



Long-Term Care Community Diversion Pilot Project

2008-2009 Legislative Report

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Executive Summary

The Long-Term Care Community Diversion Pilot Project (Diversion) is now in its eleventh year of operation. The program was authorized by the 1997 Florida Legislature, and was launched in December of 1998. Similar to other major Department of Elder Affairs programs, the Diversion project provides frail elders who are at risk of nursing home placement an individualized package of services designed to help delay or prevent nursing home placement. The Diversion project serves very frail elders, who have medical and functional profiles similar to elders who reside in nursing homes. Whereas most of the Department's home- and community-based services programs operate on a fee-for-service basis, Diversion providers are paid a capitated monthly rate, and implement a managed care model. Unlike fee for service providers, Diversion providers assume the financial risk of paying for nursing home care when their clients require such care.

Funding for the Diversion project has increased from almost \$23 million in its first year of operation to over \$306 million for State Fiscal year 2008-2009. As of December 2009, statewide enrollment was approximately 16,500 elders. All participants meet financial and medical/functional criteria for Medicaid nursing home placement. The monthly cost to serve an elder through Diversion is \$1,631.01 compared to \$4,194.47 for Medicaid nursing home placement. Based on this cost difference, the Medicaid program avoided approximately \$419 million in costs that would have been paid if all eligible enrollees were served in nursing homes instead of through Diversion.

In the upcoming year, initiatives and priorities for the program will include careful review of service utilization trends, examination of the feasibility of restoring transportation services to the program's service array, the addition of transition case management service, continued efforts to implement a rate-setting methodology based on the frailty level of the specific clients served by each provider, and continued collaboration with stakeholders to enhance and expand the Diversion project statewide.

Project Background

Following authorization by the 1997 Florida Legislature, the Diversion project was implemented in December 1998. The Diversion project is designed to serve the frailest individuals. The target population qualifies for Medicaid-funded nursing home placement, and the Diversion program offers home- and community-based services, a less costly option, to permit these frail elders to remain in the community. Diversion providers assume the risk of the cost of nursing home placement for the individuals whom they serve.

The array of Diversion services includes home- and community-based services such as personal care assistance and homemaker services, which may be provided in a private residence or an assisted living facility; Medicaid-covered medical services for persons who are aged 65 or older (e.g., Medicare coinsurance and deductibles); and nursing home care. The objective of the program is to provide less-costly alternatives to nursing home placement for elders who are financially and medically eligible for nursing home placement and who can remain safely in the community. 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, 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 must select providers who demonstrate the capacity and experience to maximize placement of participants in the least restrictive, most appropriate care settings. Managed care contractors* 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 capitation 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.

*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 a Diversion provider. Examples of potential OQPs are nursing homes, home health agencies, hospices, adult day care centers, and assisted living facilities.

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
 - 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 providers coordinate medical and long-term care services and provide a full continuum of long-term care services for individuals who are dually eligible for Medicaid and Medicare. These services include an array of home- and community-based care services, coordination of acute care services, assisted living facility care, prescription drugs (the Medicaid formulary not covered by Medicare Part D), Medicare coinsurance and deductibles, and nursing home care when needed.

Long-term care services available through the program include the following: adult companion; adult day health; assisted living services; case management; 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; coordination of prescribed drugs; visual/hearing/dental; and some expanded benefits.

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. Diversion contractors provide case management directly; however, the Department is examining the possibility of permitting this service to be subcontracted in order to help facilitate establishment of Diversion services in rural areas.

Acute care services offered through Diversion 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 policies.

The continuum of services offered through Diversion has changed very little since the program was launched 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, which is a great benefit to the elders.

An anticipated new service is "Transition Case Management." This service, which is intended to help assist clients transitioning from nursing homes back into community settings, is being added to several other programs administered by the Department. AHCA submitted a waiver amendment request to the Centers for Medicare and Medicaid Services (CMS) requesting the addition of this service, and approval is fully anticipated. This service will provide a valuable new tool to facilitate the Department's ongoing effort to help elders live in the most cost-effective and least restrictive environments, and remain safely in the community.

Integration of Acute and Long Term-Care Services

The Diversion project is statutorily directed to integrate acute and long-term care services. To advance this goal, the Department is working with CMS, the Center for Health Care Strategies (CHCS) via a grant the Department was awarded, and AHCA to analyze possible program design changes that would allow for even better integration of Medicaid and Medicaid funding and services. In recent years, CMS added incentives and opportunities for states to better integrate services. CMS is considering a requirement that states must contract with Medicare Advantage and Special Needs Plans to advance integration. CMS is expected to make even more changes in the next few years depending on the direction from the new administration and Congress.

Between December 2005 and early 2008, the Center for Health Care Strategies offered the Integrated Care Program (ICP) to promote state programs that integrate the financing, delivery, and administration of primary, acute, behavioral health, and long-

term supports and services for those dually eligible for Medicaid and Medicare (as well as Medicaid-only persons with disabilities). Five states -- Florida, Minnesota, New Mexico, New York, and Washington -- were competitively selected and received technical assistance and training for the development and implementation of integrated care programs. Efforts specifically focused on planning requirements for state contracts with Medicare Advantage Special Needs Plans as well as on three state-identified priority areas: (1) *administrative simplification*; (2) *rate setting and risk adjustment*; and (3) *performance measurement*. The Department participated in this program until early 2008 and was awarded a second similar grant from CHCS in 2008. Quarterly technical assistance for grantees occurred in 2009; however, collaboration has been minimal, pending federal health care reform directives. Integration will continue to be limited by the State's ability to combine contracts between Medicaid and Medicare providers and to simplify administration between two separate government entities, federal and state.

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. In January 2006, the total number of Diversion project slots increased by approximately 1,000 due to the implementation of Medicare Part D, which shifted the payment for prescription drugs from Medicaid to Medicare. 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 \$338,177,729, a gain appropriated to serve approximately 2,200 additional clients. 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. The totals listed include funding for Program of All Inclusive Care for the Elderly (PACE) clients for SFY 2002-2003 and subsequent years.

TABLE 1: APPROPRIATION HISTORY

STATE FISCAL YEAR	COMBINED FEDERAL AND STATE FUNDING (DOLLARS)
1995-1996	(Federal Only) 112,692
1996-1997	11,117,454
1997-1998*	22,769,909
1998-1999	22,907,907
1999-2000	22,769,907
2000-2001	22,769,907
2001-2002	26,119,143
2002-2003	30,916,013
2003-2004	68,082,110
2004-2005	128,457,002
2005-2006	209,983,617
2006-2007	200,870,188
2007-2008	224,335,496
2008-2009	306,373,201
2009-2010	338,177,729

* Source: AOB. Project implementation began 12/98.

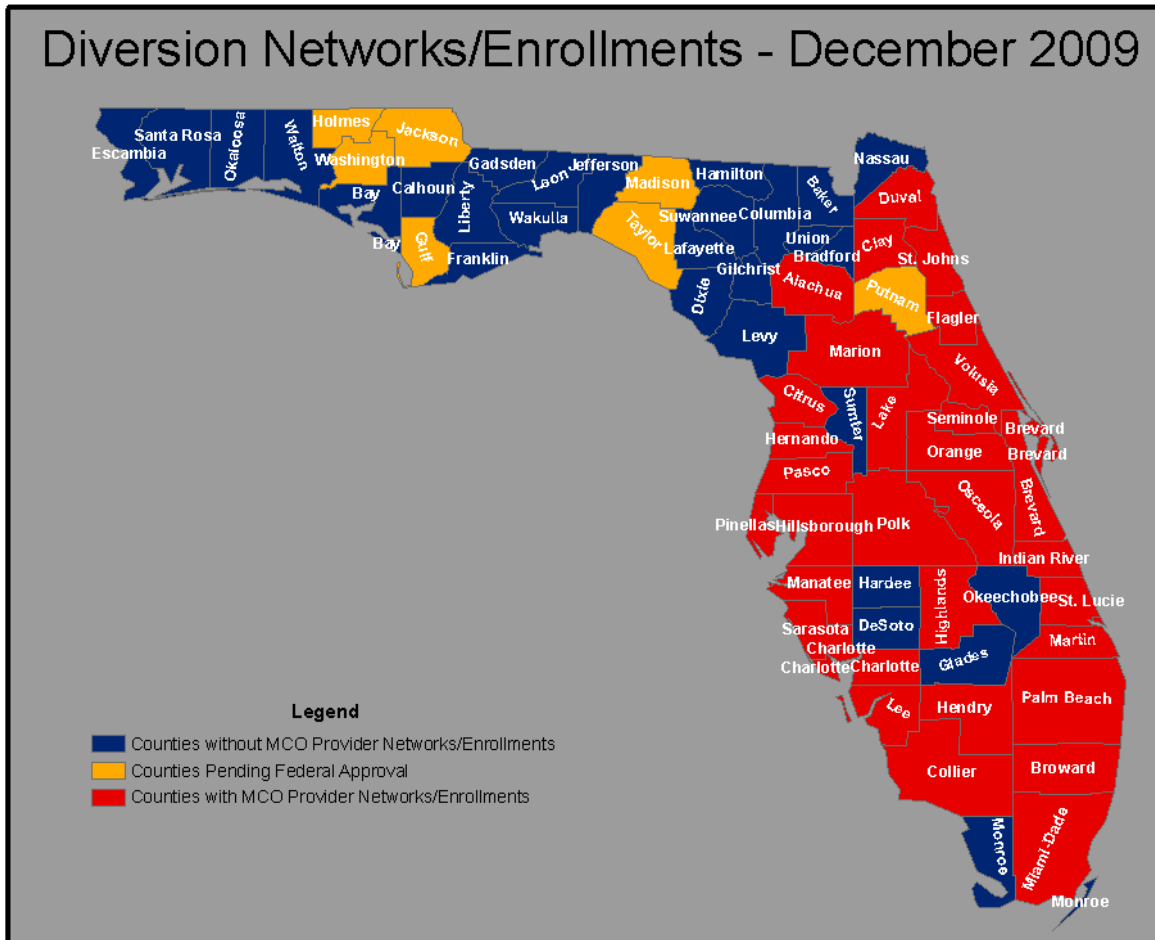
Counties and Providers Approved for Diversion Projects

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. Subsequently, CMS has approved three expansions to the project's potential service area and a fourth expansion is pending. 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 CMS, and an additional 23 counties were added to the project's potential service area. In April 2007, a third expansion expanded 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. The Department hopes to receive approval for those remaining seven counties, which include Gulf, Holmes, Jackson, Madison, Putnam, Taylor, and Washington, in early 2010.

While the Department expects to receive the requested approval from CMS to expand to all 67 counties, Diversion is currently available in only 33 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.

Sixteen providers serve the 33 existing counties. As of July 2009, a total of 12 Diversion providers served Miami-Dade County. Conversely, there are no approved providers in West Florida, which is a predominantly rural area of the state. However, as of December 2009, the Department is finalizing the review of expansion requests to offer services in Escambia, Okaloosa, Santa Rosa, Sumter and Walton counties by early 2010. Additionally, a new managed care organization seeking to serve West Florida submitted an application to the Department in November 2009. This application is currently under review.

Map 1: Counties of Operation



Enrollment Trends

Since the 2006-2007 fiscal year, Diversion project enrollment has almost doubled. Diversion project enrollment grew from 7,219 enrollees at the beginning of state fiscal year 2006-2007 to almost 16,500 enrollees as of December 2009. Enrollment in this program was frozen between July 1, 2007, and June 30, 2008, then again for the first half of 2009, to ensure Diversion program spending 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. Due to the continued follow up and processing of individuals waiting for services, Diversion enrollment reached its highest

peak ever, 16,240 enrollees as of March 2009. New enrollments remained frozen until June 2009, when the Department released over 1,000 individuals from the waiting list in anticipation of the \$35 million increase from the Legislature effective July 1, 2009. As of December 2009, the Department released all persons from the waiting list who accumulated throughout 2009 (approximately 9,000 elders), and the program is open to new enrollments. Charts 1 and 2 display enrollment trends for the period December 2007 through December 2008 and throughout all of calendar year 2009, respectively.

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 before, during, and after the managed care organizations submit enrollments to the Medicaid fiscal agent. While the Department considers CARES 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 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.

Chart 1: Statewide Census by Month December 2007-December 2008

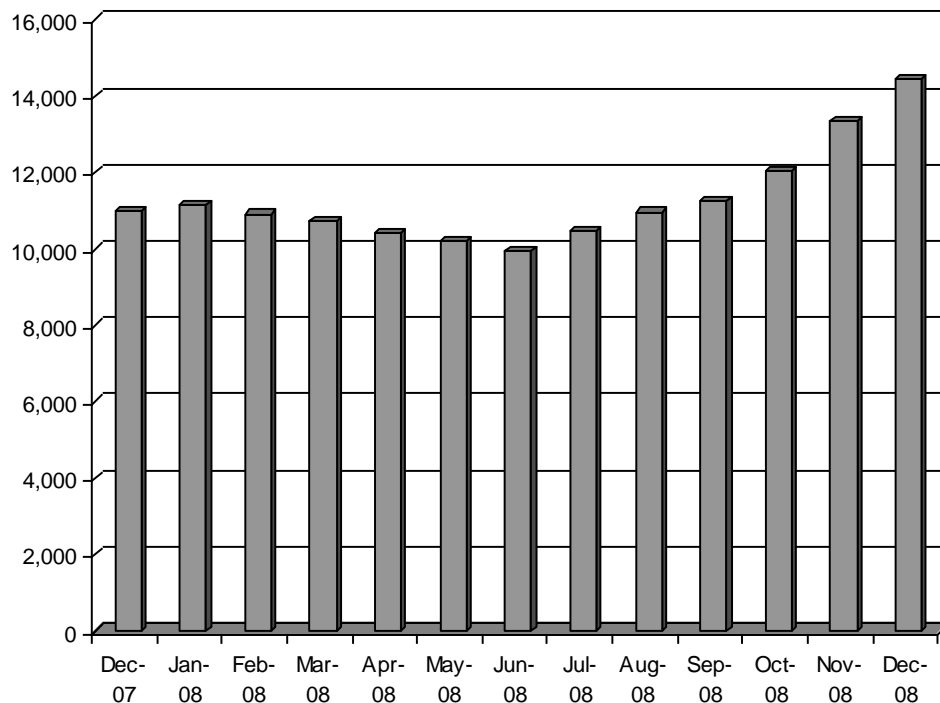
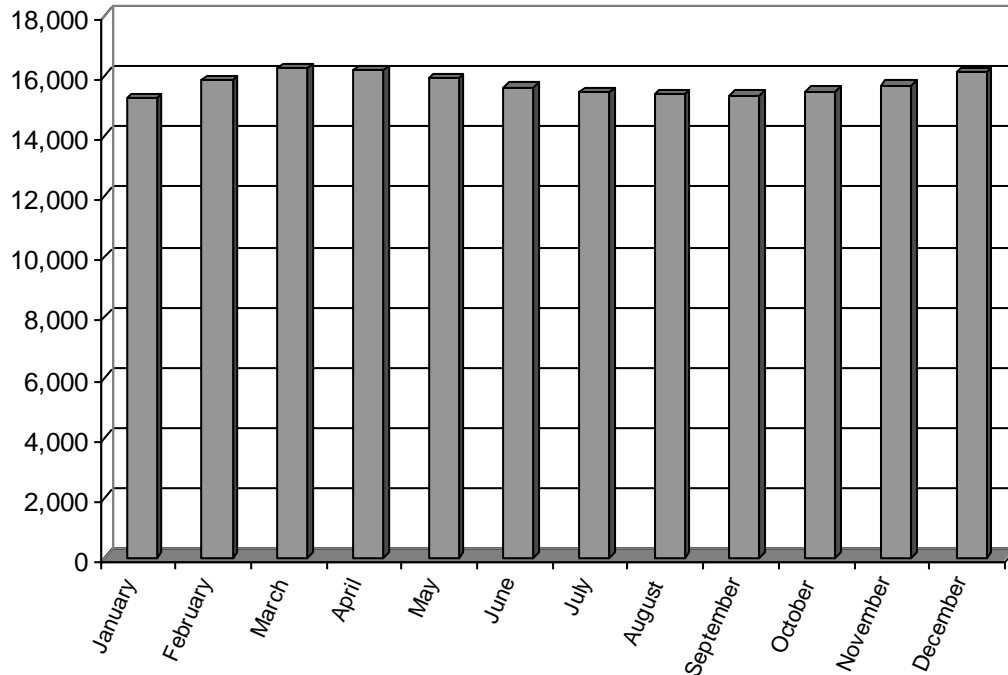


Chart 2: 2009 Statewide Census by Month

Comparison of Diversion to Other Long Term Care Alternatives

The primary goal of most 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.

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 the cost of Diversion is higher than the average cost of the Department's other programs, but it is far less costly than nursing home care.

Frailty Levels of Participants

Diversion project participants have the highest average risk scores as determined through a standardized comprehensive assessment, compared to elders served through all other programs administered by the Department. In fact, 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 Program 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 that 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. With regard to the average ADL score, Diversion participants are identical to nursing home residents, and are more impaired than participants in the Department's other major statewide programs. With regard to the average IADL score, Diversion participants need slightly less assistance than nursing home residents but need more help than participants in the Aged and Disabled Adult Waiver and the Community Care for the Elderly programs. Diversion participants and Assisted Living for the Elderly Waiver participants (who all live in Assisted Living Facilities) have 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 in the Assisted Living for the Elderly, Aged and Disabled Adult, or Community Care for the Elderly programs, and in fact, is even greater than among nursing home residents.

Table 2: Frailty Profile of Active Clients by Program, State Fiscal Year 2008-09

	Medicaid Nursing Home	Diversion Project	Assisted Living for the Frail Elderly Waiver	Medicaid Aged and Disabled Waiver	Community Care for the Elderly
Average Nursing Home Risk Score* (range 0–100)	78.47	65.75	62.60	40.13	34.83
Average Number of ADLs Requiring Assistance (range 0–5)	5.00	5.00	4.27	3.47	2.90
Average Number of IADLs Requiring Assistance (range 0–8)	7.72	7.58	7.58	6.46	6.16
Percentage with Incontinence	67%	75%	70%	68%	56%
Percentage with Dementia	60%	63%	62%	31%	36%

*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 individuals who are financially and medically eligible for Medicaid nursing home placement. The average annual cost to serve an elder in a nursing home is \$50,334, compared to \$19,572 for Diversion services. Therefore, the annual cost of Diversion services for a frail elder is \$30,672 less than the cost of nursing home placement.

During state fiscal year 2008-09, the Diversion project served 19,083 enrollees for a total of 163,555 case-months. The average monthly cost for Medicaid nursing home placement is \$4,194.47, compared to \$1,631.01 for Diversion. Based on a cost difference between nursing home and Diversion care of \$2,563 per month, the state avoided approximately \$419 million in costs that would have been paid if all eligible enrollees were served in nursing homes instead of through Diversion. Table 3 shows a comparison of cost and utilization information for individuals in nursing homes, the Diversion project, the Assisted Living for the Frail Elderly Medicaid Waiver, the Medicaid Aged and Disabled Waiver and the Community Care for the Elderly program (a non-Medicaid General Revenue-funded program). As previously noted, Diversion participants are significantly frailer than elders served through the Department's other major statewide programs.

**Table 3: Program Cost and Utilization by Program
For State Fiscal Year 2008-09**

	Medicaid Nursing Home	Diversion Project	Assisted Living for the Frail Elderly Waiver	Medicaid Aged and Disabled Waiver	Community Care for the Elderly
Amount Paid	\$1,838,908,900	\$266,759,483	\$23,374,857	\$72,759,922	\$44,757,050
Case Months	438,413	163,555	29,875	104,043	87,511
Unduplicated Clients	61,508	19,083	3,423	10,600	15,772
Annual Cost Per Client	\$50,333.61	\$19,572.09	\$9,389.06	\$8,391.91	\$6,137.34
Average Monthly Cost Per Client	\$4,194.47	\$1,631.01	\$782.42	\$699.33	\$511.44

Initiatives and Future Direction

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 eligibility 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 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, Medicaid Pending client enrollments must be processed manually, which has created a heavy administrative burden that has resulted in payment delays to Diversion project contractors. Significant back payments were owed to providers as a result of the manual process and glitches with the new fiscal agent system. While most outstanding payments to providers were paid in the 2008-2009 fiscal year, the manual processing remains cumbersome and burdensome. An additional implementation challenge has been that for some clients who are found not Medicaid eligible, it has been difficult to pay for the services that have been provided. 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 CMS requires that the Department contract with an actuarial consultant for assistance with rate setting. The consultant recommended this significant change. 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 certified by the actuary. 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 2009, the Department, AHCA, providers, and the actuarial consultant have been working to update the assessment-rating factor. This factor will foster rates that consider the average frailty level of the clients served by each provider. This change will be completed in 2010 and implemented as a part of the 2010-2011 rates.

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.

Monitoring

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. Additionally, the reallocation of resources has permitted more in-depth claims reviews. The Centers for Medicare and Medicaid Services is providing additional direction to the State regarding oversight of long-term care waivers in 2010.

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 4).

Table 4: 2009 Program Performance Measures

	Performance Measure Rate		
	Highest Rate	Median	Lowest Rate
Disenrollment Rate	26.3%	18.4%	6.6%
Retention Rate	98.6%	94.9%	88.9%
Voluntary Disenrollment Rate	10.3%	4.2%	2.1%
Average Length of Enrollment (Months)	32.83	16.08	5.09

Diversion providers also began a new performance improvement measure exploring timeliness of services delivered to Diversion enrollees. This project will be ongoing in 2010.

Conclusion

December 2009 marks the eleventh year the project has provided services to frail elders. For the 2009-2010-contract year, which began September 1, 2009, a 100 percent capitation-rate-setting methodology was implemented and contracts were signed by 16 organizations. The Diversion program represents Florida's most integrated 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 approximately \$419 million dollars were 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.