Long-Term Care
Community Diversion
Pilot Project

2011-2012 Legislative Report

Rick Scott, Governor

Charles T. Corley, Secretary
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Executive Summary

The Department of Elder Affairs (DOEA) Long-Term Care Community Diversion Pilot Project (Diversion Program or Diversion) has been in operation for 14 years. The Diversion Program 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 contracts with Managed Care Organizations (MCOs) to provide eligible individuals with a continuum of Medicaid long-term care services and to coordinate their acute care services. Diversion MCOs assume the full financial risk of these services, including the cost of nursing home placement.

The Diversion Program model offers significant advantages to both the State and to Florida’s elders. For the elders receiving services, the Program helps preserve dignity, maximum possible independence, and a sense of continued connection to the community. In addition, benefits to the State include the financial predictability, service flexibility, and program accountability associated with a managed care service delivery model. 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 elder population that is dually (Medicaid and Medicare) eligible. These individuals also meet specified medical criteria that would otherwise qualify them for full-time nursing home care (see detailed eligibility criteria in Program Background section below).

Diversion MCOs contract to provide a comprehensive set of long-term care and case management services. They are required to coordinate recipients’ acute care 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 MCOs. 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. Furthermore, since the Program’s inception in 1998, the average payment rate has been reduced by more than 38 percent from approximately $2,300 per client per month in 1999 to the current rate of approximately $1,435 per client per month.

As illustrated in Chart 1, the contract cycle between September 2011-August 2012 statewide average capitated rate of $1,439.37 per member per month (PMPM) remains well below the comparable Medicaid reimbursement schedule for full-time nursing home care of $6,555.57 per month and the difference between costs of the two approaches
has been widening. The statewide average capitated rate was reduced again, to $1,421, for the contract cycle September 2012-August 2013.

**Chart 1: Comparative Cost Trends, FY2006 – FY2012**

During the 2011 legislative session, legislation was passed to establish a new program that will transform the way Medicaid recipients receive care in Florida. Beginning in 2013, Diversion enrollees will transition to the new Statewide Medicaid Managed Care Long-Term Care Program (SMMCLTCP).

Diversion Program staff have been working closely with the Agency for Health Care Administration (AHCA) in the development of the new SMMCLTCP, including actively participating in implementing a quality assurance strategy to fulfill the legislative mandate to monitor the performance of the plans and to ensure a smooth transition for all enrollees.

One of the barriers in previous years for the Diversion Program was the limited availability in under-served and rural areas of the state. Due to the upcoming implementation of SMMCLTCP, there was an increase in expansion requests from current MCOs, compelling the Diversion Program to expand into previously underserved areas.
Diversion is now operational in 66 of the 67 counties in Florida. In addition to the expansion of current MCOs, DOEA approved three new Diversion MCOs.

The Diversion Program has been under an Enrollment Management System since 2010 due to budgetary constraints. During this time, the Diversion Program enrollment has been facilitated through waitlist releases conducted by DOEA. These releases are intended to increase enrollment while still ensuring the Program stays within its legislative funding allocations. DOEA is proactively working to reduce the waitlist, where approximately 10,500 individuals are currently waiting to receive services. Since releases began in August 2011, DOEA has released approximately 20,000 individuals from the waitlist into Diversion.

Program Background

The Diversion Program 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. DOEA administers the Program in partnership with AHCA through a cooperative agreement.

The Diversion Program 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. The Diversion Program, 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, DOEA requires that potential MCOs demonstrate the capacity and experience to maximize placement of participants in the least restrictive, most appropriate care settings. Managed care contractors receive a per member per month fixed payment to provide, manage, and/or coordinate the client’s full continuum of long-term care and medical care, including nursing home costs, if necessary.

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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, Florida Statutes, 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.
Eligibility

Program clients must be age 65 and older, and enrollment is voluntary. Clients 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 program 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
  - 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.

Frailty Levels of Participants

The average risk score, as determined through a standardized comprehensive assessment, for Diversion participants is much higher than the average score for participants in the Aged and Disabled Adult Waiver (ADA) and Community Care for the Elderly (CCE) Programs and slightly higher than the average score for elders served through the Assisted Living for the Elderly Waiver (ALE). Only nursing home residents have a higher average risk score than Diversion participants (see Table 1).

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 1, 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 DOEA’s other major statewide programs. Comparing the average IADL scores, Diversion participants need slightly less assistance than nursing home residents, but they 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.

More than three-quarters of Diversion participants suffer from incontinence, and 62 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 program, including Medicaid nursing home residents.

**Table 1: Frailty Profile of Active Clients by Program, State Fiscal Year 2011-2012**

<table>
<thead>
<tr>
<th>Program</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>79</td>
<td>66</td>
<td>61</td>
<td>41</td>
</tr>
<tr>
<td>Average Priority Score (range 0-100)</td>
<td>32</td>
<td>27</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Average Number of ADLs Requiring Assistance (range 0-8)</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Average Number of IADLs Requiring Assistance (range 0-8)</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Percentage with Incontinence</td>
<td>68%</td>
<td>78%</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>Percentage with Dementia</td>
<td>62%</td>
<td>62%</td>
<td>60%</td>
<td>32%</td>
</tr>
</tbody>
</table>

NOTE: The source of the information in this chart is the Client Information and Registration Tracking System (CIRTS).

**Services**

Diversion MCOs coordinate a mandatory array of **acute care services** and are directly responsible for **long-term care** and **case management** support as well as 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 services, adult day or assisted living facility care when needed, payment of Medicare coinsurance and deductibles, and skilled nursing home care as needed.
**Acute care services** offered through the Diversion Program include 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 care. Diversion MCOs 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 policies.

**Long-term care services** available through Diversion MCOs 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, respiratory, and speech therapies; nursing facility services; and coordination of prescribed drugs and other Medicare-funded services. Some MCOs also offer expanded benefits, such as Medicare Advantage coverage, enhanced visual/hearing/dental services, an over the counter stipend, transportation, and other services.

**Case management services** ensure coordination and integration of care delivery. Case managers facilitate client access to needed medical, transportation, social, and educational services from a variety of community resources. In accordance with federal requirements, Diversion MCOs are required to provide case management directly. This requirement is expected to change in the SMMCLTC Program to allow the MCOs to subcontract the case management function.

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

**Services are coordinated, and in some cases integrated,** for clients who voluntarily choose to enroll with a Diversion Plan that also offers a Medicare Advantage product. Services may be integrated at the plan level, meaning one provider coordinates services for the individual enrolled in two of their managed care products, a Medicare Plan and a Medicaid Plan (Diversion). Payment is not integrated. Otherwise, the Plan coordinates each client’s service delivery to ensure a seamless plan of care that includes all long-term care and acute care needs.
Program Funding

The Diversion Program was implemented in December 1998 with approximately $22 million in Medicaid funding. In state fiscal year 2003-04, the program 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. For the 2009-2010 state fiscal year, funding totaled $327,899,046, an increase appropriated to serve approximately 2,200 additional clients. An additional 1,000 slots were added to the program and funding was increased to $355,766,698 for 2011-12. Funding was increased by approximately $3.3 million for the 2012-2013 contract year bringing the total 2012-13 appropriation to $359,036,110.

In October 2012, statewide enrollment was approximately 20,706 elders and growing. Based on current capitation rates, the Medicaid Program is avoiding as much as $547 million in additional costs that would have to be paid if all current clients 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.

**TABLE 2: APPROPRIATION HISTORY FY 1997 – FY 2012**

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Combined Federal and State Funding</th>
<th>Unduplicated Clients Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-1997</td>
<td>$11,177,454</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>$26,117,143</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>Year</td>
<td>Funding</td>
<td>Clients</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>---------</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>2010-2011</td>
<td>$337,924,993</td>
<td>23,292</td>
</tr>
<tr>
<td>2011-2012</td>
<td>$355,766,698</td>
<td>24,539</td>
</tr>
<tr>
<td>2012-2013</td>
<td>$359,036,110</td>
<td></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.

* Program implementation began 12/98.
** Includes reduction in funding via Legislative Special Session mandate.

Source: Department program data and CIRTS reports.

**Enrollment Trends**

Since the 2006-2007 fiscal year, Diversion’s enrollment has almost tripled, growing from 7,219 clients at the beginning of state fiscal year 2006-2007 to just over 20,700 clients as of October 2012. 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 which is tracked manually.

Chart 2 displays enrollment trends for the period January 2008 through October 2012. Drops in total enrollment indicated on the chart reflect periods when Diversion reached capacity and had to temporarily halt all enrollment except nursing home transition enrollments. Under the Program’s enrollment management system, the number of new clients referred to Diversion MCOs is closely monitored to ensure enrollment remains consistent with current budget allocations and assigns priority status to those with the highest risk of nursing home placement based on frailty criteria. Current funding should accommodate enrollment of approximately 24,000 eligible clients, and monthly releases from the waitlist should continue through 2012.
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 DOEA released over 1,000 elders from the waitlist in anticipation of the $35 million increase from the Legislature effective July 1, 2009.

By December 2009, DOEA had released all persons from the waitlist 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 of 21,644 clients as of July 2010.

Diversion continues to operate under the Enrollment Management System that was implemented in 2010. Monthly reviews are conducted to closely assess funding availability to ensure the Diversion Program provides services to as many elders as possible. Since August 2011, the Department has released approximately 20,000 individuals from the waitlist. As of November 2012, there were approximately 9,909 individuals still waiting to be released. The waitlist is weighted for medical risk and adjusted constantly as medical risk factors of those on the waitlist change and as new clients are added to the waitlist.
Counties and MCOs Approved for Diversion Programs

Diversion Program 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 Program 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 Program’s potential service area.

In April 2007, a third expansion broadened the Program 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 included Gulf, Holmes, Jackson, Madison, Putnam, Taylor, and Washington.

As of 2012 the Diversion Program is now offered in 66 of 67 counties in Florida. Map 1 highlights the availability of Diversion and how many MCOs are located within each county. Currently 20 Diversion MCOs serve clients in 66 counties. As of October 2012, a total of 13 Diversion MCOs served Miami-Dade County. In addition, 64 of the 66 counties have three or more MCOs available to the elder population.

Map 1: Counties of Operation, October 2012
**Comparison of Diversion to Other Long-Term Care Alternatives**

The primary goal of many of DOEA’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. The State benefits through reduced Medicaid expenditures, since Medicaid nursing home placement costs dramatically more than home and community-based alternatives.

The Diversion Program serves very frail clients. On average, Diversion participants are more similar to nursing home residents than they are to elders served by DOEA’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 DOEA’s other HCBS programs that serve less frail elders.

**Diversion Cost Compared to Other Department Programs and Nursing Home Placement**

The Diversion Program 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 2011-2012 was approximately $61,000, compared to a cost of $17,000 for alternative Diversion services, yielding an estimated annual cost savings of $44,000 per client compared to nursing home placement (see Table 3).

During state fiscal year 2011-2012, the Diversion Program served 24,539 unduplicated clients for a total of 221,193 case-months of service. Based on the most conservative cost estimates, the Diversion Program saved Florida at least $547 million last year. Table 3 shows a comparison of cost and utilization information for individuals in nursing homes, the Diversion Program and other DOEA 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 DOEA’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 3: Program Cost and Utilization by Program
For State Fiscal Year 2010-11

<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>$2,516,690,799</td>
<td>493,717</td>
<td>61,025</td>
<td>$61,169.23</td>
</tr>
<tr>
<td>2</td>
<td>Medicaid Long-term Care Diversion Project</td>
<td>$314,388,026</td>
<td>221,193</td>
<td>24,539</td>
<td>$17,055.95</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid Assisted Living for the Elderly Waiver</td>
<td>$37,773,706</td>
<td>43,904</td>
<td>4,595</td>
<td>$10,324.45</td>
</tr>
<tr>
<td>6</td>
<td>Medicaid Aged/Disabled Adult Waiver</td>
<td>$99,655,146</td>
<td>108,150</td>
<td>11,045</td>
<td>$11,057.44</td>
</tr>
</tbody>
</table>

Initiatives and Future Direction

Statewide Medicaid Managed Care Program

One of the most significant outcomes of the 2011 Legislative session was the passage of legislation to create a Statewide Medicaid Managed Care Program. Under the timeline included in the legislation, DOEA staff will continue to work alongside AHCA to develop the Long-Term Care piece of the Statewide Medicaid Managed Care Program. The goal is to ensure that the new program incorporates the most successful strategies, lessons learned, and best practices identified in the Diversion Program.

Like the Diversion Program, the new all-inclusive Medicaid managed care service delivery model will be a capitated program with a limited number of regional MCOs selected through an Invitation To Negotiate (ITN) process. Medicaid recipients are scheduled to begin moving to the new program in 2013. The new program will eventually replace all existing Medicaid waiver programs, including the Diversion Program.

Clearly, the managed care approach in the Diversion Program has both helped reduce the need for many clients to enter more expensive skilled nursing facilities, thereby reducing the costs of serving the frail elder population in institutional settings. Capitation rates for the Diversion Program have continued to be cut over four consecutive years, indicating the economies that can be realized through the managed care approach.

During the 2012-2013 contract year, because of recent federal requirements, the Diversion Program MCOs will implement an HCBS framework to help ensure that home and community-based characteristics are promoted throughout the service continuum.
for Diversion participants. Specifically, MCOs must create and implement an individualized, person-centered care plan for all enrollees. The person-centered care plan is based on a comprehensive assessment that identifies not only the enrollee’s physical and functional needs, but also his psychosocial needs, or those needs that relate to his mental, social, and emotional well-being, and implements interventions to meet those identified needs. Consideration of an enrollee’s values, culture, traditions, experiences, and preferences are also important in developing a person-centered care plan. Implementing these strategies will promote community integration and help ensure all participants, including those in an assisted living facility, are residing in a home-like environment.

**Rate-Setting Methodology**

As part of its on-going effort to enhance rate-setting methodology to better reflect both the priorities of the Diversion Program and the actual experience of its plans, DOE A continues to fine-tune both the rate setting methodology and the capitation rates for its plans. After implementing a new Diversion Program capitation rate methodology in September 2006, DOE A 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 (CMS) 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, DOE A based rates exclusively on encounter data as required by the CMS. On a statewide basis, this resulted in a 3.3 percent decrease in the rates paid to MCOs. 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, DOE A and the actuarial consultant worked on another update to the assessment-rating methodology. This new methodology improves the alignment between payment rates and the average frailty level of the clients served by each provider. The revised ARF was first applied during the 2011-12 contract cycle. The decision was made to phase in the ARF application so that no MCO would realize a decrease greater than -3% and an increase greater than 9%. The phased implementation was continued for the 2012-13 contract and rate setting cycle. DOE A continues to use actuarially sound methods and capitation rates continue to decline.

**Assisted Living Facilities**

Diversion staff participate in a monthly workgroup with AHCA to discuss Assisted Living Facilities (ALFs), monitor any pending issues including closures, license revocation, and
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moratorium on admissions. Diversion Plans are notified by DOEA when action is taken and AHCA, DOEA, and the plans work quickly to ensure the health, safety, and welfare of all Diversion enrollees living in ALFs.

DOEA continues working with AHCA and Diversion plans to develop an electronic notification system that would alert Diversion contractors to incidents that occur in ALFs and that are reported on AHCA’s Health Finder database. When implemented, the system will provide Diversion plans with the most current information about the status of a facility so that they can make more informed care determinations for enrollees who reside in or may require the services provided by ALFs.

In addition, during the 2012-2013 contract year DOEA has been working with the CMS to develop a definition and monitoring strategy to help ensure the home-like environment of assisted living facilities in Florida. A home-like environment is considered to be a setting that allows residents to control the access to and furnish their private living areas, receive visitors and make telephone calls in privacy, and access food and a kitchen at their discretion. The State recognizes the importance of and is committed to ensuring that enrollees who reside in ALFs reside in home-like environments and experience community inclusion to the fullest extent possible.

**Monitoring**

DOEA conducts monitoring of Diversion plans routinely throughout the course of the year to ensure contract compliance. The monitoring strategy consists of desk reviews, conducted in the fall, that review many aspects of the plan’s day-to-day operation, including, but not limited to, the enrollee materials, policies and procedures, and staff training. On-site monitoring is conducted in the spring that includes an in-depth assessment of network credentialing, case file reviews, and claims payment. Along with the desk review and on-site monitoring, each plan is required to submit reports throughout the year detailing enrollment, disenrollment, financials, network and staffing, and various other elements that are reviewed by Diversion staff and assessed to determine that all contractual obligations are being fulfilled. A clinical review team also performs care and service delivery focused monitoring throughout the year on a stratified sample.

Additionally, DOEA developed new performance measures to comply with federal requirements for monitoring six subassurance areas. The subassurance areas (Level of Care, Service Plan, Qualified Providers, Health and Welfare, and Financial Accountability), have historically been monitored by DOE. However, CMS is requiring additional performance measures of all states. New indicators measure criteria such as subcontractor performance; health, safety, and welfare issues; and staff training. For example, some performance measures assess whether services are being provided to enrollees as instructed in the enrollee's care plan; whether case managers are discussing advanced directives with enrollees; whether subcontractors are qualified service providers; and whether subcontractors have received the appropriate training for
reporting abuse, neglect, and exploitation. New performance measure indicators have been implemented effective for the 2012-2013 contract year.

**External Quality Review Activities**

In addition to participating in monitoring by DOEA, Diversion MCOs participate in AHCA’s external quality review (EQR) activities. Diversion contractors are required to submit two performance improvement projects (PIP) a year to DOEA and to AHCA’s external quality review organization, Health Services Advisory Group (HSAG), for validation.

One project is chosen by the Diversion contractor and must be designed to address deficiencies identified by the contractor through monitoring, performance measure results, member satisfaction surveys, or other similar means. The second PIP is the statewide collaborative PIP, which is coordinated by HSAG and completed by all Diversion contractors. The current collaborative PIP assesses the timeliness of service implementation for three major services: home health services, adult day health care, and home-delivered meals.

**Conclusion**

October 2012 marks the 14th year that the Diversion Program has provided services to frail elders. For the 2012-2013 contract year, which began September 1, 2012, contracts were signed with 19 managed care organizations. DOEA continues to strive to provide the highest quality home and community-based care while still offering a more cost effective alternative.

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. More than 24,000 elders were served in a community-based setting, and savings of approximately $574 million were realized relative to the alternative costs of nursing home placement.

The primary goal of DOEA remains improvement in the delivery and integration of care for elder clients within this model pilot program that has proven to continually generate cost savings for Florida. As Florida moves toward a managed care model for its other Medicaid services, it is also a key goal to work closely with AHCA to develop the most efficient and effective delivery system possible and to ensure that current Diversion clients have a smooth transition into the new program when it is implemented in 2013-14.