
</tr>
<tr>
<td>2004-2005</td>
<td>$128,457,002</td>
<td>7,480</td>
</tr>
<tr>
<td>2005-2006</td>
<td>$209,000,000</td>
<td>9,348</td>
</tr>
<tr>
<td>2006-2007</td>
<td>$200,870,188</td>
<td>5,319</td>
</tr>
<tr>
<td>2007-2008</td>
<td>$224,335,496</td>
<td>13,024</td>
</tr>
<tr>
<td>2008-2009</td>
<td>$306,373,201**</td>
<td>19,032</td>
</tr>
<tr>
<td>2009-2010</td>
<td>$327,899,046</td>
<td>25,165</td>
</tr>
<tr>
<td>2010-11</td>
<td>$337,924,993***</td>
<td>26,925***</td>
</tr>
</tbody>
</table>

**NOTE:** Funding amounts represent combined federal and state appropriations. Funding includes Program of All-Inclusive Care for the Elderly (PACE) clients for FY 2002-2003 through FY 2008-2009.

* Project implementation began 12/98.
** Includes reduction in funding via Legislative Special Session mandate.
*** Projection (includes PACE clients).

*Source: Department program data and CIRTS reports.*

### Enrollment Trends

Since the 2006-2007 fiscal year, Diversion project enrollment has almost tripled. Diversion project enrollment grew from 7,219 enrollees at the beginning of state fiscal year 2006-2007 to almost 20,000 enrollees as of December 2010.
Chart 1 displays enrollment trends for the period January 2008 through December 2010.

**Chart 1: Diversion Enrollment Trends (self-reported by plans)**

Enrollment in this program was frozen between July 1, 2007, and June 30, 2008, then again for the first half of 2009, and again in May of 2010 to ensure that Diversion program expenditures did not exceed the legislative allocation. After July 1, 2008, following an increase in legislative funding, there was sufficient funding to release all persons from the waitlist. Between August and December 2008, enrollment in the Diversion program increased by almost 1,000 frail elders per month. In anticipation of reaching the state fiscal year 2008-2009 appropriation cap and federal enrollment cap, new enrollment was frozen in January 2009 when the census hovered around 15,300.

New enrollments remained frozen until June 2009, when the Department released over 1,000 elders from the waiting list in anticipation of the $35 million increase from the Legislature effective July 1, 2009. As of December 2009, the Department had released all persons from the waiting list that accumulated throughout 2009 (approximately 9,000 elders), and the program remained open to new enrollments until May 2010. Due to the continued follow up and processing of individuals in the pipeline waiting for services, Diversion enrollment reached its highest peak ever, 21,644 enrollees as of July 2010.

The function of enrolling individuals into Diversion is currently performed by the Department’s CARES staff and maintained in the Department’s Client Information and Registration Tracking System (CIRTS) system. Managed care organizations are required to submit enrollments to the Medicaid fiscal agent where the enrollment and payment records are also maintained, except for the “Medicaid Pending” population. While the Department considers CARES to be the appropriate staff to perform choice counseling
functions, the Department believes the establishment of an enrollment broker for Diversion would serve to simplify the eligibility process and provide for successful enrollment processes for frail elders, their families and the Department. The establishment of an enrollment broker for Diversion would offer resources and technology to improve successful enrollment and wait list management.

**Counties and Providers Approved for Diversion Projects**

Diversion project operations began during the 1998-1999 State fiscal year. Initially, the program was available in just four counties—three in Central Florida and one in Palm Beach County.

In July 2003, a significant expansion effort was initiated and by mid-2004, the Diversion project was operational in the majority of the 26 approved counties throughout the state. In November 2005, a second expansion was approved by the Centers for Medicare and Medicaid Services (CMS) and an additional 23 counties were added to the project’s potential service area.

In April 2007, a third expansion broadened the project service area to include Clay and Nassau counties. Approval to expand to all but seven Florida counties was granted in mid-December 2008, and in 2010, the Department received approval for the remaining seven counties, which include Gulf, Holmes, Jackson, Madison, Putnam, Taylor, and Washington.

While the Department has received approval from CMS to expand to all 67 counties, Diversion is currently available in only 40 counties. Barriers to expansion include difficulty establishing a network of providers in rural counties, and additionally, in rural areas, it is often difficult to meet the federal requirement to ensure that participants have a choice of at least two available providers for each service. Map 1 highlights counties with provider networks and those without.

Seventeen providers serve the 40 existing counties. As of December 2010, a total of twelve Diversion providers served Miami-Dade County. Conversely, there are still no approved providers in North Central Florida, which is a predominantly rural area of the state. In a March 2010 report, the Office of Program Policy Analysis and Government Accountability recommended the Legislature “designate that any future Nursing Home Diversion waiver program funding increases be used to expand the program to counties not currently served.”
Comparison of Diversion to Other Long Term Care Alternatives

The primary goal of many of the Department’s programs and services is to prevent or delay nursing home placement through the provision of long-term care services in less restrictive and less costly community settings. Delaying or preventing nursing home placement benefits the State as well as elders. Virtually all elders and their families prefer community living settings, which may include private residences or assisted living facilities, to nursing home care, and the State benefits through reduced Medicaid expenditures, since Medicaid nursing home placement costs dramatically more than home- and community-based alternatives.

The Diversion project serves very frail clients. On average, Diversion participants are more similar to nursing home residents than they are to elders served by the Department’s other major statewide programs. Therefore, it is not surprising that while the cost of Diversion is far less than the cost of nursing home care, it is more costly than the Department’s other HCBS programs that serve less frail elders.
Frailty Levels of Participants

Diversion project participants have higher average risk scores as determined through a standardized comprehensive assessment than elders served through all other programs administered by the Department. The average risk score for Diversion participants is much higher than the average score for participants in the Aged and Disabled Adult Waiver and Community Care for the Elderly Programs and slightly higher than the average score for elders served through the Assisted Living for the Elderly Waiver. Only nursing home residents have a higher average risk score than Diversion participants (see Table 3).

An important measure of frailty and risk is the number of routine self-care activities such as eating, bathing, and taking medications a person requires assistance to complete. These activities are termed Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). As shown in Table 3, Diversion participants require assistance with an average of five ADLs, which is the maximum score. The average ADL score of Diversion participants is virtually identical to elders receiving full-time Medicaid nursing home care, and they are more impaired than participants in the Department’s other major statewide programs. Comparing the average IADL scores, Diversion participants need slightly less assistance than nursing home residents but need more help than participants in the Aged and Disabled Adult Waiver. Diversion participants and Assisted Living for the Elderly Waiver participants (who all live in assisted living facilities) have nearly identical average IADL scores.

Three-quarters of Diversion participants suffer from incontinence, and 63 percent suffer from some form of dementia, such as Alzheimer's disease. The percent of Diversion participants with dementia and incontinence is greater than participants in any other programs, including Medicaid nursing home residents.
Table 3: Frailty Profile of Active Clients by Program, State Fiscal Year 2009-10

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Nursing Home</th>
<th>Long-term Care Diversion</th>
<th>Assisted Living for the Frail Elderly Waiver</th>
<th>Medicaid Aged and Disabled Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Nursing Home Risk Score (range 0-100)*</td>
<td>78.73</td>
<td>65.19</td>
<td>63.37</td>
<td>41.36</td>
</tr>
<tr>
<td>Average Priority Score (range 0-100)</td>
<td>32.96</td>
<td>27.89</td>
<td>20.81</td>
<td>28.75</td>
</tr>
<tr>
<td>Average Number of ADLs Requiring Assistance (range 0-8)</td>
<td>5.15</td>
<td>5.06</td>
<td>4.35</td>
<td>3.54</td>
</tr>
<tr>
<td>Average Number of IADLs Requiring Assistance (range 0-8)</td>
<td>7.71</td>
<td>7.55</td>
<td>7.6</td>
<td>6.49</td>
</tr>
<tr>
<td>Percentage with Incontinence</td>
<td>67%</td>
<td>75%</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Percentage with Dementia</td>
<td>60%</td>
<td>63%</td>
<td>62%</td>
<td>32%</td>
</tr>
</tbody>
</table>

*Risk score indicates the client’s risk of nursing home placement

Diversion Cost Compared to Other Department Programs and Nursing Home Placement

The Diversion project targets frail elderly individuals who are financially and medically eligible for Medicaid nursing home care and are considered at risk for nursing home placement. The average annual cost for Medicaid to serve an elder in a Florida nursing home in FY 2009-10 was $58,055 compared to a cost of $18,504 for alternative Diversion services, yielding an estimated annual cost savings of $39,551 per enrollee compared to nursing home placement (see Table 4).

During state fiscal year 2009-10, the Diversion project served 24,927 unduplicated enrollees for a total of 204,818 case-months of service. With a monthly average cost differential of $3,296, the Diversion program saved Florida approximately $675 million in costs that would have been paid if all eligible enrollees were served in nursing homes instead of through Diversion. Table 4 shows a comparison of cost and utilization information for individuals in nursing homes, the Diversion project and other Department programs for the elderly. Those other programs generally provide a less extensive array of support services, but also may have less stringent medical eligibility requirements.
As previously noted, Diversion participants are significantly frailer than elders served through the Department’s other major statewide programs and typically require more services to remain in home or community-based settings for an extended period of time.

Table 4: Program Cost and Utilization by Program
For State Fiscal Year 2009-10

<table>
<thead>
<tr>
<th>Frailty Rank</th>
<th>Program</th>
<th>Annual Cost</th>
<th>Total Case Months</th>
<th>Unduplicated Clients Served</th>
<th>Annual Cost per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicaid Nursing Home Payments Only</td>
<td>$2,056,075,104</td>
<td>424,992</td>
<td>61,781</td>
<td>$58,054.98</td>
</tr>
<tr>
<td>2</td>
<td>Medicaid Long-term Care Diversion Project</td>
<td>$315,826,519</td>
<td>204,818</td>
<td>24,927</td>
<td>$18,503.83</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid Assisted Living for the Elderly Waiver</td>
<td>$29,943,282</td>
<td>36,287</td>
<td>3,960</td>
<td>$9,902.15</td>
</tr>
<tr>
<td>6</td>
<td>Medicaid Aged/Disabled Waiver</td>
<td>$86,285,651</td>
<td>114,720</td>
<td>11,825</td>
<td>$9,025.70</td>
</tr>
</tbody>
</table>

Initiatives and Future Direction

Medicare and Medicaid Integration Options

Nationally, over 8.8 million Medicaid and Medicare dual eligible individuals consume almost half of Medicaid expenditures and close to one quarter of Medicare costs (Kaiser Commission on Medicaid Facts, 2008). The Agency for Health Care Administration’s data (December, 2010) defined the number of dually eligible persons enrolled in the Florida Medicaid program as “a total of 589,000 Medicare recipients who receive some sort of assistance from Medicaid (including the Full Duals, Qualified Medicare Beneficiaries, SLMB and QI1 groups).” AHCA reported that as of August 2010, “There are approximately 320,000 full duals.” Fewer than 21,000 duals are enrolled in an integrated or coordinated managed care program. To decrease State of Florida Medicaid long term care expenditures, the Diversion model targeting services to the over 300,000 duals can be modified to achieve further integration and cost containment. Medicaid and Medicare integration options the State can explore, as summarized by the Center for Health Care Strategies, include the following:

1) Incorporation of Medicare Advantage and/or Special Needs Plan contracting;
2) Expansion of the Program of All Inclusive Care for the Elderly (PACE);
3) A shared savings model; or
4) The State of Florida as an integrated entity.
Determining a course of action to contain Medicaid long-term care costs while the population ages and the need for services continues to increase remains the Diversion program’s biggest challenge. Other operational improvements underway relate to the enrollee status categorized as Medicaid Pending, concerns about ensuring quality of care and sufficient clinical oversight, and evaluating disenrollment.

**Implementation of “Medicaid Pending” Status**

In 2006, the Legislature amended Section 430.705 (5), F.S., to create an option for Diversion project applicants to choose to receive services prior to the conclusion of the Medicaid financial eligibility determination process, which is performed by the Department of Children and Family Services. Under the new legislation, Diversion project applicants can be designated as “Medicaid-Pending” after they have been determined medically eligible by CARES staff but not yet determined financially eligible for Medicaid. However, elders who opt to use this option assume financial risk, as the client is liable for the costs of Diversion project services already received if he or she is determined not to be financially eligible for Medicaid.

Implementation of Medicaid Pending status in 2007 has been associated with some operational challenges. While the capacity to provide services to frail elders quickly is a benefit of this legislation, the existing Medicaid fiscal agent does not have a way to enroll these individuals while they are being served in Medicaid Pending status. Currently, some Medicaid Pending client enrollments must be processed manually, which is an administrative burden for the state operating agencies and the providers. In addition, it has been difficult for the providers to collect payment for the services provided to clients that are determined ineligible for Medicaid. The enrollment broker option could potentially resolve the manual processes.

**Rate-Setting Methodology**

After implementing a new Diversion program capitation rate methodology in September 2006, the Department instituted another change in the rate setting methodology for the contract year beginning September 2008. For the September 2008 – August 2009, contract year, the change represented the first time Diversion program rates were set using plan utilization data. The Centers for Medicare and Medicaid Services requires that all Medicaid capitation rates be certified by an actuary. Using the new methodology, rates were set based on 50 percent weight of encounter data and 50 percent use of the prior methodology.

For the contract year beginning in September 2009, the Department based rates exclusively on encounter data as required by the Centers for Medicare and Medicaid Services. On a statewide basis, this resulted in a 3.3 percent decrease in the rates paid to providers. This decrease followed a 2 percent rate cut effective in March 2009, in response to the directive of a special Legislative Session. The utilization of 100 percent encounter data eliminated the need for the nursing facility disenrollment fee prescribed
in Chapter 2007-326 Laws of Florida. During the last quarter of 2010, the Department and the actuarial consultant have been working to update the assessment-rating methodology. This new methodology will improve the alignment between payment rates and the average frailty level of the clients served by each provider. The impact analysis will be completed in 2011, and consideration will be given to implementing this new methodology in setting the 2011-2012 rates. While the implementation of the new assessment methodology will not reduce overall payments, it is anticipated to shift monies from providers serving less frail clients to those serving more frail clients.

During 2010, the Department also worked with the contracted actuary to receive proposals to further enhance the rate setting methodology for the upcoming 2010-2011 contract cycle. The suggestions for consideration include:

- Changes to increase Diversion provider retention of nursing facility risk;
- Consideration of the requirement for Diversion providers to submit Diversion-specific audited financial statements;
- Dedication of Department resources to quarterly encounter data validation and review to assist plans with improving the quality of data submitted; and
- Completion of the Adjustment Rate Factor plan specific modeling and implementation of updates.

Finally, in August of 2010, the United States General Accounting Office (GAO) released a report assessing CMS’s oversight of states’ compliance with the actuarial soundness requirements and efforts to ensure the quality of data used to set rates. The GAO recommends that CMS implement a mechanism to track state compliance with the requirements, clarify guidance on rate-setting reviews and make use of information on data quality in overseeing states’ rate setting.

**Program Enhancement Workgroup**

At the end of 2008, the Department created a Diversion program workgroup charged with making recommendations to improve operation and provider communications and with exploring new initiatives. Issues explored by the workgroup and its various subgroups included streamlining the medical and financial eligibility processes, consideration of uniform protocols for facility subcontractor billing, program expansion, and rate-setting methodology. Future workgroup topics will likely include consideration of the expansion of network boundaries to cover multiple counties, which may facilitate expansion to rural areas. Due to lack of provider participation, workgroups were suspended for the 2009-2010 fiscal year. However, the Department does conduct monthly calls with Diversion contractors to address program issues.
Monitoring

Across all states, CMS is requiring the designated Medicaid agencies to alter their operating agreements to provide more accountability to CMS for waivers with regard to monitoring and other substantive operational issues. The Agency for Health Care Administration and the Department of Elder Affairs are being asked to significantly alter the interagency agreement governing the Diversion program, as a result of the new CMS mandates.

Meanwhile, the Department has recently implemented changes in its monitoring process. Existing Department resources were reallocated to permit an increase in the number of face-to-face enrollee visits by Department staff for the 2008-09 monitoring cycle and again for 2009-10. As a part of the 2009-10 monitoring review, completed in the fourth quarter of 2010, the Department is focusing on technical assistance to providers aimed at enhancing the effectiveness of providers related to the program’s mission to coordinate acute (Medicare) and long term care (Medicaid) and in the area of care planning and service delivery. The Department is also exploring additional clinical resources to evaluate and effectuate improved quality of care.

Although the Department is taking the initiative to continuously refine and enhance the Diversion model, the Centers for Medicare and Medicaid Services audit results received in 2010 reported CMS satisfaction with the program and the Department’s oversight and management. Furthermore, consumer satisfaction surveys reflect high satisfaction, also evidenced by the program’s high participant retention rate.

In addition to participating in monitoring by the Department, Diversion providers participate along with all Medicaid managed care contractors in AHCA’s external quality review (EQR) activities. In 2009, Diversion providers completed a performance improvement project related to enrollee retention. The following results were reported by the Health Services Advisory Group (see Table 5).
The performance improvement project related to enrollee retention is continued for fiscal year 2010-2011. Diversion providers also began a new performance improvement measure exploring timeliness of services delivered to Diversion enrollees. This project will be ongoing in 2010 and 2011.

### Disenrollment

Unlike many states with similar programs, enrollment and disenrollment in the Diversion program is voluntary, with some prescribed exceptions that must be approved by the Department in advance. The overwhelming majority of program disenrollments occur due to death. The second most common reason for disenrollment is the enrollee going back to the more costly fee-for-service Medicaid nursing home care.

The number of enrollees returning to Medicaid fee-for-service nursing home care – 409 in 2007-08 and 401 in 2008-09 – raises justifiable concerns regarding the program’s effectiveness in achieving cost savings. While there are many benefits of a voluntary program, the current model has few or no incentives for: 1) Diversion providers to retain enrollees who require or elect nursing home care, 2) nursing facilities to contract with Diversion providers, and 3) enrollees to utilize nursing homes within a Diversion provider’s network or follow a provider’s placement recommendations.

Moreover, the coordination between Medicare and Medicaid (long-term care) is a challenging issue facing many states. Specifically, individuals are often discharged from hospitals into nursing homes for short-term rehabilitation with Medicare as the primary payer. If these individuals are also enrolled in a Medicaid long-term care program such as Diversion, there is no formal mechanism that coordinates or transitions the Medicare nursing home short-term coverage with the Medicaid long-term care component. For example, elders discharged from hospitals into nursing homes under Medicare may find...
themselves having to disenroll from the Diversion program when their Medicare stay ends if they are in an “out of network nursing home,” or if they or their family prefer for the elder to remain in the nursing home setting. Simultaneously, the Diversion provider may have assessed the elder and determined that a less costly, alternative setting, such as an ALF, is more appropriate.

The Department, in consultation with the Medicaid Agency and the independent actuary, is currently analyzing alternatives that would improve retention of Diversion enrollees in community-based settings whenever possible, and perhaps discourage both plans and individuals from prematurely terminating enrollment in the Diversion program. Below is a list of the alternatives being analyzed:

- Providers are charged nursing home risk (limited in some way: e.g., 180 days) if admitted within a certain period after disenrollment;
- Enrollees must remain in their plan for 12 months, similar to Medicare Advantage;
- Mandatory managed care for the NHD population – with a 12-month lock-in to a plan; or
- Create “quality” score for NHD plans that includes disenrollment rate and other measures. A low quality score could reduce rates, freeze or limit enrollment, or affect the plans in other ways.

**Conclusion**

December 2010 marks the twelfth year that the Diversion project has provided services to frail elders. For the 2010-2011 contract year, which began September 1, 2010, a 100 percent capitation rate-setting methodology was implemented and contracts were signed by 17 organizations.

With the exception of the Program of All Inclusive Care for the Elderly, the Diversion program represents Florida’s most coordinated model of medical and community-based care for frail elders on Medicare and Medicaid. Almost 20,000 elders were served in a community-based setting, and an expenditure of approximately $419 million dollars was avoided relative to the cost of nursing home placement.

Primary goals of the Department remain the facilitation of the successful expansion of the program to rural counties and improvement in the delivery and integration of care for elder enrollees within this model pilot program that has proven to continually generate cost savings for Florida.