Long-Term Care Community Diversion Pilot Project

2010-2011 Legislative Report

Rick Scott, Governor

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Executive Summary

The Department of Elder Affairs Long-Term Care Community Diversion Pilot Project (Diversion) has been in operation for 13 years and 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 (Providers) to provide eligible individuals with a continuum of Medicaid long-term care services and to coordinate their acute care services. Diversion providers assume the full financial risk of these services including the cost of nursing home placement. This key feature of the Diversion Program 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 elderly by helping preserve dignity, maximum possible independence, and a sense of continued connection to the community for the elder while providing 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. Since its inception, it is conservatively estimated that the Diversion program has generated savings of $1.734 billion for the State of Florida compared to the costs that would have been incurred if its clients had opted for standard institutional care in skilled nursing facilities.

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

Diversion providers contract to provide a comprehensive set of long-term care and case management services, and 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 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. Furthermore, since the program's inception in 1998, the average payment rate has been reduced by more than 35 percent from approximately $2,300 per client per month in 1999 to the current rate of approximately $1,480 per client per month.
As illustrated in Chart 1, the 2011-12 statewide average capitated rate of $1,479.51 per member per month (PMPM) remains well below the comparable Medicaid reimbursement schedule for full-time nursing home care of $5,113.37 per month and the difference between costs of the two approaches has been widening.

There are several benefits to serving elders through the Diversion Program; however, the program continues to offer some challenges that the Department is actively addressing. One challenge is the Department’s ongoing effort to balance cost-control with quality of care for the vulnerable, frail elders served through this program. The Department continues to enhance its monitoring processes and to develop a more sensitive system of checks and balances.

Another barrier was the limited availability of the Diversion option for many residents who live in under-served areas. However, with the Legislative mandate to institute statewide managed care for all Medicaid recipients by 2014, there has been a substantial increase in provider requests to expand into rural communities. With this, the Diversion program anticipates that every Florida county will have at least one Diversion provider, and most will have two or more by the end of 2012.
Other geographic areas, particularly the large urban centers, continue to benefit from robust competition and a wealth of choices for potential program participants.

Diversion enrollment was closed for 15 months in 2010 and 2011 because the program had reached its legislative funding capacity, but enrollment for waitlist recipients reopened in August of 2011 and the Department has begun to reduce the waitlist of more than 11,000 potential participants. As of December 2011, the Department has released over 8,000 waitlist recipients. Even though the program was allocated an additional 1,000 enrollment slots, we expect to remain under enrollment management in the year ahead. Enrollment management reviews are conducted monthly to ensure that enrollment remains within current budgetary limits.

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. The Department administers the program in consultation with the Agency for Health Care Administration (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, 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 contractors¹ are currently selected through a review process that accepts applications year-round for underserved, mostly rural counties with two or fewer providers, but accepts applications for more heavily served areas only once each year, in September. Managed care organizations

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.
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. 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**

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.

**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, respiratory (starting March of 2012), 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 client access to needed medical, transportation, social, and educational services from a variety of community resources. In accordance with federal requirements, Diversion contractors are required to provide case management directly.

In addition to case management, the four most utilized services are assisted living, adult day health care, personal care, and homemaker services. The range of services offered through Diversion has changed very little since its inception in 1998, with three notable exceptions. 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, which is a great benefit to many elders. And by March of 2012, all Diversion programs must also offer respiratory therapy services in response to a new mandate from the Centers for Medicare and Medicaid Services (CMS).

The Diversion Program 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 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. 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.

The Department also recently completed a study of integration of care in other states to identify strategies that might enhance Florida’s Diversion Program. As an active participant in various workgroups developing implementation strategies for Florida’s new Medicaid managed long-term care program, the Department will offer its assistance and
extensive experience in the long-term care arena to help implement best practices in the program.

**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 million. For the 2009-2010 state fiscal year, funding totaled $327,899,046, an increase appropriated to serve approximately 2,200 additional clients. During the past Legislative session, an additional 1,000 slots were added to the program and funding was increased to $355,766,698 for 2011-12.

In December 2011, statewide enrollment was approximately 17,600 elders and growing. Based on current capitation rates, the Medicaid Program is avoiding as much as $675 million in additional costs that would have to be paid if all current clients were served in nursing homes instead of through Diversion. Even using a more conservative methodology based on actual claims rates and assumptions about the number of the eligible participants who might actually require nursing home placement, the program generates annual savings of more than $450 million a year. Table 1 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>
<thead>
<tr>
<th>STATE FISCAL YEAR</th>
<th>COMBINED FEDERAL AND STATE FUNDING (DOLLARS)</th>
<th>UNDUPPLICATED 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>Fiscal Year</td>
<td>Funding (in thousands)</td>
<td>Enrollment</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------</td>
<td>------------</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>2010-2011</td>
<td>$337,924,993</td>
<td>23,292</td>
</tr>
<tr>
<td>2011-2012</td>
<td>$355,766,698</td>
<td>24,750</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.
*** Projection (includes PACE clients).

Source: Department program data and CIRTS reports.

**Enrollment Trends**

Since the 2006-2007 fiscal year, Diversion's enrollment has more than doubled growing from 7,219 clients at the beginning of state fiscal year 2006-2007 to just over 17,600 clients as of December 2011.

Chart 2 displays enrollment trends for the period January 2008 through December 2011. Drops in total enrollment indicated on the chart reflect periods when the program reached capacity and had to temporarily halt all except nursing home transition enrollments.

Under the program’s enrollment management system, the number of new clients referred to Diversion plans 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 medical criteria.

Current funding should accommodate enrollment of approximately 21,000 eligible clients, and monthly releases from the waitlist should continue through 2012. New plans and expansions currently being processed should expand enrollment into previously underserved regions of the state, as well.
Enrollment in this program was frozen between July 1, 2007, and June 30, 2008. It was also frozen for the first half of 2009, and again from May, 2010, until August, 2011, 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 waitlist in anticipation of the $35 million increase from the Legislature effective July 1, 2009. By December 2009, the Department 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, 21,644 clients as of July 2010.

Currently, Diversion continues to operate under the Enrollment Management System; however, beginning in August 2011 the Department began releasing individuals from the waitlist. As of December 2011, the Department has released almost 8,800 elders from the waitlist, with approximately 7,000 still awaiting referrals. 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.

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.

**Counties and Providers 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.

While the Department has received approval from CMS to expand to all 67 Florida counties, Diversion is currently available in only 46 counties. Map 1 highlights counties with provider networks and those without.

Currently 17 Diversion providers serve clients in 46 counties. As of December 2011, a total of 12 Diversion providers served Miami-Dade County. Conversely, there are still no approved providers in much of North Central Florida, which is a predominantly rural area of the state, although that should change in the months ahead.

While there previously have been barriers to expansion of the program into less populated rural areas, the passage of new Medicaid Long-Term Care legislation has sparked a renewed interest in the Diversion Program. Applications for seven new Diversion plans and more than 70 expansion requests from existing plans should provide statewide coverage for the first time in 2012.

If approved, the requests would extend the Diversion Program to serve all 67 Florida counties, with all but six of those counties having two or more plans in place. The
provider networks in some counties would remain fairly small, but for the first time all Floridians would have access to the Diversion alternative.

**Map 1: Counties of Operation, December 2011**

**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. 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 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 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 2).

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 2, 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.

More than three-quarters of Diversion participants suffer from incontinence, and 60 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 2: Frailty Profile of Active Clients by Program, State Fiscal Year 2010-11

<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>78.81</td>
<td>66.03</td>
<td>58.68</td>
<td>41.19</td>
</tr>
<tr>
<td>Average Priority Score (range 0-100)</td>
<td>32.48</td>
<td>26.68</td>
<td>20.88</td>
<td>28.41</td>
</tr>
<tr>
<td>Average Number of ADLs Requiring Assistance (range 0-8)</td>
<td>5.21</td>
<td>5.17</td>
<td>4.10</td>
<td>3.49</td>
</tr>
<tr>
<td>Average Number of IADLs Requiring Assistance (range 0-8)</td>
<td>7.72</td>
<td>7.55</td>
<td>7.53</td>
<td>6.48</td>
</tr>
<tr>
<td>Percentage with Incontinence</td>
<td>68%</td>
<td>77%</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td>Percentage with Dementia</td>
<td>60%</td>
<td>63%</td>
<td>61%</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 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 2010-11 was $61,360 compared to a cost of $17,754 for alternative Diversion services, yielding an estimated annual cost savings of $43,606 per client compared to nursing home placement (see Table 3).

During state fiscal year 2010-11, the Diversion Program served 23,292 unduplicated clients for a total of 238,213 case-months of service. Based on the most conservative cost estimates, the Diversion Program saved Florida at least $450 million last year. Table 3 shows a comparison of cost and utilization information for individuals in nursing homes, the Diversion Program 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 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>$2,512,498,804</td>
<td>491,359</td>
<td>60,406</td>
<td>$61,360</td>
</tr>
<tr>
<td>2</td>
<td>Medicaid Long-term Care Diversion Project</td>
<td>$352,437,830</td>
<td>238,213</td>
<td>23,292</td>
<td>$17,754</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid Assisted Living for the Elderly Waiver</td>
<td>$33,346,388</td>
<td>39,404</td>
<td>4,767</td>
<td>$10,155</td>
</tr>
<tr>
<td>6</td>
<td>Medicaid Aged/Disabled Adult Waiver</td>
<td>$99,363,658</td>
<td>114,244</td>
<td>11,732</td>
<td>$10,437</td>
</tr>
</tbody>
</table>

Initiatives and Future Direction

Statewide Medicaid Managed Care Program

One of the most significant achievements 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, work began this year on the key elements to be included in the new Medicaid service delivery model.

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 providers selected through an ITN process. Medicaid recipients are scheduled to begin moving to the new program in 2013, and it will eventually replace all existing Medicaid waiver programs, including the Diversion Program.

Because of the Department’s experience with the Medicaid managed care waivers, Department staff are working closely with AHCA and health care providers to ensure that the new program incorporates the most successful strategies and best practices identified in our programs as we develop this comprehensive new Medicaid service delivery system.

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, and has reduced the costs of serving a frail elder population in home and community-based settings, despite dramatic increases in the overall costs of healthcare nationwide.
Capitation rates for the Diversion Program have fallen for three consecutive years, indicating the economies that can be realized through the managed care approach while maintaining the quality of life and medical care of clients.

Implementation of “Medicaid Pending” Status

In 2006, the Legislature amended Section 430.705 (5), F.S., to create an option for Diversion Program 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 Families. Under the new legislation, Diversion Program 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 Program 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 who are later determined ineligible for Medicaid.

The approach has, however, resulted in more timely delivery of needed services for clients. All of our current Diversion programs have opted-in to Medicaid Pending enrollment, and the number of clients later found to be financially ineligible has remained small.

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, the Department 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, 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 (CMS). 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 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.

**Assisted Living Facilities**

At the direction of CMS, the Department has been working with AHCA and Diversion plans to develop an electronic notification system that would alert Diversion contractors to incidents that occur in Assisted Living Facilities (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 requires the services provided by ALFs.

Additionally, at CMS’s direction, the Department and AHCA have developed defining characteristics and an assessment tool for determining whether an ALF is promoting a home-like environment for its residents. This is an important consideration for the Diversion Program moving forward because the Department wants to ensure that Diversion enrollees residing in ALFs are residing in the least institutional setting possible.

**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. AHCA and the Department has significantly altered the interagency agreement governing the Diversion Program, as a result of the new CMS mandates.

Meanwhile, the Department has implemented significant changes in its monitoring process. As a part of the 2009-10 monitoring review, completed in the fourth quarter of 2010, the Department shifted more attention to 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.
Over the last year, the Department also has been working to better analyze contractors’ performance by creating and instituting new performance measures. 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.

Although the Department is taking the initiative to continuously refine and enhance the Diversion model, CMS 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.

External Quality Review Activities

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.

AHCA’s external quality review organization, Health Services Advisory Group (HSAG), validates the performance improvement projects (PIP) submitted by the Diversion contractors on an annual basis.

Diversion contractors are required to submit two PIPs a year to the Department and to 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

December 2011 marks the 13th year that the Diversion Program 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 with 17 managed care 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. More than 24,000 elders were served in a
community-based setting, and savings of approximately $451 million were realized relative to the alternative costs 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 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.