Preliminary Evaluation of Medicaid Waiver Managed Long-Term Care Diversion Programs: Final Report

Conducted for the Florida Department of Elder Affairs

Purchase Order #S6500 031499

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November 27, 2001

Table of Contents

Executive Summary 1

Managed Long-Term Care Background and Formative Evaluation Plan 5
- Background 5
- Formative Evaluation Plan 10
- Research Questions 11
- Data Sources 12

Florida Managed Long-Term Care Contractors: Program Descriptions 15
- Previous Experience in Managed Long-Term Care 15
- CARES, Department of Children and Families (DCF), Choice Counseling And Referrals 15
- Program Philosophy, Case Management, and Services 16
- Quality Assurance 25
- Financial Viability 26
- Lessons Learned 27
- Client Characteristics 28

Service Utilization and Cost Neutrality 32

Unmet Need, Consumer Satisfaction, and Disenrollment 41

Recommendations for Future Evaluations 48

Appendix A: Data Collection Forms 50

Appendix B: Contractor Response 55

Executive Summary

The first Diversion project began in December 1998 in Orange, Osceola, and Seminole counties. Two others followed in September and October 1999 in Palm Beach County:

- A total of 1,254 individuals enrolled in the Diversion program in the first 31 months: 111 in 1998-99; 723 in 1999-00; and 420 in 2000-01.
- Beacon had a total of 181 enrollments in 22 months of operation.
- Health and Home Connection had a total of 653 enrollments in 31 months of operation.
- Summit had a total of 420 enrolments in 21 months of operation.

Diversion contractors have different approaches to providing case management:

- One uses telephone contact only with nurse visits; two use face-to-face meetings with case managers.
- Two have a substantial number of clients in assisted living facilities and are able to see clients more often. One of these has a higher case manager/nurse to client ratio (1:48).
- Two have a 1:33 or 1:34 case manager/nurse to client ratios.
- All three contractors have much lower ratios than available in most aging services providers.

Contractors have vastly different numbers of providers (37 to 91) in their provider network and there are substantial differences in the array of providers and the number of agencies who provide a particular service (such as meals or homemaker services).

- Two contractors have over 20 providers that offer the standard set of in-home services; one contractor has five such providers.
- Two contractors make high use of assisted living facilities; one contractor has just two ALFs in its provider network.
- One contractor makes high use of adult day care facilities.
- Two contractors have a good number of nursing facilities in their network; the other has three.
- One contractor does not indicate who provides financial or nutritional assessments, although these services are part of the Diversion contract.

Diversion contractors serve a frail population of elders. On average, clients enrolled in the Diversion Project are more impaired than the typical Medicaid elder. They are also more impaired than comparison groups, such as Medicaid Aged/Disabled Adult (ADA) Waiver clients.

- Diversion clients need assistance with 4.5 out of 6 activities of daily living compared to ADA Waiver clients who need help with 3 ADLs.
- Diversion clients need help with slightly more IADLs on average (7) compared to ADA Waiver (6).
- Just 18% of Diversion clients are living with an informal caregiver at home, compared to 43% of ADA Waiver clients.
- Diversion clients have an average of 3.31 chronic health conditions (out of 10) and ADA Waiver clients have 3.24 conditions.

The Diversion contractors were unwilling to provide service cost information on long-term care services. They did report units of care. Some services may be under- or over-reported due to different reporting standards by contractors. The ADA Waiver program also reimburses providers for a similar range of long-term care services with the exception of assisted living and nursing facility services, which are paid from other Waiver or State Plan programs.

- On average, all clients received between .33 to 9.54 units of adult companion services a month (one contractor coded many other in-home services under this category which may explain the wide variance). Each month, they received between .20 to 12.91 hours of adult day health; 8-11 meals; 1-7 hours of homemaker services; and 6-15 hours of personal care. These averages are useful for examining the structure of the capitated rates.
- Comparing only clients who receive a particular service, average units of services are higher (e.g. 9-23 hours of adult companion services; 20-39 meals a month for those who receive the service).
- The costs to Florida Medicaid for these long-term care services for ADA Waiver clients average $525 per month for home and community-based services and $50 per month for nursing home care (units of care for long-term care services are not easily available for ADA Waiver clients but could be included in an in-depth analysis).
- Diversion clients received, on average, zero to 12.33 days of assisted living and zero to one day of nursing facility care per month. Among those who received this service, they had 18-21 days of nursing services and 7 to 30 days of assisted living services per month.

Information on cost of acute care services was made available by the Diversion contractors. While there are relatively small overall differences in the expenditures made by Medicaid under the State Plan for the ADA Waiver clients and the Diversion contractors for their clients, there are differences by category.

- If one compares the average monthly client expenditures for a basket of services that includes diagnostic laboratory/x-ray services, inpatient hospital care, outpatient care, physician services, and prescription drugs, the difference is $76 per month ($371 for Diversion Project contractors, compared with $295 for Medicaid ADA Waiver clients).
- Diversion clients, on average, have more monthly client expenditures for: lab/xray, outpatient, and physician services. They also have substantially more hours of home health.

Durable Medical Equipment (DME) and consumable supplies are two other areas where Diversion Contractors pay for services, which are not included under the ADA Waiver program. DME is covered as a State Plan benefit for which Diversion contractors are responsible for co-payments and deductibles. There is wide variation between contractors on the number and average cost of DME and consumables.

- One contractor provided oxygen-related DME 162 times. Bathroom and toileting aids were other high use items.

In the past two years, all three contractors had disenrollment rates of 3% in 1999-00 and 2% in 2000-01. Disenrollment is mostly due to death (41%), unspecified “other” voluntary or involuntary reasons, loss of Medicaid eligibility, and moving out of the service area. Better

coding of the "other" categories may help to understand the full range of reasons for disenrollment. There are some significant differences between providers.

- One contractor was more likely (32%) to disenroll for other voluntary reasons.
- One contractor was more likely (25%) to disenroll for other involuntary reasons.

Complaint logs are a good source of on-going data for contractors' continuous quality improvement efforts.

- The most frequent complaint is dissatisfaction with a caregiver, usually because of unreliability.

Clients were generally more satisfied with the Diversion programs than with the ADA Waiver programs. Diversion clients reported a lower average number of areas where they had unmet need compared to ADA Waiver clients (1.24 vs. 1.58 out of 6), although there were no significant differences in terms of which service areas were lacking.

- One contractor has significantly more unmet need than the other two. One contractor had significantly lower levels of unmet need in: chore/homemaker services, respite, and personal care.
- Diversion clients were significantly more satisfied with case management even though they had more case managers in the past year than did ADA Waiver clients. They also talked to their case managers more often.

Diversion Contractors identified several lessons learned from their 21 to 31 months of experience:

- Client record keeping systems are critical and should be thought out in advance of creating client forms. Systems should be completely computerized for tracking, sharing records, billing, and reporting to DOEA. Systems need to incorporate standardized billing formats for the providers and for billing AHCA.
- Problem of being associated with a managed care organization, especially billing problems since the MCO uses different billing/payment systems than nursing homes and other providers use.
- Problem of being the secondary payer (after Medicare) and therefore less access to medical records that could help case managers do a better job of coordinating services.
- It may be viable to expand diversion projects to include private pay clients (similar to a long-term care insurance product).
- Case managers need ongoing training to understand the extensive number of services needed by and available to frail elders.
- Need to hasten the eligibility process with CARES and DCF.
- New enrollee orientation is critical to client use of services. It helps to read the handbook out loud.
- Use temporary letters of agreement with non-contracted ALF and NH facilities until contractual arrangements can be resolved.
- Caps on enrollment change the actuarial equation. In effect, current enrollees become more frail and potentially more expensive, while new enrollees with fewer needs (although still quite frail) are not available to balance the risks of expensive care for the Contractor.

- The availability of a wide network of potential providers allows the Contractor to accept bids from the most cost effective provider who provides a good quality of service.

Managed Long-Term Care Background and Formative Evaluation Plan

Background

Florida has nearly 20 years of experience with pilot programs that provide managed long-term care services to an impaired population. Two programs are funded and administered by the Agency for Health Care Administration (AHCA). The Channeling Project was part of a national demonstration project to evaluate the effectiveness of diverting potential nursing home residents to receive in-home services. This program began in 1982 and was continued by the state in 1985 under a 1915(c) Waiver. It is operated by Miami Jewish Home and Hospital for the Aged in Dade and Broward counties and serves 1,563 individuals who are 65 or older, qualify for nursing home care, meet SSI or ICP income and asset requirements, and receive Medicaid services. The state has funded the Frail Elder project (ElderCare) since 1987 when it was operated by Mount Sinai Medical Center. It is now operated by United Healthcare and serves 4,869 clients who are 21 and older, on SSI, and meet requirements for nursing home level of care. Florida also has two national managed long-term care models planned for South Florida: Program for All-Inclusive Care of the Elderly (PACE) and a Social HMO (SHMO).[1]

In 1995, the Department of Elder Affairs (DOEA) received a $215,000 planning grant from the Robert Wood Johnson Foundation to develop an integrated managed acute and long-term care delivery model for elders who were dually eligible to receive Medicare and Medicaid services and meet the same requirements for nursing home care as the original programs in South Florida. (See Table 1 for a timeline of key events). A year later, the Kiser Commission on Long-Term Care recommended to the State Legislature that Florida develop an integrated acute and long-term care system, and during the 1996 legislative session, proviso language authorized

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[1] Barber, J. (2001). History of Managed LTC Programs in Florida. Presentation to Florida Council on Aging Annual Meeting, Ft. Lauderdale, FL, August 15.

the implementation of such a program and provided $11 million dollars in funding for the first year.

Staff at DOEA and AHCA met with Health Care Financing Administration (HCFA) staff in 1996 to develop a protocol and application for a Medicaid Waiver application. The State applied for a 1915(c) Waiver which allows "untraditional home and community-based services" (e.g. homemaker services) in Medicaid managed care programs.

In 1997, the Florida legislature enacted the Long-Term Care Community Diversion Pilot Project Act (FS 430.701-710) to provide comprehensive acute and long-term care services to individuals who are dually eligible for Medicare and Medicaid. Medicaid pays for Medicare co-insurance and deductibles, prescription drugs, and other medical services not covered by Medicare. It also pays for nursing home care and more recently with the Assistive Care Services Waiver, pays for assistance with activities of daily living in assisted living facilities. Diversion Project contractors are at risk for in-home and nursing home services and may choose to use assisted living facilities as a lower cost option to nursing home care when appropriate. When ALFs are used, the contractor is responsible for assistive services but not room and board. SSI-eligible clients may use OSS and SSI to pay for room and board.

From the beginning of the Diversion program, the Medicare HMO capitated rate was not adjusted for the higher acuity levels of this population (as it is in PACE programs) and so the first potential contractor, Orlando Regional Health System decided to withdraw its application. In addition, HCFA required the State to allow clients to opt out of enrolling in the contractor's Medicare HMO for acute care services (e.g., clients could enroll in another Medicare HMO or with a fee-for-service provider). As a result, contractors have opted for the Medicaid and long-term care services capitated rate and not the Medicare capitation. Contractors provide

"coordinated" rather than "integrated" care. The Fiscal Year 1999-2000 capitated rate was $2,342.41/month (for Medicaid state plan and long-term care services). Contractors are responsible for all long-term care services (including nursing home care, prescription drugs, acute care co-payments, and deductibles) as long as the client is enrolled in the program.

Table 1
Diversion Project Timeline

Date	Event
1995, January	DOEA receives a two-year $215,000 planning grant from The Robert Wood Johnson Foundation to develop a managed long-term care services delivery model in Florida.
1996, February	The Florida Legislature's Commission on Long-Term Care recommends: 1) integration of medical and long-term care; and 2) creation of managed long-term care system.
1996, May	DOEA and AHCA, through proviso language, receive legislative authorization to develop and implement the "Capitated Nursing Home Diversion Waiver" with $11 million in appropriations.
1996, June	DOEA and AHCA meet with HCFA staff to develop protocols for Medicaid Waiver.
1996, October	DOEA and AHCA submit a 1915(c) Waiver to HCFA.
1996, November	Eight organizations submit letters of intent to participate in managed long-term care program.
1997, March	HCFA approves 1915(c) Waiver. RWJF awards a second two-year $300,000 grant to implement managed long-term care program.
1997, May	Legislature enacts "Long-Term Care Community Diversion Pilot Project Act" (FS 430.701-710) and appropriates additional $11 million in funding (total for SFY 1997-1998 $22 million).
1997, June	DOEA and AHCA develop and distribute managed long-term care program model contract to all Medicare HMOs in Orlando and Palm Beach areas.
1997, July	Orlando Regional Health Systems (ORHS) submits letter of intent to participate in program.
1998, March	DOEA, AHCA, and ORHS sign a contract to implement managed long-term care program in Orlando, contingent on DOEA and AHCA approving formal application.
1998, May	United Healthcare submits formal application to operate in Orlando area.
1998, October	Medicare HMOs announce withdrawal from selected Florida markets. United Healthcare plans withdraw its Medicare HMO in Orlando area. ORHS withdraws its application for the managed long-term care program, citing concerns over the Medicare capitation rates.
1998, December	United Healthcare begins operation as a managed long-term care contractor in the Orlando area, under the name "Health and Home Connection."
1999, January	Beacon Health Plans submits a letter of intent to participate in the managed long-term care program in Palm Beach area. Physicians Healthcare Plan meets with DOEA staff to discuss application for managed long-term care program in Palm Beach area.
1999, February	Beacon Health Plans submits formal application to operate a managed long-term care program in Palm Beach area.
1999, May	Physicians Healthcare Plans submits formal application to operate a managed long-term care program in Palm Beach area.
1999, September	Beacon Health Plans begins managed long-term care program in Palm Beach County under the name "Beacon Independence Plan."
1999, October	Physicians Healthcare Plans begins managed long-term care program operations in Palm Beach County under the name "Summit Plan."
2000, July	Legislative Task Force on Availability and Affordability of Long-Term Care is established. One goal is to improve the availability of home and community based alternatives to nursing homes.
2000, August	Managed long-term care programs reach their funding capacity of approximately 800 enrollees and all contractors are capped.

2001, February	Task Force on Availability and Affordability of Long-Term Care forwards its final report to the legislature with a recommendation to "integrate acute and long-term care" including an evaluation of existing managed long-term care programs (Three diversion projects, Channeling, and Frail Elder Project), moving ahead with PACE Medicare-Medicaid Managed Care project in Miami, and new Integrated Long-Term Care System based on risk contracts and capitated rates.
2001, June	Cap is lifted for final month of fiscal year. DOEA contracts with Florida Policy Exchange Center on Aging to conduct an evaluation of the Diversion projects.

A note on nomenclature. The three diversion projects in this evaluation are called contractors. They subcontract most of the services provided for clients to providers. Although contractors use several terms to identify clients, we have standardized on the word client to describe the beneficiary of these services.

Health and Home Connection, a United Healthcare program, began operations in December 1998 in Orange, Osceola, and Seminole Counties, and enrolled its first 10 clients; enrolling 10-15 clients a month for the first year and 30-40 a month until the cap was placed on new clients in Fall 2000. Beacon Independence Plan began operations in September 1999 in Palm Beach County and enrolled its first 39 clients, most of whom were already in assisted living facilities. They averaged 15-20 new clients a month until early 2000 when they were capped at 105 clients due to concerns regarding a corporate merger. The cap was lifted and since January 2001, they have averaged 7-12 new clients a month. Summit Care Plan (Physicians Healthcare Plans, Inc.) began operations in October 1999 in Palm Beach County with six clients, had a slow start, and was also capped in the Fall 2000 when all three programs were capped because of lack of additional funding for the pilot program. Table 2 and Figure 1 show the total new enrollments for the first 31 months of the program. Overall, the diversion programs enrolled 1,254 individuals over the life of the program: 181 in Beacon, 420 in Summit, and 653 in Health and Home Connection (HHC). Using net enrollment (subtracting disenrollments; Table 2 and Figure 2), the program grew from 93 slots in Year 1 to 824 slots in Year 3.

Table 2
Total New Enrollments by Contractor

	Beacon	HHC	Summit	Total
New Enrollments				
1998-99	0	111	0	111
1999-00	110	393	220	723
2000-01	71	149	200	420
Total	181	653	420	1,254
Cumulative Net Enrollments[1]				
1998-99	0	93	0	93
1999-00	83	360	199	642
2000-01	120	391	313	824
Total Client Months				
1998-99	0	376	0	376
1999-00	912	3,807	707	5,426
2000-01	1,715	7,206	4,131	13,052
Total	2,627	11,389	4,838	18,854

[1]Cumulative Net Enrollments=total enrollments minus disenrollments to date.

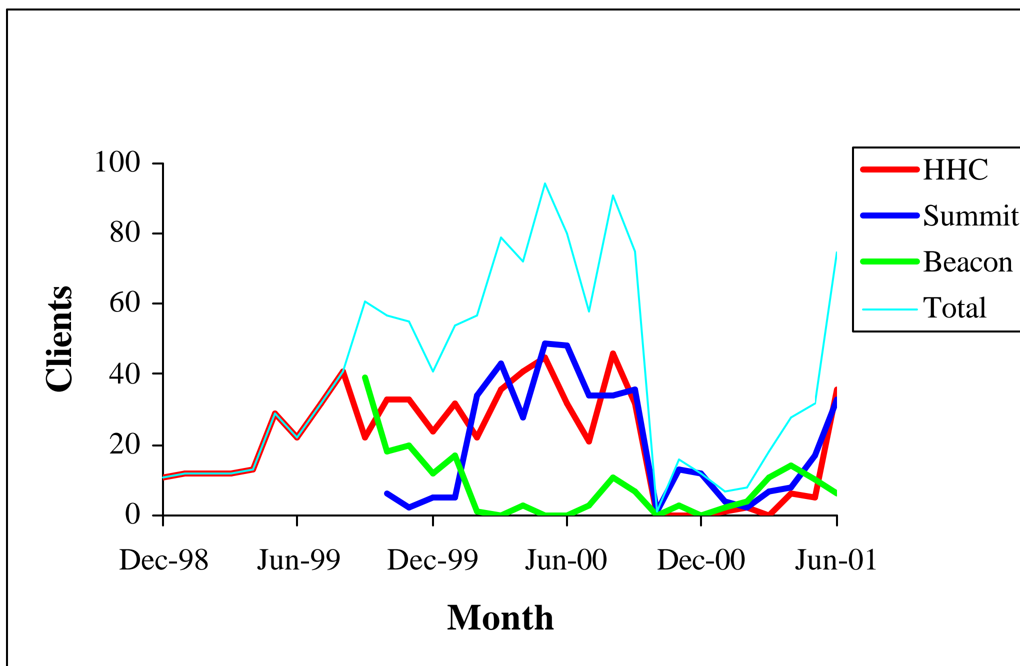

Figure 1. Total New Enrollments by Contractor.

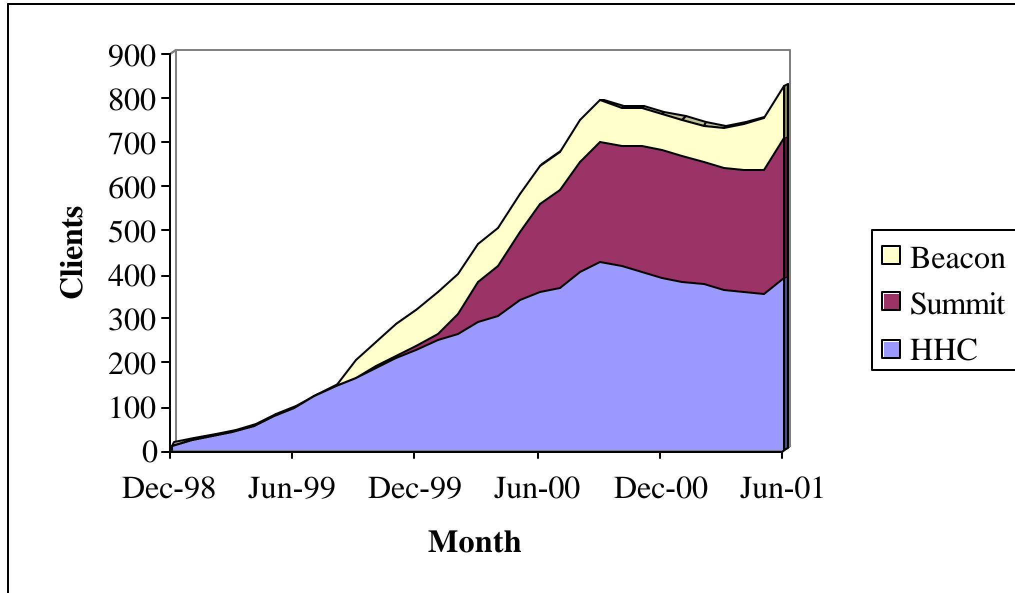

Figure 2. Net Enrollments (Enrollments – Disenrollments) by Contractor.

Formative Evaluation Plan

Under FS 430.709, the Department of Elder Affairs has the authority to contract with an independent evaluator for an evaluation of the Diversion Projects. Florida Policy Exchange Center on Aging (FPECA) staff proposed to conduct a formative evaluation to provide the Department data in order to make mid-course corrections. This preliminary evaluation was the first comprehensive evaluation of the program and is based primarily on the experience of the first full fiscal year of operation (July 1999-June 2000). FPECA staff proposed to use the existing Aged/Disabled Adult (ADA) Medicaid Waiver program as a comparison group to help understand program strengths and weaknesses. The ADA Waiver comparison group was limited to the same four counties served by the Diversion Project – Orange, Osceola, Palm Beach, and Seminole. The ADA Waiver program was selected because of similar eligibility criteria and Medicaid payment for a similar basket of home and community-based services.

The Florida Policy Exchange Center on Aging was uniquely situated to conduct this formative evaluation due to an ongoing contract between the State Data Center on Aging at

FPECA and Florida Medicaid to build a decision-support system for program evaluation and policy-related research using data in administrative databases from the Florida Agency for Health Care Administration, Florida Department of Elder Affairs, Florida Department of Health, and the Center for Medicare and Medicaid Services.

Research Questions

The following research questions are addressed in this report:

1. How do Medicaid Diversion projects compare in terms of program characteristics: staffing, services, administrative structure, access to providers along the continuum of care (HCBS, ALF, and NH)?
2. How do Medicaid Diversion and ADA Waiver clients compare in terms of use of services (measured in terms of units, types, and costs of services received)?
3. How do Medicaid Diversion projects compare in terms of cost neutrality with nursing home care (e.g. capitated rates compared to local nursing home reimbursement rates)?
4. How do Medicaid Diversion projects compare in terms of disenrollment rates and reasons for disenrollment?
5. How do Medicaid Diversion and ADA Waiver clients compare in terms of satisfaction with long-term care services? Did the managed long-term care program maintain or improve the quality of care and quality of life of the participants?
6. What are the lessons learned by DOEA, AHCA, and the Diversion Projects that could improve implementation of Diversion programs across the State or in other states?

Data Sources

Several sources of data were used for the analysis in this report:

- Data collected by DOEA from the Diversion Project contractors.

- CARES evaluations from DOEA.
- CIRTS evaluations from DOEA.
- Florida Medicaid claims.
- Consumer Satisfaction Survey collected by DOEA.
- Key Informant Interviews by FPECA staff.

Data collection forms for the Diversion Program contractors were developed with the assistance of DOEA staff. The elements in the data collection were based on the specifications in the Diversion Project contract (Section 8: Reporting Requirements). Contractors provided data from the beginning of each project through March 31, 2001 (see Appendix A for reporting requirements). Some data was available for April-June 2001 as well. These data include:

- Total unduplicated number of enrollees to date.
- Total cost of payments made to each managed care organization to date.
- Units of service (long-term care, acute care, durable medical equipment and supplies.) provided to enrollee.
- Disenrollment reasons.

The CARES and CIRTS databases are maintained by the Florida Department of Elder Affairs. These databases include evaluations of functional status, mental impairment, chronic health conditions, nutrition, and social support for Florida elders who are candidates for long-term care in a nursing home (CARES) or who receive home- and community-based services administered by DOEA (CIRTS).

The Florida Medicaid claims files track individual claims in the Florida Medicaid Management Information System (FMMIS). For this analysis, the monthly claims file was used. The monthly claims file aggregates claim activity by claimant each month with a series of

appropriation code “buckets”. Both the number of units and the dollar value of claims paid are available for commonly used expenditure categories, such as inpatient hospital care.

There is an inherent time lag between claims activity and the accurate reporting of that activity. Health care utilization data is typically not accurate for the most recent six months. This is due to delays in submitting and processing claims and owing to inevitable corrections made to claims. For this reason, this report uses only data for SFY 1999-2000 (July 1999-June 2000) for comparison with ADA Waiver clients.

The State Data Center on Aging (SDCA) is a unit within the Florida Policy Exchange Center on Aging. The SDCA has an on-going contract with Florida Medicaid to provide a decision-support system (sometimes called a “data warehouse”) to help provide Florida policymakers with accurate and timely information on Florida’s long-term care population. As part of that contract, the SDCA links administrative files from Florida Medicaid, Florida Department of Elder Affairs, and Florida Department of Health. For this contract, administrative records from Florida Medicaid claims files were linked with DOEA CARES records for the Nursing Home Diversion Project clients and with DOEA CIRTS records for ADA Waiver clients. The result was an analytic file yielding monthly Medicaid eligibility and claims data for Diversion and ADA Waiver clients together with needs assessments (ADL, IADL, cognitive function, and caregiver availability).

SDCA staff use a technique called probabilistic record matching to link data files. Probabilistic record matching is a statistically sound technique for matching data across different databases. The technique considers the reliability of the information used to link records. It can compensate for errors in data collection and recording, such as transpositions of characters, errors in entering dates, and reversals of names. It can also compensate for common

misspellings, such as “White” for “Whyte”. The technique uses multiple passes combined with clerical review of candidate matches to increase the number and improve the quality of matches.

The Consumer Satisfaction Survey was conducted by staff at the Department of Elder Affairs, under the direction of Horacio Soberon-Ferrer, Ph.D. The survey was conducted on a sample of in-home clients from the Diversion and ADA Waiver programs. The survey provides client assessment of unmet need, adequacy of services, adequacy of case management, and degree of personal control and quality of life provided by the programs.

Key Informant Interviews were conducted with Department of Elder Affairs and key staff at each Diversion Project. Interviews covered:

1. Administrative structure of Diversion Projects.
2. Number, credentials, and FTE of program staff (e.g., in-house case managers) and contracted providers’ staff.
3. Number, size, and location of facility providers in network (home health, hospitals, assisted living facilities and nursing homes).
4. Service area size (geographic and population).
5. Capitated rates for each program.
6. Disenrollment rates and reasons.
7. Quality assurance processes.
8. Lessons learned regarding implementation of projects.

Florida Managed Long-Term Care Contractors: Program Descriptions

Group interviews were conducted with key staff for each Managed Care Contractor. Interviews lasted for 5-6 hours and covered a range of topics. A separate 3-4 hour observation of case managers was conducted at each location on a separate day. The results of these interviews and observations are summarized below.

Previous Experience in Managed Long-Term Care

Contractors had 0-14 years of previous experience with managed long-term care. All three contractors had experience with managed health care and two of the programs hired directors who had extensive experience in other home care and managed long-term care programs. One program was initially developed by a consultant with extensive experience in PACE and other managed long-term care programs. The advantage of building on an existing managed long-term care program is that staff can adapt or use existing guidelines and forms. Even so, staff reported benefits from starting fresh so that they could develop new ways of providing services. Some of the contractors have access to experienced staff and consultants including geriatricians, nurse practitioners, risk managers, and others who are included in weekly team meetings and quality assurance meetings.

CARES, Department of Children and Families (DCF), Choice Counseling, and Referrals

Contractors reported that the CARES and Department of Children and Families eligibility processes typically take six months. They identified the financial eligibility process as the main reason for the length of time, although a backlog in the CARES office in Palm Beach County was significant enough for DOEA to add staff in order to improve turn around time. Staff allegations were not verified empirically, but one of the items on the governor's Health Care Task Force (Sen. Ron Silver, Chair) is to address the DCF eligibility process. Generally, clients

are receiving services from the Community Care for the Elderly (CCE) lead agency while they await eligibility. Clients who are already in assisted living facilities may be covered by the Optional State Supplement (OSS) and the Assistive Care Services or Assisted Living for the Elderly Waivers, or be paying privately and running out of resources. But in some cases, staff report that the delay in eligibility means the potential client moves to a nursing home. This may happen because families wait until they are "at the end of their rope" to ask for assistance and a six-month delay at that point is more than they can manage. Delays in enrollment mean that the CARES evaluation is usually out of date and the client needs more assistance than is documented in the initial CARES assessment. CARES and DCF are co-located in Orange and Palm Beach Counties. In one case, they are in the same building as one of the contractors, as well. Contractors that have developed collegial relationships with CARES, DCF, and the lead agencies appear to have better success with referrals and in getting clients processed more quickly.

Program Philosophy, Case Management, and Services

Two of the three programs had a written philosophy but staff at all three programs articulated a philosophy of helping frail elders to remain in the community for as long as possible. Case managers are the core of all three programs but are used differently. Two programs use case managers for initial face-to-face evaluation and follow-up visits, and consult with nurses on medical issues. The case manager selects the array of services based on meeting with the client and family. In the third program, case managers rarely meet the client face-to-face but conduct the initial evaluation and follow-up contact over the phone. Based on an in-house assessment tool, the case manager selects an array of services within a limited range of total hours available to the client. A nurse conducts a follow-up face-to-face interview to explain the program in greater detail and ascertain that the services in the care plan are appropriate. Staff

in all three programs stated that it was better to start slow and then add services. There were two rationales for this procedure: 1) to encourage the client and family to do as much as possible on their own which helps to maintain function; and 2) to not be put in the position of needing to take away unnecessary services after the fact. Two of the contractors indicated that case managers on their staff conduct the follow-up evaluations of clients who are also enrolled in the Home Care for the Elderly (HCE) program and also for CARES.

Case managers in all three programs operate as advocates for their clients. They maximize the Medicare and Medicaid benefits. They coordinate medical and related appointments and help with arranging transportation although transportation is not required in their contracts. The ratio of case managers to clients is optimal (1:33 to 1:48; see Table 3), compared to ratios for case managers and clients in other long-term care programs which can be as high as 1:100. Summit has the highest ratio (1:48) but over half of its clients are in assisted living facilities. This allows the case manager to keep in close contact with clients with fewer visits. In addition, many of the case management tasks are handled by ALF staff.

Contractors have different levels of computer automation of client records. One contractor has an integrated system that allows all case managers and nurses access to all client records and all aspects of the individual's care is in the computerized case record. A second contractor uses a combination of hard copy for case notes but computerized system for billing. The third contractor has a hard copy record keeping system and everything about a client is stored in a single notebook.

Case managers are the primary contact with service providers (although each contractor designates one staff person who is in charge of setting up the initial contracts with providers).

Case managers call or fax potential providers of personal care, meals, or other services and negotiate a service plan that meets the needs of the client. Case managers have 37 to 91

Table 3
Case Manager/Nurse to Client Ratio by Contractor[1]

	Case Managers and Nurses	Clients (6/30/01)	Ratio
Beacon	3.5	120	1:34
HHC	12	391	1:33
Summit	6.5	313	1:48

[1] Ratios include staff with regular direct contact (by phone or in person) with clients for the purpose of assessment and providing services. Some contractors use nurses as part of case management (home visits, etc.) and so are included in the overall ratio.

businesses in their provider networks (Table 4). The majority of providers offer a set of home care services: adult companions, chore, escort, family training, home health care, homemaker, occupational, physical, and speech therapy, personal care and respite. They know the capacities of the providers in terms of geographic coverage, flexibility with hours, and special services such as bilingual caregivers. When there are multiple providers, case managers can negotiate a good deal for the client in terms of days of the week and time of day. There is the potential to use free market competition to keep prices down and services up. This works best when there are sufficient providers. For example, two of the contractors had trouble finding providers to do environmental adaptations because most handymen want bigger jobs (not just installing a grab bar in a shower). Without provider options, the contractor does not have negotiating power.

Contractors had some difficulty developing contracts with assisted living facilities and nursing homes. This was especially a problem when the managed care organization was accredited under JCAHO or another accrediting board that required that all providers also be accredited under the same board or commission. In one case, DOEA allowed the contractor to develop letters of agreement with the facilities until the process could be completed.

Table 4
Provider Networks for Long-Term Care Services by Contractors (as of June 2001)

	Beacon	HHC	Summit
Adult Companion Services; Chore; Escort, Family Training Services, Home Health Care, Homemaker, OT, PT, Speech, Personal Care, Respite Services[1]	5	22	23
Adult Day Care[2]	1	4	10
Assisted Living Facilities	24	2	36
DME/Consumables, Environmental Adaptations[3]	2	4	4
Financial Assessment Services[4]	Not listed	1	2
Home Delivered Meals	1	5	2
Nursing Facility	3	11	9
Nutritional Assessment	Not listed	1	3
Personal Emergency Response System	1	1	2
Total Providers	37	53	91

Unduplicated count of providers except as noted below:
[1]Includes ALF or NH that provide respite care.
[2]Includes ALF or NH that provide adult day care.
[3]Includes Occupational Therapy providers who also sell/install DME.
[4]Provided as part of adult day care or home health services.

All contractors use a client orientation packet with a list of services. Some services are used more often than others. The two Palm Beach contractors make heavier use of assisted living facilities so many of the home based services are not used as often, although Summit has a broad network of home care providers for its in-home clients. An advantage of using assisted living facilities is that it reduces the time case managers need for visiting clients. The case manager can visit several clients at one time. In addition, ALFs allow case managers access to client records. To some extent, Diversion clients in assisted living facilities get double supervision—from the contractor and from the ALF staff.

Contractors report some difficulty with working with health care providers who distrust managed care organizations or simply do not feel it is necessary to comply with requests for medical record information since the Diversion project is the secondary payer. Yet, contractors have had success with regularly contacting pharmacists and physicians to verify that the current set of medications is still appropriate. One reports a 98% response rate. One contractor reported

that they have better cooperation with fee for service providers than with other managed care organizations (including their own). Also, Diversion clients will enter a hospital or even a nursing home and not tell the provider that they are covered under the Diversion contract. Each contractor has a special ID card that the client is encouraged to keep with the Medicaid card. When the Diversion project ID number is scanned into the centralized statewide computing system, the managed care provider name is shown which can cause some providers to deny services since they do not have contracts with that provider, yet, they do have a contract with the Diversion contractor. The Diversion project ID numbers could be linked to the name of the Diversion project rather than the managed care organization to reduce confusion.

The contractors offer nearly all of the services as specified in their contract but have had different levels of use (Table 5). Adult companion services are either combined with homemaker services or not used because the client receives services at least three days a week and is assumed to get sufficient companionship from these other caregivers. Adult Day Care or Day Health Care are used by a few clients who have found a Center that is compatible in terms of cultural/language compatibility or level of impairment. For example, some clients do not want to go to a Center if they are cognitively in tact. It is an important option for clients with working caregivers. Chore services are a one-time service, often when the client first enrolls. One contractor did not list chore service in its client handbook. Consumable medical supplies are covered. Incontinence and nutrition products are used the most. DME supplies are part of the State Plan so contractors are responsible for the Medicare copayment, yet they are not listed in one contractor’s client handbook as a service. One contractor pays for additional DME not covered by Medicare, in order to keep clients at home. Few clients use the environmental adaptation services or financial services.

Escort services are provided in vastly different ways. In some programs, the provider drives and provides assistance at a medical appointment; in others, the provider uses the same transportation as the client. Contractors try to use the same escort each time so the escort knows about the client's history. Home delivered meals are popular and most clients want frozen meals. Homemaker services, personal care, and respite services are high use services and are often combined. One contractor has used a nursing facility for a short-term respite stay to provide a caregiver with a vacation. Mental health is covered as part of Medicare with a Medicaid copayment. One contractor noted that case managers can bring mental health issues to the attention of the primary care provider. Nutrition assessment is covered by all contractors but generally at the initial assessment or if there is a weight change. Over half of all clients use the personal emergency response system. All contractors provide a prescription drug benefit. Occupational therapy (OT), physical therapy (PT), and speech therapy (ST) are provided through Medicare (with Medicaid copayment). Assisted Living Facility care is not a required service but often is used as a less expensive alternative to nursing home care. Nursing facilities are a required service and the contractors are at risk for the entire length of stay for long-term clients (short-term rehabilitation is still covered under the Medicare benefit).

Table 5
Experience with Service Packages Provided by Diversion Project Contractors

	Beacon	Health & Home Connection	Summit
Adult Companion Services	Combined with the homemaker visits (see Homemaker Services below).	Not highly used service since homemakers and other providers make regular visits. In general clients need higher level of care than companionship.	Covered
Adult Day Health and Adult Day Care Services	Spanish speaking ADC is used much more than the English speaking one. English speaking clients are not as interested in ADC and being with folks who have dementia.	Use day health care although they find that some (not all) centers will restrict their services to clients with lower impairment levels, are continent, and mobile.	Fewer people use it but they are heavy users. It is good for people who need high supervision and have a working caregiver. It would help if there were more centers that served people without dementia and were closer to people's homes.
Chore services	One-time heavy cleaning at the beginning to make the home safe and clean; some clients get a monthly service as well.	Usually provided at the beginning of enrollment to bring the house up to safety and cleanliness standards and some clients use it for spring cleaning.	Not listed in client handbook but staff report that it is a covered service.
Consumable Medical Supplies	Covered.	The biggest use items are incontinence supplies, nutrition products, and skin integrity creams. Offers a $10/month benefit for over-the counter medications.	Nutrition supplements and incontinence products are used the most. There is also a $15/month over-the-counter benefit for vitamins, cough syrup, etc. ALFs have to be trained to use Summit contracted providers for these benefits (rather than billing Summit after the fact).
DME	Not listed but is covered.	DME Supplies are provided but are not part of the HHC contract. HHC has provided lift chairs, orthotics, and other DME that improve quality of life and decreases nursing home use.	A large part of the health plan DME cost is for Medicare co-payments.
Environmental Accessibility Adaptation Services	Have found a good provider to provide these services.	This is not used a lot and it is hard to find contractors who are willing to come in for small jobs like installing ramps but they do install a lot of grab bars.	Low use service.
Escort Services to medical appointments	Service is utilized for those clients that require assistance at medical appointments and not just for transportation. Try to use the same escort.	This is used a lot but does not include transportation. Escort travels with the client on whatever form of transportation is used. They try to get the same escort each time so that the client's history is known and the escort can be useful.	Not huge volume; done mostly by family and included in some ALF contracts if the facility's transportation does not provide this service.

	Beacon	Health & Home Connection	Summit
Family Training	LPN or RN talks to the family about specific problems addressed by CM and provide literature on the problem (e.g. incontinence, safety, etc.). Literature is also given to clients upon enrollment regarding incontinence and home safety.	This is mostly provided during RN visits or by providing respite so caregivers can go to special classes they want to attend.	This will not be captured in statistics (e.g. as a separate service) but is done by CM and providers (e.g. home health training). Use respite to provide for caregivers to go to outside training.
Financial Services	Have not yet encountered a need for this service.	There is very little call for this since clients are very low income.	This will not be captured in statistics. Mostly done when a client moves to an ALF.
Home Delivered Meals	Use three providers [although only 1 is listed on Contractor's provider list] who provide both frozen and hot meals to about half of the in-home clients.	Clients get 1-2 meals a day. They use both a frozen food provider and meals on wheels. The majority of clients choose the frozen meals because they can choose what to eat and at what time. The frozen food provider provides diet specific meals (based on health) and ethnic specific meals.	High use service. There is a choice of frozen or hot dinners and most people choose frozen. Breakfast and dinners are available.
Homemaker services	On average, clients get this service 3 times a week or in combination with Respite Care if they need a home health aide (e.g. one Respite Care worker can provide both homemaking and home health).	Provided as often as three times a week—especially for someone who lives alone or the caregiver's own health is impaired. It is important when a client is incontinent and may need clothes and bedding washed more often or if they are completely unable to do dishes.	Combined with personal care (see below).
Mental Health	Covered under Medicare.	Covered under Medicare.	Low use due to Medicare coverage. CM helps by bringing MH issues to the attention of the primary care physician—especially the use of psychotropic medications.
Nutrition assessment and risk reduction	Covered.	This is part of the initial assessment by the nurse but the client can be referred to a registered dietician. This is also coordinated with the frozen food provider.	Less use--mostly when there is weight change or the client appears to be a risk from a nutritional stand point.
OT, PT, Speech Therapy (ST):	Medicare is the primary on this; most people use physical therapy. Beacon pays the copayment and will communicate with Primary Care Physician to determine whether additional therapy is needed beyond Medicare benefit.	This is mostly covered by Medicare. Most clients use PT services more than the other OT and ST.	Not used very much except for OT, due to Medicare coverage of benefit.

	Beacon	Health & Home Connection	Summit
Personal care services	Most used service.	Provided to most clients and includes CNA assistance with ADLs.	Big component of services. Also used for respite care (so respite may be under-reported in any statistics). Personal care and respite care cost about the same unless it is 24-hour respite.
PERS (Personal Emergency Response System)	Half of the clients use this service.	50-60% of the clients have this service.	High use.
Prescription drugs	Clients currently average $200-250/month for prescriptions.	Covered.	Increasing cost since Medicare HMOs are dropping Rx benefit or increased client's share of cost (which the health plan covers), as well as increasing cost of drugs.
Respite Care	Most are on a regular schedule; some will need a 24-hour period of respite when emergencies occur with current support services that are in place. In addition, ALFs will provide respite care for in-home clients.	Respite care provides both personal care and homemaking. Also use SNF for caregiver vacations. There is regular respite care (e.g. for a working caregiver) or episodic respite care.	Included under personal care services (see above).
Transportation	Mostly provided through Medicaid. The Homemaker or Companion will drive client to store.	Not listed.	Not listed in client handbook but staff report that it is provided for adult day care and other services when Medicaid transportation is not available.
Assisted living facilities	Most clients started in an ALF but there is also movement from in-home to ALF. ALFs will contact Beacon to enroll new clients. Beacon staff work to integrate with the ALF services and get involved when the ALF is having trouble getting a primary care physician to respond. Some ALFs include consumables and some do not.	Network includes just two facilities.	About 50% of the clients are in an ALF.
Nursing Facility Services	First client may be entering a nursing home.	There had been early disenrollment initially when residents went to non-contracted nursing facilities but this was changed when the Contractor was permitted to use a letter of agreement.	About 9 (out of 285) of the clients are in nursing homes, not including those who are receiving short-term rehabilitation.

Quality Assurance

The three contractors use similar approaches to quality assurance but with automation of record keeping, some contractors can use data more readily. All three contractors use the monthly phone calls and visits to clients as a way to monitor service quality and identify problems to resolve. Chart audits are conducted to look for problems in charting and to identify potential problems with medications and other common problems. All three contractors state that they are involved in research studies on the implementation of clinical practice guidelines; two contractors provided evidence that the studies were in full-swing. Two contractors set benchmarks for services (e.g. percent of new clients contacted within certain timeframes; percent who receive a flu vaccine; etc.). The data are used to identify problems that can be solved. All contractors conduct an in-house satisfaction survey: two conduct this for the Diversion project clients only; one conducts it as part of the managed care organization's survey of clients.

Complaint logs are maintained by all contractors. Dissatisfaction with caregivers appears to be the main complaint across sites. The number one reason for dissatisfaction was unreliable aides. One contractor had many complaints from a single home health agency including stealing, inappropriate medical care, and aides not showing up for work. Since this contractor had several home health agencies listed in its provider network, it wasn't clear why this one provider was still part of the network. There wasn't a relationship between number of complaints and overall satisfaction with services. For example, one contractor had an extensive complaint log but high consumer satisfaction, which may demonstrate the effectiveness of addressing complaints for quality improvement. Complaint logs did not follow the same format across contractors. The most useful data to report would include: complaint date, client name, provider name, description of the problem and problem code, action taken with date, and follow-up action with date. Logs

that were set up to be sorted by any of these fields, had the most potential for being used to troubleshoot recurring problems.

Financial Viability

The Diversion Project contract specifies minimum requirements for financial viability and reporting for each contractor:

1.3. Insolvency protection account must accrue 5% of each capitation rate monthly until 2% of total current contract amount is reached. This amounts to $117/month per client for five months for a total of $562/client/year. A contractor with 300 clients would need $168,600 in insolvency protection in an interest bearing account and no interest can be withdrawn.

1.4. Surplus requirement for ongoing contractors is 1.5 times monthly capitation amount. This is $3513/client or $1,053,900 for 300 clients. The surplus should be in cash or short-term investments (180 days). A guaranteeing corporation with 5 years of business operation and assets in excess of $50 million can guarantee the contractor in lieu of cash assets.

1.5. Blanket fidelity bond on all personnel and board of directors for $250,000 per occurrence is required.

1.6. General and professional liability insurance, malpractice insurance, property insurance, and workmen’s compensation is required.

1.7. Interest and savings not already addressed are the property of the contractor.

According to financial and insurance analysts at the Agency for Health Care Administration, which monitors these requirements, as of the quarterly report dated June 30,

2001, all three contractors meet these requirements. Beacon and HHC meet the standard surplus requirements in 1.4; PHP uses a guaranteeing corporation.

Lessons Learned

The contractors identified the following lessons learned in the first two and a half years of operation:

1. Client record keeping systems are critical and should be thought out in advance of creating client forms. Systems should be completely computerized for tracking, sharing records, billing, and reporting to DOEA. Systems need to incorporate standardized billing formats for the providers and for billing AHCA.
2. Problem of being associated with a managed care organization, especially billing problems since the MCO uses different billing/payment systems than nursing homes and other providers use.
3. Problem of being the secondary payer (after Medicare) and therefore less access to medical records that could help case managers do a better job of coordinating services.
4. It may be viable to expand diversion projects to include private pay clients (similar to a long-term care insurance product).
5. Case managers need ongoing training to understand the extensive number of services needed by and available to frail elders.
6. Need to hasten the eligibility process with CARES and DCF.
7. New enrollee orientation is critical to client use of services. It helps to read the handbook out loud.

8. Use temporary letters of agreement with non-contracted ALF and NH facilities until contractual arrangements can be resolved.
9. Caps on enrollment change the actuarial equation. In effect, current enrollees become frailer and potentially more expensive while new enrollees with fewer needs (although still quite frail) are not available to provide some savings for the Contractor.
10. The availability of a wide network of potential providers allows the Contractor to accept bids from the most cost effective provider who provides a good quality of service.

Client Characteristics

The client populations for Beacon, HHC, and Summit are not homogenous. There are important differences in client characteristics. Table 6 compares frailty levels of the clients enrolled with each contractor. Information on client frailty comes from the CARES database for Diversion Project clients and the CIRTS database for ADA Waiver clients. Activities of Daily Living (ADLs) measure the functional capacity of clients to perform routine tasks, such as bathing, dressing, and eating. CARES and CIRTS both use a traditional five point scale to measure ADLs– ranging from “no assistance required” to “total help required.” In Table 6, the average number of ADLs is based on the number of ADLs where the client needs any assistance at all.

Average ADLs may understate the actual level of care needed. Comparisons between contractors or across different programs require care. In one case, a large number of activities may require coaching or assistance. In another case, a large number of activities might require

total help. Both would register as a large number of ADLs requiring assistance. Future analyses could compute a risk score based on mean scores for each ADL.

HHC and Summit clients have a slightly more impaired client profile. HHC clients need assistance, on average, with 4.66 ADLs (from a total of 6 measured ADLs). Summit clients need assistance with and 7.37 IADLs (out of 8). HHC clients are more likely to live with a caregiver (23.5%) compared to Beacon (16.5%) and Summit (5.3%). Beacon clients were more likely to have been assessed in an ALF (32%) and Summit clients were most likely assessed in a nursing home (60%) before entering the Diversion program. It is likely that individuals who are assessed in an ALF no longer have a caregiver available at home. Nursing home assessments are more complicated and require more analysis. In some cases, the nursing home assessments occur at the end of a short-term nursing home stay following a post-acute care hospitalization.

When Diversion Project clients and ADA Waiver clients are compared, important differences also appear. On average, Diversion clients have need assistance with more ADLs (4.53) compared to ADA Waiver clients (2.99) and are half as likely to live with a caregiver (17.63% vs. 43.39%). Generally, absence of an available caregiver increases the risk of nursing home placement.

The percentage of those who meet eligibility requirements in Table 6 is based on criteria that are mutually exclusive. Each successive criterion applies to clients in a hierarchical fashion. The eligibility for each client was determined in the following way, as specified by the Diversion project contract:

- The client requires some assistance with five or more Activities of Daily Living (ADLs), OR

- The client requires supervision of medications (an IADL) and some assistance with four or more ADLs, OR
- The client is totally dependent upon help with two or more ADLs, OR
- The client has Alzheimer's Disease or some other form of dementia AND requires assistance with three or more ADLs, OR
- The client has a condition that requires daily nursing services.

The last criteria – 'requires daily nursing services' – was a residual category. No reliable way to measure this was found in the CARES or CIRTS databases.

Table 6
Level of Need: Comparison of Diversion Project Contractors (SFY 1999-2000)

	Beacon (N=85	HHC (N=217)	Summit (N=95)	Diversion (N=397)	ADA Waiver (N=1,809)
Level of Need					
Average number of ADLs [1] requiring assistance	4.32	4.66	4.42	4.53	2.99
Average number of ADLs needing some help	3.33	2.94	2.85	3.00	1.89
Average number of ADLs needing total help	.99	1.72	1.57	1.53	1.10
Average number of IADLs [2] requiring assistance	6.98	7.00	7.37	7.08	6.33
Percent Living with a caregiver	16.47	23.50	5.26	17.63	43.39
Percent assessed in an ALF	31.76	1.84	4.21	8.82	.28
Percent assessed in a Nursing Home	21.18	37.79	60.00	39.55	0.00
Meeting Diversion Eligibility Requirements [3]					
Some help with 5+ ADLS	50.59	65.90	62.11	61.71	28.49
Some help with 4 ADLS + supervision of medications	12.94	10.60	9.47	10.83	6.24
Total help with 2+ ADLs	1.18	2.76	1.05	2.02	4.25
Alzheimer's Disease diagnosis or other dementia and require some help with 3+ ADLs	7.06	2.76	0.00	3.02	2.10
Other (includes chronic condition requiring daily nursing).	28.24	17.97	27.37	22.42	58.92

Notes: Data based on most recent CARES assessment: 62% of Diversion clients have complete eligibility data (N=397).
[1] ADLs include bathing, dressing, eating, transferring, toileting, and walking.
[2] IADLs include doing heavy chores, light housekeeping, making a telephone call, managing money, preparing meals, shopping for personal items, taking medication, and using available transportation.
[3] From Contract Requirements, Section 2.1.E. Hierarchical unduplicated count (i.e., individuals needing total help with 2+ ADLS actually needed some (or more) assistance with 5+ ADLS and so are included in the highest level instead).

Diversion clients were significantly more likely to need assistance with 5+ ADLs, compared to ADA Waiver clients (62% vs. 28%). Of the remaining clients (i.e., those that do

not need help with 5+ ADLs), both programs were equally as likely to have clients who need total help with 4 ADLs plus supervision of medications or 2+ ADLs. Diversion Program had many fewer clients who fell into the "residual" category—those who may need daily nursing assistance or who may not meet the criteria for the program (22% vs. 59%). The ADA Waiver program has a slightly less stringent set of eligibility requirements but their clients are being compared to the Diversion program clients here. This is likely the reason that they have a higher percentage of clients who do not meet these requirements.

Important differences also exist in the incidence of chronic health problems. Clients in HHC are less likely to suffer from dementia than other Diversion Program clients (Table 7). The same is true for ADA Waiver clients. They are less likely than Diversion Program clients to have dementia listed as a chronic health problem.

Table 7
Chronic Health Problems: Comparison of Diversion Project Contractors (SFY 1999-2000)

	Beacon (N=85)	HHC (N=217)	Summit (N=95)	Diversion (N=397)	ADA Waiver (N=1,809)
Arthritis	50.59	52.07	52.63	52.89	82.59
Decubitus Ulcers (Bed Sores)	9.41	13.36	12.63	12.34	4.70
Cancer	18.82	17.97	12.63	16.88	14.26
Dementia	50.59	36.87	43.16	41.31	25.70
Diabetes	23.53	32.72	17.89	27.20	35.38
Emphysema / COPD	30.59	23.96	28.42	26.45	17.80
Heart Problems	55.29	62.21	52.63	58.44	61.19
Incontinence	58.82	65.90	60.00	62.97	48.20
Liver Problems	4.71	3.23	4.21	3.78	3.48
Stroke	22.35	32.72	31.58	30.23	30.85
Avg. Number of Conditions	3.25	3.41	3.16	3.31	3.24

Another feature is evident in Table 7. Most of the Diversion Program and ADA Waiver clients suffer from multiple chronic health conditions (3.31 and 3.24, respectively). Especially pronounced chronic health problems in these frail populations include arthritis, dementia, diabetes, heart disease, and incontinence.

The sizes of the respective populations in Table 6 and Table 7 require brief mention. The populations reflect clients with matching evaluations in the CARES/CIRTS databases. For Diversion Project clients, a matching record was found in the CARES electronic database proximate to SFY 1999-2000 for approximately 81% of the clients. ADA Waiver clients matched at a higher rate, approaching 99% in the CIRTS database.

Service Utilization and Cost Neutrality

Service utilization data for the Diversion Project clients was provided by all three contractors. The contractors were not willing to provide actual service costs for long-term care services. They agreed, instead, to provide information on service units per client, per month.

The data are reported here in two different ways. The first is the average units of service per capita (Table 8). The second is the average units of service per client, when they use a particular service (Table 9). In the first case, zeros are included when clients do not use a particular service. In the second case, those zeros are excluded.

There is considerable variation in the long-term care services provided by the three Diversion Project contractors. This is due, in part, to different reporting standards. Beacon claims that many services coded “adult companion services” included home health, personal care, and homemaking services. Regardless, it is still evident in Table 8 that Beacon clients, on average, received both a smaller set of services and fewer units of service. Both Beacon and Summit make higher use of ALFs for serving clients. These clients receive long-term care services through the ALF. Those services are paid for by the contractor but are not captured here because they are part of a service package and not part of the contractor’s record keeping system.

Table 8
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Average Monthly Long-Term Care Services (per client, per month)[1]

Total Client Months	Beacon N=337	HHC N=2,895	Summit N=620
	Mean Number of Units		
Adult companion services (hours)	9.54	0.43	0.33
Adult day health services (hours)		0.20	12.91
Case management[2] (dollars)	$148.86	$170.30	109.41
Chore services (hours)		0.01	0.11
Environmental accessibility adaptations (episodes)		0.01	0.04
Escort services (hours)		0.05	
Family training services (episodes)			
Financial assessment/risk reduction services (hours)			
Home delivered meals (meals)	7.86	9.98	10.62
Homemaker services (hours)		7.05	1.45
Nutritional assessment/risk reduction services (hours)			0.03
Personal care services (hours)	4.53	5.68	15.27
Personal emergency response system installation (episodes)		0.06	0.10
Personal emergency response system use (days)		0.40	9.15
Respite care (hours)		7.36	4.73
Occupational therapy (hours)	0.38		0.09
Physical therapy (hours)	0.53	0.20	
Speech therapy (hours)	.19		
Skilled Nursing Facility (days)		0.53	1.08
Assisted Living Facility (days)	0.68		12.33

[1]From Contract Requirements, Section 4.2
[2]Self-report by Contractors (average case management salary and benefit costs per client, per month)

All three contractors reported adult companion services, home delivered meals, and personal care services. With the exception of home delivered meals, there is wide variation in the units of service the contractors reported. Beacon averaged 9.54 hours of adult companion services per client per month, while HHC and Summit reported only a fraction of an hour each. The remaining set of long-term care services are reported by just one or two contractors. Only HHC and Summit reported adult day health services, chore services, environmental accessibility adaptation, homemaker services, personal emergency response installation and call services, respite care, and skilled nursing. Beacon and Summit reported occupational therapy. HHC is the only contractor to report escort services. Summit is the only contractor to report nutritional assessments. Beacon and HHC reported physical therapy. Beacon and Summit provided care in

Assisted Living Facilities (ALFs), with Summit providing appreciably more care in that setting (12.33 days, on average, compared with slightly less than one day).

The data in Table 8 reports per capita units for long-term care services. This is useful for determining capitation rates. Each cell sums the units of service and divides by the number of client months. If a client is enrolled with a contractor but does not receive the service during the month, the month is still counted in the denominator.

Another way to consider the service utilization data is to exclude client months where the client did not receive the service. This is less useful for determining capitation, but it does describe the average units of service consumed during a month, when a client receives the service. This is a measure of average intensity of service. Table 9 presents long-term care services per client, per month of received service.

The numbers change from Table 8 to Table 9. This is expected. For example, HHC provides adult companion services to just a small number of clients. If we consider all of the HHC clients, on average, they receive less than one-half hour (.43 hours) of adult companion services each month. However, if we drop the months with no adult companion services, we can see that clients who receive adult companion services during a given month average 22.56 hours.

The essential features remain consistent across both tables. The basket of services that clients typically receive in the Diversion Program varies across the three contractors. The average number of units received by clients also varies.

Table 9
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Average Monthly Long-Term Care Services (per client, per received month of service)[1]

	Beacon		HHC		Summit	
	Mean Number of Units (Numbers in parentheses are client service months)[2]					
Adult companion services (hours)	22.32	(144)	22.56	(55)	9.27	(22)
Adult day health services (hours)			7.53	(75)	121.30	(66)
Chore services (hours)			2.09	(11)	5.15	(13)
Environmental accessibility adaptations (episodes)			1.26	(34)	1.35	(17)
Escort services (hours)			5.04	(28)	2.00	(1)
Family training services (episodes)	1.00	(1)				
Financial assessment/risk reduction services (hours)						
Home delivered meals (meals)	20.21	(131)	32.35	(893)	39.44	(167)
Homemaker services (hours)			16.60	(1230)	12.5	(72)
Nutritional assessment/risk reduction services (hours)			1	(1)	1	(18)
Personal care services (hours)	11.21	(136)	15.31	(1074)	35.07	(270)
Personal emergency response system installation (episodes)			1.01	(178)	1	(59)
Personal emergency response system use (days)			1.04	(1124)	30.01	(189)
Respite care (hours)			31.23	(682)	52.39	(56)
Occupational therapy (hours)	9.23	(14)	1.25	(4)	8.14	(7)
Physical therapy (hours)	5.94	(30)	24.50	(24)		
Speech therapy (hours)	7.28	(9)				
Skilled Nursing Facility (days)			20.89	(73)	18.14	(37)
Assisted Living Facility (days)	7.19	(32)	7.53	(75)	29.96	(255)

[1]From Contract Requirements, Section 4.2
[2]This sums the number of months of service for all clients.

We can see in Table 9 that some lines of long-term care service generate considerable amounts of service. When home delivered meals are required, clients average between 20 and 40 meals per month. Adult companion services, when required, average between 9 and 23 hours of care. Respite care and skilled nursing facility care were reported only by HHC and Summit during SFY 1999-2000. These were also resource-intensive lines of service, when clients received them. Clients who required respite care or skilled nursing facility care, received between 31 and 52 hours of respite care and between 18 and 21 days of care in a skilled nursing facility.

Further analysis is required to compare the basket of services received by ADA Waiver clients. The monthly claims file includes a bucket for “Aging Services”. This bucket is used to

aggregate claims for HCBS-related services, including personal care, chore services, homemaker services, and the like. The average Aging Services monthly expenditure for the ADA Waiver clients in this study was $525.82 during SFY 1999-2000 (not displayed). This does not include ALF or SNF costs. Future cost comparisons would benefit from contractors providing actual costs for units of services or analyzing units of care provided by ADA Waiver clients.

ADA Waiver clients who enter long-term nursing home care are transferred out of the ADA Waiver program because they no longer receive community-based services. The contractors in the Diversion Project are at-risk for the nursing home care required by their clients so long as they remain a contractor. The average monthly expenditure on nursing home care for the ADA Waiver clients was $50.60 during SFY 1999-2000. Diversion clients who received SNF care, spent 18-21 days in a nursing home. Presumably, these individuals were still using their Medicare benefit for post-acute short-term nursing home care, with the contractor paying for the Medicaid co-payment only.

If an ADA Waiver client required nursing home care, Medicaid could expect an average monthly expenditure of $1,781. This average monthly expenditure is about half of the actual Medicaid reimbursement rate for nursing home care. As an average, it reflects the fact that individuals are receiving care for less than one month as they transition in or out of the ADA Waiver program or are receiving post acute care. This average expenditure does not include Medicaid deductibles and co-payments for dual eligible clients for whom Medicare is the primary payer.

The Medicaid rate in Florida for large Central region nursing homes (including Orlando, Osceola, and Seminole Counties) is $105.19 a day or $3,155.70 a month. The rate for large Southern region nursing homes (including Palm Beach County) is $109.56 a day or $3,286.80 a

month. The rates for small nursing homes in these two areas are slightly higher ($3,381.90 in Central Florida and $3,517.70 in South Florida). In comparison, Diversion clients cost the state $2,342.41 a month. If these clients are diverted from entering a nursing home by enrolling in the Diversion program (rather than being diverted from other HCBS programs), then the state is saving anywhere from $10,285 to $14,811 a year (depending on the region and size of nursing home) for each Diversion client.

Table 10
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Acute Care Services[1] (per client, per month)

	Beacon	HHC	Summit	Diversion	ADA Waiver
Client Months	N=493	N=2,895	N=653	N=4,041	N=1,846
Home Health Care (Hours)	19.35	1.90	0.25	3.76	0.47
	Average Dollars Spent			Average Dollars Spent	
Inpatient Services	94.67	86.15	4.75	74.04	72.12
Independent Lab or X-ray	54.94	.33	1.68	7.21	0.32
Mental Health		.02	.21	.05	N/A
Outpatient Services	98.02	83.54	40.13	78.29	34.95
Physician Services	3.53	16.47	16.30	14.86	8.81
Prescribed Drugs	321.54	185.09	152.50	196.47	178.92
Transportation to Med. Appts.	.50		1.86	.36	N/A
Vision Services	.87	1.09		.88	N/A

[1]From Contract with Providers, Section 4.3

Table 10 presents information on acute-care services. These are services for which the three Diversion Project contractors are also at-risk. All three contractors were willing to share cost information on acute-care charges. The data in Table 10 is helpful for determining capitation. It is the average client expenditure per month of enrollment.

The average monthly expenditures for acute care among Beacon clients are considerably different from the pattern for HHC and Summit clients. In every expenditure category except "Physician Services", the monthly per client expenditures are higher for Beacon clients.

Care must be taken when comparing average monthly expenditures between Diversion Program clients and ADA Waiver clients. Diversion Program clients are eligible for both Medicare and Medicaid benefits. The contractors are at-risk for Medicare cross-over payments

for Diversion Program clients. Cross-over payments cover Medicare deductibles and co-insurance. Diversion contractors are also financially at risk for Medicare-covered services when the client exceeds caps established by the Medicare program, such as the 90-day per benefit period limit on inpatient hospital care. With ADA Waiver clients, there is no requirement of dual eligibility. Medicaid is at-risk for the total cost of acute care for those ADA Waiver clients who are not eligible for Medicare. ADA Waiver providers are not responsible for these costs.

Table 10 indicates that the overall costs of acute care for Medicaid ADA Waiver clients are not grossly different from the costs of acute care that the Diversion Program contractors bear. There are differences within individual categories of services. Prescription drug costs is the largest acute care expenditure category for both programs. For ADA Waiver clients, Medicaid payments for prescriptions averaged $178.92 per client, per month. For the Diversion Program contractors, the average cost was $196.47. If we sum the basket of acute care services in Table 10 for the Diversion Project clients and the ADA Waiver clients, the difference amounts to just $76 per month ($371 for Diversion Program clients, compared with $295 for ADA Waiver clients). That difference is explained in part by different average costs for certain services. More dollars were spent, on average, for Diversion clients on labs/xrays, outpatient, and physician services.

We can also calculate acute care costs by dropping months of enrollment where no service was provided, just as we did with long-term care services. Table 11 presents average client costs, per month of received service.

One of the remarkable features in Table 11 is the variation in average costs when the Diversion Project contractors pay for acute care co-payments and deductibles. Inpatient service costs vary among the three contractors, from an average of $606 to $1,485, over a two-fold

difference in costs. Physician services show nearly a three-fold difference. Outpatient services show more than a two-fold difference.

Table 11
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Acute Care Service Co-Payments and Deductibles[1]
(Per client, per received month of service; Numbers in parentheses are number of client service months)[2]

	Beacon		HHC		Summit		Diversion		ADA Waiver	
Home Health Care (hrs)	30.88	(309)	25.36	(217)	18.33	(9)	28.43	(535)	1.48	(593)
	Average Dollars Spent						Average Dollars Spent			
Inpatient Services	606.16	(77)	1484.61	(168)	776.00	(4)	1201.58	(249)	270.03	(493)
Independent Lab/X-ray	459.14	(59)	59.74	(16)	47.83	(23)	297.40	(98)	8.72	(68)
Mental Health			15.88	(3)	10.54	(13)	11.54	(16)	N/A	
Outpatient Services	268.48	(180)	490.57	(493)	639.11	(41)	443.11	(714)	91.25	(707)
Physician Services	33.48	(52)	58.49	(815)	95.02	(112)	61.34	(979)	27.58	(590)
Prescribed Drugs	508.07	(312)	221.42	(2420)	256.66	(388)	254.47	(3120)	234.24	(1410)
Transportation to Med. Appts.	4.61	(54)			12.53	(97)	9.70	(151)	N/A	
Vision Services	36.09	(12)	40.32	(78)			39.76	(90)	N/A	

[1]From Contract with Providers, Section 4.3
[2]This sums the number of months of service for all clients.

The differences in average expenses for months of service are more dramatic when we compare Diversion Program clients and ADA Waiver clients for inpatient and physician services and for prescribed drugs. Diversion Program clients have higher acute care service costs, on average for each month of service, for inpatient services, independent laboratory and x-ray services, outpatient, and physician services. They also provide significantly more hours of home health care (28 vs. 1.5 hours per month per client receiving the service).

In addition to long-term care and acute care services, the three Diversion Program contractors also provide Durable Medical Equipment (DME) and consumable supplies to their clients. Table 12 shows the DME usage by Diversion Program clients. The pattern is a familiar one. There is considerable variation across the three contractors. HHC provides a larger basket of services than Beacon or Summit. The most common DME made available to Diversion Program clients were bathroom and toileting aids, oxygen and oxygen-related equipment, and wheelchairs.

Table 12
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Durable Medical Equipment Co-Payments and Deductibles (per client, per received month of service)
(Numbers in parentheses are number of services provided during SFY)

DME Item	Beacon		HHC		Summit	
Ambulatory Aids			51.70	(27)	36.59	(17)
Bathroom and Toileting Aids	N/A	(2)	57.86	(120)	54.67	(30)
Hospital Beds, Mattresses, and Rails	N/A	(9)	26.65	(41)	22.12	(4)
Nebulizer			4.47	(20)		
Orthopedic Devices			124.09	(5)		
Oxygen and Oxygen-Related Equipment			33.54	(162)		
Patient Lifts			110.55	(10)		
Prosthetic Devices	N/A	(11)	612.86	(2)		
Suction Machines			11.04	(28)		
Traction Equipment	N/A	(5)				
Trapeze Equipment			4.04	(17)		
Ventilator						
Wheelchair	N/A	(18)	28.92	(203)	5.00	(1)
Other	N/A	(6)			10.94	(35)

N/A=substantial number of records were missing cost data so average cost cannot be calculated.

Our final table on service utilization is Table 13, which presents information on consumable supplies. The average costs in Table 13 are per client, per month receiving the supply. The numbers in parentheses are the number of service months, which change from one supply item to the next. The largest category of consumable supplies is the "Other" category. This is an assortment of consumable supplies that do not fit into the Medicaid State Plan categories. Among the identified supplies, the largest categories are for bathroom, toileting, and incontinence. The average costs of these supplies vary between contractors.

Table 13
Service Utilization: Comparison of Diversion Project Contractors (SFY 1999-2000)
Consumable Supplies (per client, per month of service)
(Numbers in parentheses are number of services provided during SFY)

Consumable Supply Item	Beacon		HHC		Summit	
Bathroom and Toileting Aids	N/A	(182)				
Glucose Monitors and Blood Lanclets	N/A	(3)	59.80	(8)		
Home Enteral Supplies and Equipment	N/A	(92)	125.76	(299)		
Oxygen and Oxygen-Related Equipment	N/A	(10)				
Peak Flow Meter	N/A	(1)				
Other	N/A	(329)	65.08	(2081)	49.76	(318)

N/A=substantial number of records were missing cost data so average cost cannot be calculated.

Unmet Need, Consumer Satisfaction, and Disenrollment

The Department of Elder Affairs conducted a telephone survey in late May to early June 2001 of 669 randomly selected clients who receive long-term care services from the Diversion Project or through the ADA Waiver programs available through CCE lead agencies (Table 14). A total of 208 clients were not available because of death, dementia, hospitalization, or non-working phone number. Of the remaining, 244 clients participated in the interview (53% response rate). Data were analyzed by FPECA staff. All questions were tested for significant differences between the three Diversion programs and then between the Diversion programs and the ADA Waiver programs. The purpose of the survey was to identify strengths and weaknesses in the Diversion programs and also to see if there were differences between Diversion and ADA Waiver programs.

The Department did not interview individuals in assisted living facilities or nursing homes. Over half of the Summit clients are living in assisted living facilities and were not included in the survey. The results can be generalized only to in-home care clients of Diversion and ADA Waiver services.

Table 14
Consumer Satisfaction Survey Sample

	Diversion Programs			ADA Waiver Programs				
	Beacon	HHC	Summit	Orange & Seminole	Osceola	Palm Beach/ DSS	Palm Beach/MV	Total
Population	106	385	310	637	221	376	134	2189
Sample Selected	**83**	**199**	**150**	**114**	**4**	**99**	**20**	**669**
Not available or not appropriate	41	17	69	38	0	32	10	208
Final Sample	**42**	**182**	**81**	**76**	**4**	**67**	**10**	**461**
Refused/did not return phone calls	25	93	43	25	2	29	0	217
Responded	**17**	**89**	**37**	**51**	**2**	**38**	**10**	**244**
Response Rate	40%	49%	46%	67%	50%	57%	100%	53%

Most Diversion Program clients were referred by family or friends, followed by health care provider or discharge planner (Table 15). Between 18-34% were referred to by an unidentified source. There were no significant differences between the Diversion Programs and the ADA Waiver Programs in terms of the referral source (not displayed).

Table 15
Referral Source: Comparison of Managed Long-Term Care Diversion Programs

	Beacon	HHC	Summit
	Percentages		
Family or friends	17.6%	22.5%	16.2%
Volunteers	0%	5.6%	0%
Adult Protective Services	5.9%	2.2%	8.1%
Doctor, nurse	5.9%	14.6%	10.8%
Discharge planner at hospital	5.9%	12.4%	13.5%
Medicare home health aide	11.8%	3.4%	2.7%
Help line	0%	10.1%	2.7%
Walk-in	5.9%	1.1%	0%
Other	17.6%	33.7%	29.7%

Table 16
Unmet Needs Identified by Survey Respondents

	Beacon	HHC	Summit	Sig.
	Percentages			
Average unmet need (0-6) [1]	1.94	1.02	1.43	*
Transportation	23.5%	37.1%	27.0%	
Home Delivered Meals	35.3%	16.9%	18.9%	
Chore/Homemaker	47.1%	20.7%	40.5%	*
Respite	47.1%	10.2%	27.0%	***
Adult Day Care	11.8%	9.0%	5.4%	
Personal Care	29.4%	9.0%	24.3%	*

[1] Transportation, home-delivered meals, chore/homemaker, respite, adult day care, personal care
n=143 *p<=.05 **p<=.01 ***p<=.001

In-home clients of the Diversion Programs reported needing additional assistance in at least one service area (Table 16). Beacon in-home clients were more likely to report needing more assistance with personal care, respite care, and homemaker services. They also had the highest average number of unmet needs (1.94 compared to 1.02 for HHC and 1.43 for Summit). There were no significant differences between Diversion Programs and ADA Waiver programs in terms of unmet need except that the average number of unmet needs was significantly higher in the ADA Waiver Programs (1.58) than in the Diversion Programs (1.24; not displayed).

In-home clients of the Diversion Programs reported high satisfaction with case management although there were significant differences by program (Table 17). HHC had the highest average rating (1.09) and Beacon had the lowest rating (1.63). The programs were not significantly different from each other in terms of the ease of the initial process to receive services (average across programs was 1.71) and Diversion Program clients had an easier time receiving services than did the ADA Waiver clients (average rating=2.12). Most Diversion Program clients had one or two case managers in the past 12 months whereas most ADA Waiver clients had just one case manager in the same time period. Clients in both programs were not likely to have requested a new case manager in the past year. Very few Diversion clients would prefer to manage their own services, although 18% of in-home respondents from Summit said they would prefer this option. ADA Waiver clients were significantly more likely to say they wanted to do their own case management. All of the respondents at HHC and Summit and 81% at Beacon said their case managers were always helpful. There were no significant differences between Diversion and ADA Waiver clients on this question. There was also agreement that case managers arrange all of the services they need. HHC respondents were much more likely to say the case manager was available when needed. HHC uses a model where case managers contact clients only by phone and are rarely outside the office. The other two settings contact the clients in person. HHC nurses provide the in-home contact quarterly and as necessary.

Table 17
Satisfaction with Case Management:
Comparison of Managed Long-Term Care Diversion Programs with ADA Waiver Programs

	Beacon	HHC	Summit	Sig.	Diversion	ADA Waiver	Sig.
	Mean or Percent				Mean or Percent		
Overall rating of case manager (1=Excellent;5=very poor)	1.63	1.09	1.31	***	1.21	1.41	*
Average ease of process to receive long-term care services (1=very easy)	1.75	1.62	1.92		1.71	2.12	**
Number of case managers in the past 12 months:							
One	46.7%	53.5%	37.8%		48.6%	76.3%	***
Two	33.3%	38.4%	48.6%		40.6%	18.6%	
Three of more	20.0%	8.1%	13.5%		10.9%	5.2%	
Requested new case manager in past 12 months	6.7%	0%	2.7%		1.4%	3.0%	
How often talk to case manager in a month							
One	50.0%	40.0%	77.1%	**	50.7%	73.8%	***
Two	28.6%	41.2%	17.1%		33.6%	12.5%	
Three of more	21.4%	18.8%	5.7%		15.7%	13.8%	
Would you rather manage your own services (no case manager)?	0%	5.2%	18.2%	*	8.0%	25.0%	***
Case manager always willing to help							
Yes, always	81.3%	100.0%	100.0%	***	97.8%	96.8%	
Sometimes	12.5%	0%	0%		1.4%	3.2%	
Seldom or never	6.3%	0%	0%		.7%	0%	
Case manager arrange all the services you need							
Yes, always	86.7%	97.7%	90.6%		94.8%	92.6%	
Sometimes	6.7%	2.3%	3.1%		3.0%	6.4%	
Seldom or never	6.7%	0%	6.3%		2.2%	1.1%	
Case manager available when needed							
Yes, always	75.0%	96.6%	85.7%	*	91.3%	85.9%	
Sometimes	12.5%	3.4%	8.6%		5.8%	12.0%	
Seldom or never	12.5%	0%	5.7%		2.9%	2.2%	

n=143 *p<=.05 **p<=.01 ***p<=.001

Table 18
Satisfaction with Services:
Comparison of Managed Long-Term Care Diversion Programs with ADA Waiver Programs

	Beacon	HHC	Summit	Sig.	Diversion	ADA Waiver	Sig.
	Percent				Percent		
Receiving all the long-term care services you need	70.6%	89.4%	86.1%		86.2%	75.3%	*
	Mean (5=very satisfied)				Mean (5=very satisfied)		
Satisfaction with transportation	3.08	4.52	3.43	***	3.45	3.71	
Satisfaction with home delivered meals	3.80	4.52	3.43	***	4.28	4.25	
Satisfaction with homemaker services	3.22	4.56	3.88	***	4.28	4.22	
Satisfaction with respite services	4.50	4.36	4.63		4.44	4.17	
Satisfaction with adult day care	4.00	4.75	4.57		4.58	3.89	
Satisfaction with personal care	3.75	4.63	4.18	**	4.40	4.47	
Quality of life rating (for long-term care)[1]	3.88	4.56	4.11	**	4.37	4.62	*
Quality of life rating (for medical services)[2]	4.31	4.61	4.32		4.52	4.18	**
Overall satisfaction with quality of long-term care services	3.94	4.73	4.27	***	4.52	4.14	**
Overall satisfaction with medical care	3.83	4.58	4.41	**	4.47	4.12	**
Personal control score (3-17)	11.07	12.40	10.15	**	11.68	11.94	

[1]The quality of your life has been enhanced by receiving long-term care services (Strongly disagree-Strongly agree).
[2]The quality of your life has been enhanced by receiving medical services (Strongly disagree-Strongly agree).
n=143 *p<=.05 **p<=.01 ***p<=.001

Most clients report receiving all the long-term care services they need but Diversion clients are significantly more likely to say this than are ADA Waiver clients (86% vs. 75%). HHC clients were significantly more satisfied than in-home clients in the other two settings with the following services: transportation, home delivered meals, homemaker services, and personal care (Table 18). It should be noted that programs do not pay for transportation but coordinate services as part of the Medicaid contract. There were no significant differences between programs in terms of satisfaction with respite and adult day care. Quality of life because of receiving long-term care services was highest for HHC and there was no significant differences between settings in regard to quality of life due to medical services. ADA Waiver clients reported higher quality of life due to long-term care services and Diversion clients reported higher quality of life due to medical services.

The Diversion projects coordinate but do not choose nor provide medical services for their clients, yet they were significantly more satisfied with their medical care than ADA Waiver clients who do not receive the same coordination of medical services. Over one-fourth (27%) of the ADA Waiver clients stated that they would like their case manager to coordinate medical services (not displayed). Among Diversion project respondents, HHC clients were the most satisfied with their medical care.

There were significant differences in terms of sense of personal control by program: clients in HHC had the highest sense of control and Summit in-home clients had the lowest sense of personal control. There were no differences between Diversion and ADA Waiver clients in terms of personal control.

Disenrollment Rates

Of the 1,254 individuals who enrolled in the Diversion programs over the first 31 months (Table 19), 430 (34%) disenrolled for voluntary or involuntary reasons. The actual rate of disenrollment (ratio of disenrollments to total client months) is reasonable. In its first seven months, HHC had a 5% disenrollment rate but it improved in the second and third years. All three contractors had disenrollment rates of 2-3% in the last two years. Using clients who had been in the program beginning in October 1999 (when all three contractors were operating), on average, clients remained in the program from 9.4 (Beacon) to 10.25 (HHC) months and many are still in the program. In fact, since each programs inception, Beacon's clients average 510 days, HHC's clients average 503 days, and Summit's clients average 290 days (not displayed).

Table 19
Total Disenrollments and Disenrollment Rate by Contractor[1]

	Beacon		HHC		Summit		Total
	N	Rate	N	Rate	N	Rate	N
12/1998-99	-		18	5%	-		18
1999-00	27	3%	126	3%	21	2%	174
2000-01	34	2%	118	2%	86	3%	238
Total	61		262		107		430

[1]Disenrollment rate=total disenrollments/total client months.

Contractors are required to report voluntary and involuntary reasons for disenrollment of clients. The most common reason for disenrollment was death of the enrollee (41%) and this was not significantly different across contractors. Health and Home Connection was more likely to have disenrollment due to other voluntary reasons (32%) such as: entering Hospice or entering non-contracted SNFs (which occurred prior to DOEA permitting letters of agreement). Summit was more likely to have disenrollment due to other involuntary reasons (25%). Twelve percent of all disenrollment reasons was due to moving out of the area (most common for Beacon and HHC clients) and 10% was due to loss of Medicaid eligibility.

Table 20
Disenrollment Reasons: Comparison of Diversion Project Contractors (SFY 1999-2000) [1]

	Beacon (N=39)	HHC Connection (N=247)	Summit (N=136)	Total
	Percent			
Voluntary Reasons				
V1 Expects to move			4.4	1.4
V2 Wishes to see private MD or practitioner, or attend another clinic				
V3 Dissatisfied with plan policies or procedures				1.4
V4 Enrolled/enrolling in other Medicaid HMO			1.5	.5
V7 Other voluntary	23.4	32.0	12.5	15.0
Involuntary Reasons				
I1 Missed 3 consecutive appointments in a continuous six-month period				
I2 Moved out of service area	15.4	15.0	5.9	12.0
I4 Fraudulent use of Medicaid or plan ID card				
I5 Death of enrollee	41.0	42.0	37.5	41.0
I6 Loss of Medicaid Eligibility		9.7	13.0	10.0
I8 Other involuntary	10.3	.8	25.0	10.0

[1]From Contract Requirements, Section 8.3.

Recommendations For Future Evaluation

The data presented in this preliminary evaluation of the Diversion programs represent a formative evaluation of a program that is less than three years old. Follow-up evaluations could be summative and look at outcomes based on pre-established criteria. In addition, intermediate changes to the program and to the reporting requirements could be established at this juncture and be included in the follow-up evaluation.

Maintenance Activities

- Contractors should maintain the reporting mechanisms set up as part of this evaluation (Appendix A), with a few corrections based on this preliminary evaluation (e.g., change DME and Supply Codes to better represent the services provided).

Additional Data Elements

- Contractors should be required to provide cost information on long-term care services.

Follow-up Evaluation Based on Preliminary Evaluation

- Follow-up Key Informant interviews with Diversion Contractors and ADA Waiver providers (lead agencies) to interpret data in preliminary evaluation and consider alternative explanations and hypotheses to be tested in the follow-up evaluation.
- Add categories to disenrollment reports to better capture "other voluntary" or "other involuntary" reasons for disenrollment.
- Conduct consumer satisfaction survey with a sample of clients in all settings (in-home, ALF, and NH) who receive Diversion services. Consider including ALE and nursing home clients to the ADA Waiver program as part of the comparison.

New Evaluation Activities

- Develop criteria for evaluating Diversion Program Contractors and evaluate the extent to which these criteria are met. Criteria could include:
  - Staff qualifications
  - Continuing education activities and outcomes
  - Processes used for continuous quality improvement (e.g. complaint and re-staffing data) and outcomes of these processes.
  - Quality of computerized client data systems.
  - Levels of met and unmet need.
  - Financial stability and viability of Contractors (new reporting mechanism).
  - Breadth and depth of provider network.
- Compare client characteristics and utilization data between Diversion programs and ADA Waiver, ALE Waiver, and Medicaid Nursing Home clients.
- Risk adjusted outcomes (death, hospitalizations, use of more institutionalized care, declining functional status) for clients in Diversion, ADA Waiver, ALE Waiver, and Medicaid clients receiving long-term skilled nursing care.
- Conduct an actuarial analysis of the capitated rate, using three years of data to determine the trajectories of Diversion program clients and the overall cost to the Diversion contractors. In the alternative, require the contractors to provide an annual justification report for the capitation received, using an accounting firm selected by DOEA to certify the actuarial analysis and financial records provided by the contractors.

Appendix A
Data Collection Forms

MASTER RECIPIENT FILE

A master recipient file should be provided as an ASCII fixed length text file, one record per recipient, per line. Each record will have the following fields (current as of March 31, 2001).

Field Name	Description	Unit of Measurement	Length	Start Col.	End Col.	Text/Number
SSN	Social Security Number (left justify)	000000000	9	1	9	N
Medicaid	Medicaid ID Number	0000000000	10	10	19	N
First	Recipient First Name		9	20	28	T
Last	Recipient Last Name		12	29	40	T
DOE	Date of Enrollment	MMDDYYYY	8	41	48	N
DODE	Date of Disenrollment (if applicable)	MMDDYYYY	8	49	56	N
County	County of Service		15	57	71	T
Capitated	Monthly capitated rate for this person	0000.00	7	72	78	N
Contractor	Contractor ID	000000000	9	79	87	N

LONG-TERM CARE

The Long-Term Care file should be provided as an ASCII, fixed length text file, one record per recipient, per month, per line. Each record will have the following fields (see section 4.2 in your contract or Appendix A (attached) for a full description of each service). Fill with spaces if there were no units of service provided. Right justify all fields unless noted otherwise. All “Hours” fields should be accurate to the nearest quarter hour (.25). Please be sure to enter the hours as a decimal (e.g. 2.5 is two and a half hours; .25 is a quarter hour).

Field Name	Description	Unit of Measurement	Length	Start Col.	End Col.	Text/Number
SSN	Social Security Number (left justify)	000000000	9	1	9	N
MID	Medicaid ID Number	0000000000	10	10	19	N
MO	Report month	MMYYYY	6	20	25	N
HMKS	Adult companion services	Hours (00000.00)	8	26	33	N
ADHC	Adult Day Health Services	Hours (00000.00)	8	34	41	N
ALFP	Assisted Living Services	Days	5	42	46	N
CM	Case Management	Episodes	5	47	51	N
CHO	Chore Services	Hours (00000.00)	8	52	59	N
EAA	Environmental Accessibility Adaptations	Episodes	8	60	67	N
ESCW	Escort Services	Hours (00000.00)	8	68	75	N
FST	Family Training Services	Episodes	5	76	80	N
RRFA	Financial Assessment/Risk Reduction Services	Hours (00000.00)	8	81	88	N
HDM	Home Delivered Meals	Meals	5	89	93	N
HMK	Homemaker Services	Hours (00000.00)	8	94	101	N
RRNU	Nutritional Assessment/Risk Reduction Services	Hours (00000.00)	8	102	109	N
PECA	Personal Care Services	Hours (00000.00)	8	110	117	N
EARI	Personal Emergency Response System Installation	Episodes	5	118	122	N
EAR	Personal Emergency Response System	Day	5	123	127	N
RESP	Respite Care	Hours (00000.00)	8	128	135	N
OCTH	Occupational Therapy	Hours (00000.00)	8	136	143	N
PHTH	Physical Therapy	Hours (00000.00)	8	144	151	N
SPTH	Speech Therapy	Hours (00000.00)	8	152	159	N
NF	Nursing Facility Services	Days	5	160	164	N

ACUTE CARE (For programs that receive the capitated rate for Medicaid acute care services)

The Acute Care file should be provided as an ASCII, fixed length text file, one record per recipient, per month, per line. Each record will have the following fields (see section 4.2 in your contract or Appendix A (attached) for a full description of each service). Fill with spaces if there were no units of service provided. Right justify all fields unless noted otherwise. For charges, include actual amounts for Medicaid (co-pays, payments for non-Medicare covered services). All "Hours" fields should be accurate to the nearest quarter hour (.25). Please be sure to enter the hours as a decimal (e.g. 2.5 is two and a half hours; .25 is a quarter hour).

Field Name	Description	Unit of Measurement	Length	Start Col.	End Col.	Text/Number
SSN	Social Security Number (left justify)	000000000	9	1	9	N
MID	Medicaid ID Number	0000000000	10	10	19	N
MONTH	Report month	MMYYYY	6	20	25	N
MENTAL	Mental Health Services	Hours (00000.00)	8	26	33	N
DENTAL	Dental Services including dentures	Charges (000000.00)	9	34	42	N
HEARING	Hearing Services including hearing aids	Charges (000000.00)	9	43	51	N
HOME	Home Health Care Services	Hours (00000.00)	8	52	59	N
LABXRAY	Independent Laboratory or Portable Xray Services	Charges (000000.00)	9	60	68	N
INPATIENT	Inpatient hospital services, including E/R that is admitted	Charges (000000.00)	9	69	77	N
OUTPATIENT	Outpatient hospital services including E/R not admitted to inpatient	Charges (000000.00)	9	78	86	N
PHYSICIAN	Physician services	Charges (000000.00)	9	87	95	N
PRESCRIP	Prescribed Drug Services	Charges (000000.00)	9	96	104	N
VISUAL	Visual services including eyeglasses	Charges (000000.00)	9	105	113	N
TRANS	Transportation services (not included in Escort services)	Trips	5	114	118	N

SUPPLY DATA

A file with DME and Consumable supplies should be provided as an ASCII fixed length text file, one record per recipient, per medical supply code, per line. Please use the internal code found in Appendix B for each item. For Contractors who use the HCFA 1500, the Medicaid Code for each supply may be included as well (this is optional). Appendix C provides directions to retrieving the DME/Supply list from the AHCA's website. Each record will have the following fields:

Field Name	Description	Unit of Measurement	Length	Start Col.	End Col.	Text/Numeric
SSN	Social Security Number (left justify)	000000000	9	1	9	N
MID	Medicaid ID Number	0000000000	10	10	19	N
MONTH	Report month	MMYYYY	6	20	25	N
TYPE	1. DME 2. Consumable Supply		1	26	26	N
CODE	Internal Code (Appendix B)		5	27	31	T
MEDCODE	Medicaid codes for DME (Appendix C; Optional)		5	32	36	T/N
COST	Cost of Service	Charges (000000.00)	9	37	45	N

Appendix B

UnitedHealthcare

UnitedHealthcare
Health & Home Connection
FL079-1000 255 Technology Park Suite 125 Lake Mary FL 32771
Toll Free 1 877 482 9051 Fax 407 804 3760

November 6, 2001

Mr. David Oropallo
Department of Elder Affairs
4040 Esplanade Way, Suite 315
Tallahassee, FL 32399-7000

Dear Mr. Oropallo:

Health and Home Connection is been proud to have been part of the Managed Long Term Care Project from its inception in December 1998. Our program covers an extensive service area – Orange, Osceola and Seminole Counties. Our excellent relationship with the Department of Elder Affairs and the Department of Children and Families has been instrumental in the success of this program.

When we developed a case management model for Health and Home Connection, we chose to use a team approach with our enrollees. The team consists of Care Managers and Nurse Consultants who manage different aspects of our enrollees needs. Our Care Managers coordinate all services the enrollee needs including arrangements for transportation, discharge planning from hospitals and nursing homes and coordination of services within the community. The Nurse Consultants manage the medical needs of our enrollees including disease management, pharmacy management and referrals to specific community programs such as Pulmonary Rehabilitation and Neuro Muscular Rehabilitation. The Nurse Consultants serve as our eyes in the home and consult with the Care Managers to identify additional service needs.

Our program philosophy has followed the guidelines set forth by the Department of Elder Affairs and the Agency for Health Care Administration in supporting and assisting our enrollees in their desire to remain in their homes as long as possible. We use institutional care only as a last resort. We know that we are caring for the frailest of the elderly and are proactive in managing their care. We strive to maintain physical health at the highest possible level through education and appropriate services and supplies.

As we have developed our program over the past 3 years, we have identified enrollee needs and have adapted our program to accommodate them. During this time, we have seen an increase in service costs. The hourly rates for in-home services have increased approximately 32%. The Medicaid daily rate for nursing homes has increased 27%. The average Medicaid daily rate for this tri-county area is $127. The yearly cost for nursing home placement for our 391 enrollees at this rate would be $18,124,805. Our capitation for the 391 enrollees at $10,990,587 would result in savings to the Medicaid program of $7,134,218.

We look forward to a continued strong relationship with the Department of Elder Affairs and the Agency for Health Care Administration. We are all dedicated to promoting the rights and well being of seniors and their desire to remain independent in their own homes.

Yours truly,

Marti Osborne

Marti Osborne, RN, BS, CRRN
Director

MJO:mo

cc. Al Fernandez, VP of Government Programs/UHC - Regional
Matthew Davies/CEO/UHC - Orlando
Linna Van Nette, Director of Government Affairs/UHC - Regional