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FINAL REPORT FOR THE EVALUATION OF  
THE **FLORIDA ALTERNATIVE**  
HEALTH PLAN **PROJECT**

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## EXECUTIVESUMMARY

Elderly persons **85** years old and older (the "very old") are the fastest growing segment of the U.S. population. Because the very old are often disabled and frequently have tenuous informal supports, and thus have higher medical care needs and costs, **finding** a rational and cost-efficient way to meet their health care needs remains an important concern to planners and policymakers. This concern is especially acute in states such as Florida, which has a relatively large elderly population. The viability of case management and home- and **community-based** alternatives to institutional care and risk-based, **capitated** alternatives to cost-based financing have been and continue to be explored through such programs as the National Long Term Care Demonstration, the national Social/Health Maintenance Organization Demonstration, and the On **Lok** program. Florida's Frail Elderly Project joined these other programs in attempting to find a rational, cost-efficient, high-quality alternative to institutional care for the frail elderly. ✓

The Florida Frail Elderly Project-implemented as **ElderCare** by Mt. Sinai Medical Center of Miami Beach-was the third component of the four-part Florida Alternative Health Plan, one of the original Medicaid Competition Demonstrations. **ElderCare agreed** to provide a full range of medical and support services to frail elderly Medicaid beneficiaries, emphasizing home- and ✓ community-based care. The primary goal of **ElderCare** was to provide a less expensive (but no less effective) alternative to institutional care for Medicaid beneficiaries who participated in Florida's nursing-home preadmission screening program and for whom it was determined that institutionalization could be postponed or prevented if home- and community-based services were made available. **The evaluation of ElderCare**, carried out by **Mathematica** Policy Research, Inc. under contract to the Health Care Financing Administration (Contract Number **500-87-0028( 1 1)**), ✱ **is** comprised of a case study, an analysis of use and cost data, and a client survey. The evaluation had four primary objectives: to document the organization and operation of **ElderCare** (particularly



the enrollment incentives provided by the plan and its ability to minimize barriers to the access of plan services); to document the characteristics of the clients who enrolled in the plan; to assess the satisfaction of clients, their informal caregivers, providers, and the state with plan arrangements; and to compare the cost of the plan with the **capitation** payments it received, the cost of **nursing-home** care, and the cost of delivering services in **the** Medicaid fee-for-service sector.

### The Organization and Operation of **ElderCare**

**Though** it encountered numerous problems, starting with delays in implementing the plan and continuing through its 27 **months** of operations, the commitment of Mt. Sinai Medical Center and the **ElderCare** staff and their ability to identify and resolve problems created a program that was able to provide enrollment incentives that attracted a very **frail** caseload, to market the plan effectively, and to minimize barriers to plan enrollment and the receipt of plan services. Home care and unlimited prescription drugs were the most popular enrollment incentives. However, after enrollment, case management emerged as a highly valued service.

The marketing approach was made more aggressive **when** it appeared that the original conservative approach was not sufficient. The Spanish-speaking elderly of Miami Beach were targeted and the media, particularly television, was used more actively, while outreach continued to be made to organizations that served as referral sources. Formal organizations (such as hospital discharge planning departments and other service programs) were the primary source of referrals for the plan. Although fewer clients were self-referrals, television was relatively more successful than other media at attracting clients directly. It is noteworthy that physicians were seldom used as referral sources to the plan nor were they individuals with **whom** clients usually discussed their decision to enroll in the plan.

**ElderCare** and the State were successful at **minimizing** access and service barriers—for example, by intervening manually to keep enrollment procedures moving efficiently and **by** keeping the required prior authorization procedures **from** becoming overly bureaucratic.

### The Characteristics of **ElderCare** Clients

Between September 1987 and June 1989, **ElderCare** enrolled 156 clients, 16 of **whom** died and 30 of **whom** disenrolled during the period. Nearly 60 percent of the clients were Hispanic, more than half were older than age 80, most had difficulties with mobility, and many required assistance with dressing, **bathing**, or eating. **ElderCare** clients appeared to have been at least as frail as Cbanneling demonstration participants and On **Lok** clients, two groups acknowledged as frail and in need of formal assistance not readily available to community-dwelling elderly. However, most **ElderCare** clients had either informal or formal supports available before they enrolled in the plan, and fewer than 10 percent reported having been in a nursing home in the year prior to enrollment, perhaps

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reflecting a commitment by many clients and their informal caregivers to keep clients in the community, as was also noted by plan staff during case study interviews.

### The Satisfaction of Clients, Informal Caregivers, Providers, and the State

**ElderCare** staff perceived that clients and caregivers were highly satisfied with the plan, having made a number of specific changes to plan parameters to ensure client satisfaction, such as adding covered services and making arrangements for clients to keep their community physicians. A questionnaire administered to 67 clients enrolled in **ElderCare** in June 1989 showed that clients were very satisfied with the services provided and identified no major barriers in plan enrollment procedures or access to services. Respondents unanimously perceived that plan participation was responsible for keeping clients out of nursing homes, underscoring the enormous satisfaction and confidence that clients and informal **caregivers** derived from participation.

Providers seemed to have been satisfied with their contractual arrangements and the open lines of communication with **ElderCare staff**; no extensive problems with provider turnover were experienced by **ElderCare**.

The State liaison for the project and plan staff communicated freely, which facilitated identifying and resolving problems on both sides. In particular, the recordkeeping and reporting systems established by the plan were adequate to meet state needs, as well as the needs of the plan to monitor clients and service receipt. However, plan staff stated that the demonstration status of the project kept them from investing additional time and money into improving the recordkeeping systems that would have been required by a larger caseload.

### The Costs of **ElderCare**

Despite an historical concern about the ability of the capitation payments to cover the costs of the plan, the plan operated within the constraints of the payments during the 7 quarters examined by the evaluation, showing a very small surplus (2 percent of revenues) at the end of the period. The capitation payments (which at the end of the demonstration were set at between \$900 and \$1,500 per client per month, depending on the client's level of Medicare coverage) were thus adequate to cover the budget line item costs of operating the plan (at approximately \$1,000 per client per month), possibly due in part to efficient service delivery and service purchasing and the ability of the plan to limit the use of nursing-home care. However, because **ElderCare** received a substantial subsidy **from** Mt. Sinai Medical Center in the form of administrative support and the provision of direct services at very favorable rates of reimbursement, the budget **line** item costs understated the "true" costs of operating the plan.

In addition to comparing the costs of **ElderCare** with its capitation payments, costs were also compared with the costs of other types of care. At **\$1,000** per client per month, **ElderCare** costs were substantially **lower** than the \$2,400 per client per month that Medicaid reimbursed, on average, for the care of nursing-home residents in 1988. Reimbursements for and the levels of service use by **ElderCare** clients were compared with Medicaid-cover& reimbursement and service use for a sample of Medicaid

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beneficiaries in the fee-for-service sector who, like **ElderCare** clients, had been assessed by the state's nursing home preadmission screening program as requiring a nursing home level of care, but who were recommended for diversion to the community. Although this comparison was severely limited by a lack of comparable data for the two groups, it appeared that **ElderCare** spent more on its clients than Medicaid spent on the fee-for-service beneficiaries, even though **ElderCare** clients were significantly less likely to enter nursing homes. The higher level of spending by Elder-Care was attributable primarily to a higher rate of home- and community-based service use. However, the fee-for-service group may also have been receiving such services from programs not funded by Medicaid, the costs of which would not have been represented in the available data.

**ElderCare** was one of a number of programs designed in the last 15 years to find a rational, cost-efficient, high-quality alternative to institutional care for an increasingly large proportion of frail elderly citizens. **ElderCare** had a relatively small staff, which facilitated frequent communication among staff members and kept the plan from becoming overly bureaucratic and which in turn facilitated identifying and resolving problems quickly at both the plan and the client level. Thus, **ElderCare** achieved a primary goal of the Frail Elderly Project to provide a less expensive alternative to nursing-home care for frail elderly Medicaid beneficiaries, and met a variety of operational objectives. The flexible, innovative, open-minded approach of **ElderCare** staff for identifying and resolving problems was the plan's hallmark and a major source of its success, because it implicitly acknowledged that, although we speak of finding alternative ways to care for the frail elderly as a group, this group comprises human beings whose individuality must be preserved and respected by any system designed to respond to their diverse needs.

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## L INTRODUCTION

**ElderCare** was a Health Care **Financing** Administration (HCFA) demonstration to investigate potential solutions to the escalating costs of institutional long-term care services for **frail** elderly Medicaid beneficiaries. As the **surviving** component of the four-part **Florida** Alternative Health Plan Project, **ElderCare** was implemented under a prepaid, risk-based contract between the Florida Department of Health and Rehabilitative **Services (DHRS)**, which administers Florida's Medicaid program, and Mt. Sinai Medical Center in Miami Beach. The primary goal of **ElderCare** was to deliver a continuum of acute care, short-term institutional care, and home- and community-based, long-term care to **frail** elderly nursing-home and **SSI-eligible** Medicaid beneficiaries in Dade County, both to improve their health and to enhance their ability to remain in the community. This continuum of **services** was provided through a case-managed system operated by a single provider that assumed operational and **financial** responsibility for the delivery of all services.

The Florida Alternative Health Plan Project has been evaluated by **Mathematica** Policy Research, Inc. under contract to HCFA (Contract Number **500-87-0028(11)**). The **purpose** of the evaluation is threefold: to determine whether **ElderCare** met its primary goal, to **describe** the **dynamics** of the **service** and operational environment of **ElderCare**, and to **assess** the success of the project at providing highquality care to its **frail** elderly enrollees efficiently and cost-effectively. More specifically, the evaluation has **assessed** the performance of the Alternative Health Plan Project implemented by Elder-Care relative to six fundamental objectives:

1. To contract on a **prepaid** basis with a **single provider** at **financial** risk for the cost of care for the full **component** of health and **social support** services. In assessing the degree to which this task was successfully carried out, the evaluation explores the basis for the decision of Mt. Sinai to undertake the project and the fit between Mt. Sinai's previous expectations about **ElderCare** and its operational realities.

2. To set **capitation** rates for the **plan** that were cost-effective relative to **nursing-home care**. The evaluation examines the ability of the **capitation** payment to cover the operational expenses of the plan and compares the use and cost of services delivered to **ElderCare** clients with those delivered to other **frail** elderly Medicaid beneficiaries in the Dade County fee-for-service sector and with the cost of nursing-home care.
3. To prevent the premature institutionalization of clients without **compromising** the **health status of clients**. The evaluation compares patterns of nursing-home use by **ElderCare** clients with those of other frail elderly Medicaid beneficiaries.
4. To offer enrollment incentives adequate to attract the target **population** of **frail elderly Medicaid beneficiaries**. The evaluation compares the benefit offerings with the needs of clients and informal caregivers, assesses the relative effectiveness of marketing strategies, and identifies barriers to **enrollment** in the plan.
5. To attract, retain, and **satisfy** clients and **providers**. The evaluation **identifies** barriers to the satisfaction of clients and their access to plan services, as **well** as barriers to the satisfaction of providers.
6. To **develop** recordkeeping systems that meet the operational and monitoring needs of the **plan** and the state. The evaluation reviews the recordkeeping capability of the plan and compares the assessments of plan and state staff about the ability of the recordkeeping systems to meet their needs.

Finally, the evaluation describes the conditions under which **ElderCare** could be replicated in other settings.

The evaluation consists of three analytic components: (1) a case study of the operational and organizational features of **ElderCare**; (2) an analysis of a client questionnaire; and (3) an analysis of use and cost data for **ElderCare** clients. Exhibit L1 summarizes the questions addressed by the evaluation, the analytic component of the evaluation under which the questions were addressed, and the sources of data for addressing each question.

The purpose of the case study is to document the organizational characteristics and operational experience of **ElderCare** and those providers with whom **ElderCare** contracted to **serve plan** clients. The case study also documents the perceptions of plan **staff** about the satisfaction of clients with services and the adequacy of services in meeting the needs of clients and informal caregivers. In addition, the case study investigates whether the level of information recording, information exchange, and report dissemination met **the needs** of the state and **the plan**. The

**EXHIBIT L1**

**SUMMARY OF QUESTIONS TO BE ADDRESSED BY THE EVALUATION, WITH THEIR  
ACCOMPANYING ANALYTIC APPROACHES AND DATA SOURCES**

Questions	Analytic Approaches and Data Sources
<p>1. Under what circumstances will a sole provider agree to contract on a pre-paid basis to coordinate and be at financial risk for the delivery of health and social support services to a frail elderly population?</p> <ul style="list-style-type: none"> <li>o What was the basis for the decision at Mt. Sinai to take part in this demonstration?</li> <li>o Were the assumptions of the decision-making process realized?</li> </ul>	<ul style="list-style-type: none"> <li>o Case Study:               <ul style="list-style-type: none"> <li>- Administrators</li> </ul> </li> </ul>
<p>2. Was the rate-setting methodology adopted for ElderCare adequate for the population served?</p> <ul style="list-style-type: none"> <li>o What was the relationship between the capitation rate and actual costs?</li> <li>o If the rates that were set appear to have been inappropriate, did the use patterns of clients differ from those of other frail elderly Medicaid recipients?</li> </ul>	<ul style="list-style-type: none"> <li>o Analysis of Service Use and Costs               <ul style="list-style-type: none"> <li>- Quarterly financial reports for the plan</li> <li>- Plan MIS and Medicaid MIS (MMIS) for client characteristics and service use and cost data</li> <li>- MMIS for characteristics and service use and cost data for other frail elderly</li> </ul> </li> </ul>
<p>3. Did ElderCare prevent premature institutionalization without compromising the health of clients?</p> <ul style="list-style-type: none"> <li>o What were the institutionalization patterns of clients and other frail elderly Medicaid recipients?</li> <li>o What benefits and enhancements were offered that may have affected the timing of institutionalization decisions?</li> </ul>	<ul style="list-style-type: none"> <li>o Analysis of Service Use and Costs               <ul style="list-style-type: none"> <li>- Plan MIS and MMIS for client characteristics and service use and cost data</li> <li>- MMIS for characteristics and service use and cost data for other frail elderly</li> </ul> </li> <li>o Case Study:               <ul style="list-style-type: none"> <li>- Case managers</li> </ul> </li> <li>o Client Questionnaire</li> </ul>
<p>4. Were enrollment incentives adequate?</p> <ul style="list-style-type: none"> <li>o What program benefits and enhancements were offered to meet the needs of elderly clients?</li> <li>o What marketing strategies were effective for elderly clients?</li> <li>o Did the effectiveness of marketing strategies vary for different groups?</li> <li>o Did enrollment barriers exist that could be removed by the demonstration?</li> </ul>	<ul style="list-style-type: none"> <li>o Client Questionnaire</li> <li>o Case Study:               <ul style="list-style-type: none"> <li>- Administrators</li> <li>- Case managers</li> <li>- Service providers</li> </ul> </li> <li>o Client Questionnaire</li> <li>o Case Study:               <ul style="list-style-type: none"> <li>- Administrators</li> </ul> </li> <li>o Client Questionnaire</li> <li>o Case Study:               <ul style="list-style-type: none"> <li>- Administrators</li> <li>- Case managers</li> <li>- Service providers</li> </ul> </li> </ul>

EXHIBIT L1 (continued)

Questions	Analytic Approaches and Data Sources
5. What were the possible barriers to the satisfaction of providers and clients?	
o Were providers satisfied with financial arrangements, working conditions, responsibilities, etc., under the plan?	o Case Study: - Service providers
o Were clients satisfied with the plan? - Access to services - Quality of services - Coverage of services - Continuity of care - Accommodating family contingencies, emergencies	o Client Questionnaire
o How satisfied were clients with the plan relative to their previous arrangements?	o Client Questionnaire
6. Was Mt. Sinai's recordkeeping adequate to meet the needs of the State and other participants in terms of documenting:	
o Administrative procedures	o Case Study: - Administrators - Case managers - Service providers - State administrators
o Marketing techniques and programs	
o Quality of care	
o Access to services	
o Grievance procedures	
o Enrollment	
o Disenrollment	
o Fiscal management and quarterly reporting	

primary source of information for the case study is a set of structured interviews with **ElderCare** staff, an externally contracted service provider, and the liaison for the project from **DHRS**. Information from these interviews was integrated with written documentation for the demonstration and aggregate data that **describe** the service environment of Dade **County**.

The second component of the evaluation is an analysis of a questionnaire administered to clients by **ElderCare** case managers. The purpose of the questionnaire, which was part of the larger system of **ElderCare** program data for the evaluation, was to document the perceptions of clients about the adequacy of enrollment incentives, their level of satisfaction with services, and the ability of the plan to prevent premature institutionalization.

The third component of the evaluation is an analysis of use and **cost** data for plan clients and other frail elderly Medicaid beneficiaries who reside in Dade County. This analysis assesses the adequacy of the monthly **capitation** payments made to Elder-Care on behalf of clients, and the ability of **ElderCare** to delay or prevent the institutionalization of its clients. Because the evaluation did not have the advantage of relying on a randomly assigned control group or a statistically developed comparison group that was similar to the sample of **ElderCare** clients except for their nonparticipation in **ElderCare**, it is not possible to estimate the impact of **ElderCare** on institutionalization rates per se. However, this analysis does compare the nursing-home-service use and cost patterns of **ElderCare** clients with those of other elderly Medicaid beneficiaries in the Dade County area who participated in the Florida nursing-home pre-admission screening program, the larger population from which **ElderCare** clients were drawn **This** comparison, when combined with evidence from other programs for the frail elderly, enables us to accumulate evidence which may suggest that **ElderCare** delayed institutionalization or provided a cost-effective alternative to institutional care.

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**Finally**, the evaluation synthesizes the findings of the three analytic components and places this synthesis in the context of the results of previous experiments in alternative health care delivery systems, particularly those targeted toward the **frail** elderly.

In the next chapter we present the history of the Florida Alternative Health Plan Project and **describe** the health care service environment in which **ElderCare** was implemented. We also describe other programs whose operational features and outcomes are similar to Elder-Care, so as to enhance our understanding of the experiences of **ElderCare**. In Chapter **III**, we present the Endings of the case study, and in Chapters IV and V we **describe** the clients enrolled in **ElderCare** and discuss the adequacy of the **capitation** payment, the ability of **ElderCare** to prevent premature institutionalization, and the cost of **ElderCare** relative to nursing-home care. Chapter VI presents the results of an analysis of the client satisfaction **questionnaire**, and Chapter VII synthesizes the **findings** from each of the analytic components of the **evaluation**.

## II. THE HISTORY AND CONTEXT OF THE FLORIDA ALTERNATIVE HEALTH PLAN PROJECT

In 1982, when the Florida Medicaid program responded to a special solicitation from HCFA to develop projects to control Medicaid expenditures, it was already well **known** that the number and proportion of elderly individuals in the United States in general and **Florida** in particular were entering a period of sustained, **significant** expansion. **The 1980** Census indicated that elderly individuals (those **65** years of age and older) comprised 11 percent of the U.S. population and 17 percent of Florida residents. In the year 2020, when those born during the baby boom of the late **1940s** to early 1960s would enter or be well into old age, it is projected that the proportion of elderly in the nation as a whole will reach 17 percent. **Moreover, the** proportion of very old individuals (those **85** and older) is expected to increase from 1 percent in 1980 to 24 percent by **2020** and to 5.2 percent by 2050, **making** the very old the most rapidly growing segment of the population (U.S. Senate, **1987-88**). Much of this increase is of course **expected** to affect Florida, whose favorable climate and lifestyle are **likely** to continue to attract an above-average proportion of the elderly population. In order to meet the growing needs of this segment of Florida's population, the Frail Elderly module of the Alternative Health Plan Project was designed to test an alternative approach to the delivery and **financing** of long-term care services.

**In** this chapter we describe the motivation for the **Alternative** Health Plan Project in more detail and discuss the evolution of **ElderCare--the** Frail Elderly component of the **Florida** Alternative Health Plan Project. We then briefly **describe** some of the experiences of the Medicaid Competition Demonstration under which the Florida Alternative Health Plan was **originally established** as a project, as well as those of several initiatives to provide long-term care services to the **frail** elderly. We conclude this chapter with an overview of the health-care service environment of Dade County, in which **ElderCare** and its clients were **residents**.

## A. THE IMPETUS FOR ESTABLISHING THE FLORIDA ALTERNATIVE HEALTH PLAN PROJECT

Projections of the nation's elderly and very old populations are of crucial **concern** to health care service policymakers and planners, **because** the elderly, particularly the more **frail, very** old elderly population, are the heaviest consumers of health care of any segment of **the** population. **In 1984**, total medical expenditures for persons ages 65 and older, at a per capita cost of **\$4,202**, exceeded \$107 **billion** dollars. Of these expenditures, **costs** for hospital and nursing-home care comprised two-thirds of the **total**. Government expenditures (**from** Medicare, Medicaid, and other smaller programs, but primarily **from** Medicare) **accounted** for nearly 90 percent of hospital expenditures. On the other hand, government expenditures accounted only for **50** percent of the **costs** of nursing-home **services**. Of the government-covered share of nursing-home expenditures, Medicaid paid over **85** percent, while out-of-pocket expenditures (as opposed to private insurance and **other** nongovernment sources) accounted for over **95** percent of the remaining dollars spent on nursing-home care but not **covered** by the government (U.S. Senate, 1987-88).

The very old are at a higher risk of institutionalization than is the elderly population as a whole. While only **5** percent of the elderly lived in nursing homes in **1982**, **23** percent of the very old (who are disproportionately more frail) lived in nursing homes, **The** very old require more **assistance with** activities of daily living (such as eating or bathing) and with instrumental activities of daily living (such as preparing meals and shopping). For example, 45 percent of those **85** and older, compared with 15 percent of those age 65 to 69, reported **difficulty** in performing one or more activities of daily living (U.S. Senate, **1987-88**). Nearly **half reported** that they have a chronic health **or mental health** problem that is severe enough to **keep** them from using public transportation (**Longino**, 1988). Moreover, **according to a report from the General Accounting Office (1989)**, the number of elderly who require help with activities of daily **living** is likely to double by the year 2020. When their poor health and **need** for **assistance** are **considered** in conjunction with the fact that nearly a third of the very old live alone (and still others live with a

disabled spouse), it is clear why their need for long-term care **services** is so **critical** and their rates of **institutionalization** relatively high.

As noted earlier, Medicaid pays for nearly half of the nursing-home expenditures of the elderly. The Medicaid program has been criticized in recent years because its **eligibility** criteria and **its non-reimbursement** for more socially oriented home- and community-based **services** are viewed as promoting institutionalization among the elderly. In response to this criticism and due to the high cost of institutional care, the federal government and several states have instituted programs that offer a coordinated set of health care and social support **services** in a community setting as a substitute for the care that would be provided to the **frail** elderly in an institution.

Medicaid waivers have proved to be an important vehicle for investigating and funding noninstitutional alternatives to nursing-home care. **The** waivers have been granted to individual states to provide home- and community-based services for those who qualify for Medicaid reimbursement for nursing-home or inpatient **services** but are **financially** ineligible for Medicaid outside of an institution. The waived services must be provided within the context of a written plan of care and may include case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization, psychosocial rehabilitation, mental health **clinics**, and other services requested by the state. The state must ensure that average per capita expenditures under the waiver do not exceed the expenditures that the state reasonably estimates would have been spent in the absence of the waiver.

Concurrent with the evolution of these Medicaid waiver programs, cost-containment initiatives in the form of alternative **financing** mechanisms have been used to fund both **long-term** care services and acute medical services that are routinely reimbursed **by public and** private entities. Many of the alternative financing **mechanisms** (e.g., prepaid **health plans, long-term** care insurance, and **continuing-care** communities) share a common feature-in each, **financial** risk is pooled across the elderly population (that is, including both the well and **frail** elderly), and a single entity bears

**the** financial risk of providing **services** in order to reduce the costs to payers and increase the efficiency with which covered **services** are provided.

HCFA has encouraged the development of **capitated service** delivery systems because it believes that these systems can control and **ultimately** reduce the costs of publicly **financed** health **care**. In order to control **costs**, the provider that assumes the financial risk is **reimbursed** by HCFA a prepaid, per capita amount that is to be no more than, and **usually** less than, the expected cost for services delivered in the fee-for-service sector to a population who exhibits **similar** characteristics. For example, the TEFRA Medicare **HMOs** are reimbursed at 95 percent of the adjusted average per capita cost (AAPCC), an **actuarially** determined estimate of the average Medicare cost that would have been **incurred** for enrollees in the fee-for-service sector. It is then up to the provider to deliver care within the limitations of the **capitation** payment.

The incentive to the provider to enter into an agreement to provide **services** under a prepaid, per-capita system is that it **believes** that it can deliver the **services** for less than the per-capita payment. One way for the provider to do so is to deliver services more efficiently than **fee-for-service** providers and reduce **unnecessary service** use. Alternatively, providers may attempt to enroll clients who have fewer needs than average, or the highest service users may **disenroll** because they are dissatisfied with access to **services**, and thus the provider will receive a payment greater than that required to **cover** the **cost** of **services**, a phenomenon known as "**favorable** selection." On the other hand, a phenomenon known as "adverse selection" works to discourage providers **from** entering into prepaid, risk-based contracts. Adverse selection occurs when a substantially higher than average number of more disabled or sicker individuals enroll in a plan and thus require more **services** than can be covered by the per capita payment.

With the highest proportion of elderly of any state, Florida has been **particularly interested** **in finding** more **cost-efficient** methods for **delivering** care to elderly Medicaid **beneficiaries**. A 1979 study carried out by the state of **Florida** to help **reform** its Medicaid **program revealed** that, as with

other states, its Medicaid costs were rising rapidly. Furthermore, of the Medicaid funds for **fiscal** year **1979-1980**, **72** percent had been spent on institutional care. In 1983, nearly **7 percent** of the elderly population were eligible for Medicaid, and, of those eligible, 24 percent received **nursing-home** services at a cost of over \$200 million (Department of Health and Rehabilitative Services, **1986**). Clearly, the time was ripe to examine service delivery and financing **alternatives** to control Medicaid nursing-home expenditures.

In 1982, **HCFA** approved funding for demonstrations in six states (known as the Medicaid Competition Demonstrations) to test a number of alternative strategies for delivering and **financing** Medicaid-covered **services**. These **strategies included** both cost-containment features and **features** to ensure access to appropriate, highquality care. These strategies called for encouraging competition among providers, setting capitation amounts, providing case management **services**, and limiting the choice of providers by **beneficiaries**. One of the six demonstrations-the demonstration implemented by Florida-is the subject of this evaluation.

## B. THE **FLORIDA ALTERNATIVE HEALTH** PLAN PROJECT

When **the** Florida Medicaid program responded to the 1982 HCFA solicitation, it included four program modules in its **proposal**. Three were to adopt prepaid capitation systems and one **was** to adopt a case management approach for over-utilizers and high-risk recipients in a **fee-for-service** system. The case management module, whose purpose was to test varying intensities of case management models (from education and counseling to prior authorization and the assignment of beneficiaries to **specific** providers), was made part of the regular Medicaid program and thus did not require Medicaid demonstration status. **Two** of **the capitation** modules were not implemented **due to** a lack of interest by providers, stemming from concerns about the ability of the state to agree to rates that would foster **financial** viability, about limitations on the enrollment of Medicaid **beneficiaries** (**thus** not allowing **the** programs to **produce** enough **revenue** to cover **fixed** costs), and about the **frequency** with which beneficiaries eligible for Medicaid by virtue of their **AFDC**

participation lost and regained Medicaid **eligibility** (U.S. Department of Health and Human Services, 1986).

Under the remaining **capitation** module, Module C, prepaid, risk-based contracts were to be established to provide the full range of medical and support services to **frail** elderly persons in **home-** and community-based settings, with an emphasis on health maintenance and the prevention of institutionalization. Only one provider was chosen to implement Module C, Mt. Sinai Medical Center of Miami Beach. The Mt. Sinai program came to be known as **ElderCare**. Its features were originally based on an existing program run by Mt. Sinai-Project Sinai, which served just under 500 elderly patients and offered inpatient and outpatient care and transportation, escort, home health, assessment, and homemaker services (among others), provided by a multidisciplinary team of health professionals with fee-for-service **financing from** Medicare and Medicaid (U.S. Department of Health and Human **Services, 1986**).

According to U.S. Department of Health and Human Services (1986), unanticipated delays were encountered in implementing **ElderCare** that were attributed primarily to **"difficulty** in achieving agreement with HCFA over the calculation of the **capitation payment.**" The **capitation** rate was based on the utilization of and reimbursement for **Medicaid-covered services** for a group of Medicaid fee-for-service beneficiaries who had come through the state's nursing-home preadmission screening program and been recommended **for** one of the state's home- and community-based **service** waiver programs. The rate was calculated by **first** estimating Medicaid reimbursements for the individual services (e.g., inpatient, outpatient, nursing-home, **home-** and community-based services, and physician **services**) used both by group members who spent 11 months out of the year living in the community and by group members who spent at least 1 month residing in a nursing home. Then, a **weighted** average of community-resident and nursing-home resident costs was computed. HCFA was **concerned** that the **fee-for-service** group was too small, and that the **rate-setting** methodology required more **justification**.

Although the state ultimately provided the justification requested by HCFA and increased **the** size of the **fee-for-service** group, **Mt. Sinai** continued to be concerned that the capitation rate was too **low**: (1) the **estimates** for home and community-based **service** use were understated because the capitation methodology used data from two different databases to estimate home- and **community-based** service utilization and costs; (2) the estimates for the use of physician services were understated **because** notoriously low Medicaid physician reimbursement rates prompted many physicians not to submit claims for services provided to Medicaid beneficiaries; and (3) inpatient and outpatient service use estimates were understated, due to the Medicaid 45day limit on inpatient services and the annual cap of \$500 on outpatient **services**. **Overall**, as the program approached implementation, **Mt. Sinai** believed **that** institutionalization could be delayed or prevented, but that the costs would be “the same if not more than the cost of institutional care.” The State, while believing that the strength of the pilot program was the “integrity and reliability of **Mt. Sinai**,” was also concerned about the financial viability of the venture (U.S. Department of Health and Human Services, 1986).

The subsequent chapters of this report discuss the implementation and operations of **ElderCare** and compare the service utilization and costs of **ElderCare clients** with those of other groups of frail elderly. However, the remainder of this chapter briefly **describes** the experience of the other Medicaid Competition Demonstrations and other demonstrations targeted more **specifically** toward the **frail** elderly, in order to present various approaches for delivering and **financing health services** and to describe how they worked.

### C. THE MEDICAID **COMPETITION** DEMONSTRATIONS

As noted, the **Florida** Alternative Health Plan Project was one of six Medicaid Competition Demonstrations (**MCD**). **ElderCare**, the only **Florida Alternative Health Plan** project to be implemented, **differed in** a number of ways **from the** rest of the **MCD**. **Perhaps the most important** of these differences was that its goal was to provide home- and community-based services to **frail**

elderly Medicaid beneficiaries, **whereas** the other MCD programs provided regular acute care coverage to Medicaid beneficiaries who were eligible **primarily** because **they** participated in the AFDC program. However, **ElderCare** shared with the other programs an emphasis on establishing health care systems financed by prepaid, risk-based contracts, and thus the operational experiences **of the** MCD shed some light on the problems faced in developing such systems, particularly for **the** Medicaid population.

**The** purpose of the **MCD** was to test the success **of** alternative approaches to resolving a number of problems faced by the Medicaid program and its **beneficiaries**: the excessive rate of cost increases; the unnecessarily high rate at which some **services** were being used (for example, nursing-home care); inappropriate patterns of service use (such as self-referrals to **specialists** and the use of emergency rooms rather than the use of primary care physicians); the **lack** of care continuity; the lack of quality assurance; and declining participation by physicians, due to unreasonably low Medicaid reimbursement rates, the administrative burden of submitting claims, and delays in receiving payment.

**The** demonstration programs took three basic approaches to **resolving** these problems. First, **they** sought to increase **competition** by eliciting the participation of providers who had traditionally not **served** Medicaid beneficiaries, in the hopes both of improving **access** to and the quality of care and of ultimately driving down costs. **Second**, the programs implemented **prepaid, capitated payment systems** to share **financial** risk between providers and payers and give providers a stake in controlling costs. Third, **they** offered **case management services** to lock beneficiaries into a single primary care gatekeeper who could alter inappropriate patterns of service use and ensure access to required care, while also monitoring health care expenditures **overall (Hurley, 1986)**.

The MCD evaluation **identified** a number of **difficulties** encountered by the demonstration in the planning and implementation phases of the programs. As **occurred** with **ElderCare**, all the demonstrations took longer than **expected** to become operational, due to “time consuming efforts

at **consensus** building and trade-off negotiations with providers.” Moreover, “Federal, State **and** local officials had varying expectations and commitments both to the overall program and selected program features” (see Hurley, 1986). Specific disputes arose about the rate-setting process and the locus of authority for making changes necessary to implement the programs. During the **implementation** phase, programs that **served** a substantial number of chronically ill and disabled beneficiaries experienced a particular problem with **disenrollment because** beneficiaries did not like having to switch to plan providers **from** providers with whom they had longstanding relationships. **The** goal of involving providers who had not previously served the Medicaid population met with only limited success. For example, **HMOs** continued to be reluctant to **serve** Medicaid beneficiaries, due to the volatility of their Medicaid eligibility, and neighborhood **health** clinics, while enthusiastic about the opportunity to gain experience with prepayment, were apprehensive that their limited financial resources could not absorb adverse outcomes. Some providers were also concerned that the goals of case management were at odds with the traditional function of primary care providers. **Finally**, because the participating providers were unfamiliar with such systems, the demonstration programs encountered problems in developing Management Information Systems to support program operations and to monitor enrollment, **service** use, provider reimbursement, and quality in a timely manner (Hurley, 1986).

An ongoing problem for the MCD programs that cut across many other problems was the concern that the **rates** and methods of payment were neither equitable nor adequate. Conflicts arose about the arrangements to be made for sharing the **financial** risk of **high-cost** cases, as well as whether and the **degree** to which mechanisms for **cost** savings should be spelled out in the design of the programs. The rate-setting methodology emerged as one of the most controversial features of the demonstrations. Criticisms arose about **virtually** every aspect of the methodology: the composition and number of rating categories; the trending factors **used; the** use of statewide **versus** local **service** use and **cost** estimates; the adequacy of the **documentation** on the

methodology; the incorporation of funding for **reinsurance** and **stop-loss** coverage in order to protect the provider from the costs of catastrophic **illness**; and delays encountered in having the rate approaches approved at the state and federal levels. In addition, **changes** in the **fee-for-service** environment that evolved from **cost-containment** initiatives outside of the demonstration (such as the establishment of prospective payment for inpatient hospital services) led in the second year to capitation payments that were lower than the **initial** rates (**Hurley, 1986**).

Evaluators of the **MCD** found that:

- Primary care case management and capitation led to the desired reduction in service use (particularly the use of emergency room **services**).
- However, reductions in the use of demonstration services were not accompanied by substantial reductions in reimbursements relative to the **fee-for-service** sector, because capitation rates were based on fee-for-service sector use and reimbursements **from** the previous year, and concurrent service use in the fee-for-service sector was also declining.
- Limiting the choice of providers among beneficiaries did not have an adverse effect on the quality of care received relative to the Medicaid fee-for-service sector, although the evaluators noted that the quality of care received by Medicaid beneficiaries **overall** was below that received by the general public.
- No insurmountable problems were encountered in **persuading beneficiaries** to join prepaid health plans, although when a **choice of providers** was available some beneficiaries had to be auto-assigned rather than choosing a provider on their **own**.
- Rate-setting remained a crucial problem in both initiating and maintaining programs.

**Thus**, the **evaluators** concluded that, relative to fee-for-service Medicaid coverage, the prepaid, case-managed health care implemented under the MCD led to better organized, less **fragmented caregiving**, a reduction in **unnecessary** service use (accompanied **by** **modest** cost savings), and comparable quality health care (**Freund et al., 1988**).

#### D. **DEMONSTRATIONS FOR THE FRAIL ELDERLY**

**The** 1980s **witnessed** a number of demonstrations **and** programs whose primary goal was to deliver and **finance** long-term care for the **frail elderly** at less expense than would be incurred with

traditional long-term nursing home placement. Among these programs are the On **Lok** Community Care Organization for Dependent Adults (CCODA), the national S/HMO Demonstration, and the National Long Term Care Demonstration (Channeling). We briefly **describe** the features of each of these programs and their implementation in order to characterize their similarities to and **differences** from the **ElderCare** program. (**Exhibit IL1** summarizes the key features of the three programs.)

1. On Lok Community Care Organization for Dependent Adults

On **Lok** Community Care Organization for Dependent Adults (**CCODA**), in many respects a prototype of community-based long-term care, began in 1972 as **an** adult day health program for the elderly in San Francisco's Chinatown, North Beach, and Polk Gulch areas. While On Lok has continued to serve a predominantly Chinese caseload in a relatively small catchment area, it has **evolved** over the years into a comprehensive **community-based** long-term care program, sharing many of the features of **ElderCare**. On **Lok** provides clients with a full range of acute care **services**, as well as home- and community-based and institutional long-term care services. **The** relatively small size of its urban catchment area has allowed the program to use day health centers as its primary service delivery setting. An integrated case-management approach is used to provide services, and care planning and service delivery are the responsibility of multidisciplinary teams. Physicians are included in the teams, but are not considered the team leaders. On **Lok** controls all service expenditures and coordinates prospective monthly payments **from** Medicare, Medicaid, and clients (depending on the individual's entitlement), assuming full **financial** risk for the total health care of its clients. Eligibility for On **Lok** is based on state **certification** for nursing-home **care** at the SNF or ICF level (**Zawadski** and Eng, 1988).

The developers of On **Lok** have attributed their success at serving the **frail** elderly to **three** major features of the program: (1) using multidisciplinary teams, which provide a **comprehensive** integrated response to **the problems** of each client and to the continuity of care, rather than the

EXHIBIT II.1

COMPARISON OF THE FEATURES OF ON LOK, THE NATIONAL S/HMO  
DEMONSTRATION, AND CHANNELING

	On Lok	S/HMO	National Long Term Care Demonstration
Period of Operation	1972 - ongoing	1985 - 1992	1982 - 1985
Number of Sites	1 <sup>a</sup>	4	5 Basic Case Management 5 Financial Control
Population Served	Individuals age 55 and older, certified as nursing-home-eligible based on state criteria	Medicare beneficiaries age 65 and older. Expanded care provided to members certified as nursing-home-eligible (or at risk of nursing-home certification in 1 site) based on state criteria	Medicare beneficiaries age 65 and older, functionally impaired in ADLs and IADLs, and having unmet needs or a fragile informal support network
Covered Services	All health and health-related services required: acute care, home- and community-based long-term care, institutional long-term care, and case management	Expanded care includes case management, home- and community-based long-term care, <u>short-term</u> nursing home care, and a full range of acute care, plus hearing aids, eyeglasses, and prescription drugs	Case management only at Basic sites; personal care, homemaking, transportation, and home-delivered meals at Financial sites
Reimbursement Mechanism	<ol style="list-style-type: none"> <li>1. Single capitated rate<sup>b</sup></li> <li>2. Pooled funds from Medicare, Medicaid, and private resources</li> <li>3. No client-specific spending caps</li> </ol>	<ol style="list-style-type: none"> <li>1. Capitated rate at 100% of AAPCC, with higher rate for members certified as nursing-home-eligible</li> <li>2. Medicare, Medicaid, and member premiums</li> <li>3. Expanded care has annual per-member spending cap</li> </ol>	<ol style="list-style-type: none"> <li>1. Fee-for service</li> <li>2. Medicare, Medicaid, and, in Financial sites, demonstration funds</li> <li>3. Caseload spending caps</li> </ol>

SOURCES: Information on On Lok comes from Ansak and Zawadzki (1984); Zawadzki and Bag (1988); and Beresford (1989). Information on the national S/HMO Demonstration comes from Greenberg et al. (1988); Health Care Competition Week (1989); and Leutz et al. (1989). Information on the National Long Term Care Demonstration comes from Kemper et al. (1986).

<sup>a</sup>Plans to expand to 6 sites nationwide.

<sup>b</sup>For clients dually eligible for Medicare and Medicaid, the capitation payment is the sum of the average cost of Medicare-covered services for a nursing-home resident and the equivalent of California Medicaid reimbursement for long-term care services.

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piecemeal approach of providers working in isolation; (2) using the day health center as a base of operation, which makes efficient use of the time of professionals and paraprofessionals by housing **all** staff under one **roof**, and which provides clients with the opportunity to socialize, and (3) exercising total control over **financial** resources, which has allowed the team to **prescribe** and **provide** services according to the needs of clients, regardless of the payment mechanism available to a particular client. In addition, the fact that On Lok is a totally **free-standing** entity has allowed it to experiment and evolve, **although**, as its developers point out, it has evolved incrementally to ensure a firm base of community support, a level of staff capability that meets its **service** provision goals, and the establishment of solid relationships with **externally** contracted providers, private physicians in the community, and potential members in the community. They point out that, even though On Lok was **well** known in the community for many years for its original day health program, it took the CCODA three years to reach its full caseload of 300 clients (Ansak and Zawadski, 1984).

## 2. The Social/Health Maintenance Organization Demonstration

The **Social/Health** Maintenance Organization Demonstration (S/HMO), which began enrolling clients in 1985 and 1986 and which will run through 1992, **serves** both **well** and **frail** Medicare beneficiaries in four sites (Portland, **Oregon**; Brooklyn, New York; Minneapolis, **Minnesota**; and Long Beach, California). The demonstration receives funding **from** Medicare, beneficiary premiums, and, for Medicaid-eligible members, Medicaid. The S/HMO's benefits include the **full** range of acute care services covered under regular Medicare **benefits**, plus hearing aids, eyeglasses, and prescription drugs, as well as those **services** required by **frail** elderly individuals with chronic **conditions**, referred to as "expanded care." Expanded **care**, which includes personal care, homemaking, **adult** day health care, transportation, and short-term (**but not long-term**) nursing-home care, is provided through a case-managed system **for** clients **formally assessed** as **requiring** such services. The **S/HMOs** receive a **capitated** payment for each member, with a higher rate paid

for those **certified** as requiring a nursing-home-level of care (Greenberg et al., 1988; and Health Care Competition Week, 1989).

The **S/HMOs experienced** substantial difficulty in meeting early enrollment **goals**, which in retrospect may not have been realistic. After the **first** year of operation, the **demonstration** had **enrolled** only 5,523 members, compared with its target of 16,000. The low enrollment was **attributed** to a number of **factors**: the false belief held by many elderly that Medicare provides long-term care benefits; the tendency of consumers to postpone enrollment **until** they **actually** perceive the need for long-term care **services**; the **fact** that enrollees generally had to change physicians; the higher cost of the **S/HMOs** relative to regular Medicare **HMOs**; the lack of name recognition; the lack of marketing experience by the demonstration providers; and the limited duration of a demonstration program, which was mentioned in the **S/HMO** marketing literature (Greenberg et al., 1988). Due to the **lower-than-expected** enrollment, combined with **higher-than-expected** start-up and administrative **costs**, the demonstration sites lost money during the **first** two years of operation, even though hospital, expanded care, and case management costs all remained within the budgets of the plans (**Institute** for Health and Aging et al., 1987).

While the S/HMO demonstration is similar to **ElderCare** in that it uses a risk-based, **capitated** financing mechanism which it applies to **all** members, it is the subset of S/HMO clients who are **assessed** as **eligible** for expanded **care** and case management with whom the most useful comparisons with **ElderCare** (and On Lok) can be **drawn**. Expanded care in the **S/HMOs** is made available to members who meet state nursing-home **preadmission** screening criteria (and, in one site, who are judged to be at risk of meeting these criteria) (**Leutz** et al., 1989). Sites are allowed to limit the number of expanded care **recipients** to 5 percent of the total membership (approximating their prevalence in the elderly population) in order to manage the risk of **servicing members who** potentially need **very** expensive **care**. **Three** of the four **sites** have **"queued"** impaired applicants to control the case **mix**, one site has chosen to direct its marketing **efforts** at achieving

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the desired case **mix**. The three sites that have queued applicants reported that, as of the end of 1986, the queues of severely impaired elderly would have increased their **enrollment** of such members by between 50 and 100 percent had they been **enrolled** in the plans, **reflecting** the strong demand for long-term care services in the areas **served** (Institute for **Health** and Aging et al., 1987).

In addition to limiting the enrollment of **frail** members, expanded services are subject to annual per-member dollar limits. To supplement services limited by the spending cap, some members opt to pay for additional services out-of-pocket. Plans have adopted one of two philosophies for allocating their limited chronic care dollars: (1) providing early intervention to moderately impaired members to prevent or delay decline, and (2) providing intervention at the point of crisis only for the most **frail** and impaired members. **Thus**, the expanded care criteria in plans that subscrii to the latter philosophy are identical to nursing home **certification**, while plans that subscribe to the former use less stringent criteria (Institute for Health and Aging et al., 1987).

**Two** models of case management have also emerged among the sites. The first is a compartmentalized model in which:

Medical providers are responsible for medical management of patients whose unmet needs can be met by service providers in the medical system (including physiciiana, nurses, home health aides, medical social workers). If it is **perceived** that all of the patient's unmet needs can be met by medical provide\* the long-term care managers do not prescrii long-term care services, although they may be informed of actions taken by medical system providers.

**The** second model, which more closely resembles the model used by **ElderCare** and **On Lok**, takes a more integrated approach, using a multidisciplinary team, including both medical and long-term care providers/managers, to create care plans that meet the medical, functional, and psychosocial needs of each member (Abrahams et al., 1989).

Despite the early enrollment shortfall, the **full** target **caseload** of 16,000 members was achieved after four years of **operations**, and the plans are now operating at full financial risk. Evaluators

have noted that the two S/HMO sites sponsored by established **HMOs** established the S/HMO model more easily and less **expensively** than did their counterparts sponsored by long-term care organizations. Evaluators also noted that **all S/HMOs** have been **successful** at keeping the cost of expanded care within budget, a noteworthy achievement in light of the traditional skepticism voiced **by potential** insurers in both the public and private sectors that such costs can be controlled. **This** success has been **attributed** to three factors: the dollar limits placed on expanded care, the fact that **eligibility** for expanded care is linked to state preadmission requirements for nursing-home certification, and the fact that, as was **the case with** earlier programs, **the existing informal** support systems of members are being used, rather than substituted for by formal **care (Leutz et al., 1989).**

### 3. The National **Long** Term Care Demonstration

The purpose **of the** National Long Term Care Demonstration (also known as Channeling) was to test whether intensive case management and the provision of home- and **community-based services** could prevent or delay nursing-home placement for a **group of frail** elderly Medicare beneficiaries assessed as at high risk of nursing-home placement in the absence of such **services**. Between 1981 and **1985**, 10 projects across the country **assessed** applicants and provided comprehensive case management; five of those projects also received funding to cover **the** cost of home- and community-based services, **such** as personal care, homemaker services, transportation, and home-delivered meals. (The five projects **that received** funding to cover home- and community-based services were referred to as Ficial Control projects; the other five were referred to as Basic Case Management projects.) Case managers were required to keep the cost of care plans within a spending cap of 60 percent of nursing-home costs **(Kemper et al., 1986).**

The Channeling demonstration differed **from ElderCare** (and **On Lok** and the S/HMO demonstration) in two important **ways**: (1) the **providers of services** to demonstration **enrollees** were reimbursed on a fee-for-service basis; and (2) the demonstration **projects** did not provide any services **themselves** other than case management, nor did they monitor the use of acute care

services. Therefore, comparisons between outcomes for Channeling and **ElderCare clients are** likely to be misleading. However, many of the operational features of Channeling (e.g., planning and startup tasks, outreach activities, and relationships with **external** service providers) are relevant to **ElderCare** and, as such, are the focus of the comparison here.

- The Channeling projects used a variety of arrangements with home- and community-based **service** providers. Some projects used unit service rates that had been negotiated with providers, others were constrained by existing contracts and state rate-setting procedures, while others adopted more informal methods for selecting providers and negotiating rates. **Monitoring providers** and assuring the quality of care were major **undertakings** for project **staff**, and defining and measuring the quality of care proved problematic. In addition, in some projects, the supply of **service** providers was so limited that no alternatives existed when a particular provider was judged to be inadequate. In retrospect, project staff expressed the opinion that they had underestimated the complexity of and resources required for monitoring providers **effectively** (Carcagno et al., 1986).

Each project had a target caseload of between 200 and 500 clients and were given one year to achieve that target. All demonstration projects were able to reach their caseload targets. However, particularly in the nonurban projects, caseload buildup was slower than **expected**, and thus the buildup period was extended slightly and targets adjusted **downward** for some projects. Outreach activities were oriented toward existing agencies (which in some projects led to formal agreements with organizations for demonstration **referrals**) and at some, but not **all**, projects **directly** toward community residents. **The** projects that chose not to reach out **directly to** elderly individuals, but rather to **rely** on other organizations for referrals, did so because they believed both that target caseloads could be met without such **efforts** and that such **efforts attracted** too many ineligible individuals. The projects that used mass media **experienced** an increase in self-referrals **following** publicity, but, as the other **projects** had hypothesized, generated interest from many

individuals who ultimately did not meet the eligibility criteria of the demonstration (Carcagno et al., 1986).

The demonstration was successful at enrolling a very impaired population. The evaluators found that demonstration services did not substantially reduce informal caregiving efforts, and that clients and informal caregivers had more of their needs met, had more confidence in the services they received, and were more satisfied with life in general. However, the intervention did not reduce the total costs of care, because, despite the frailty of the population, very few clients would have entered nursing homes in the absence of the demonstration, reflecting a noteworthy level of determination among the elderly clients and their informal caregivers to keep clients at home. Thus, the evaluation concluded that, contrary to many previous claims, home- and community-based services (at least when delivered within the parameters of the Channeling demonstration and the service delivery environment in which the demonstration was implemented) were not a cost-effective alternative to nursing-home care. Due to the rigorous design of the evaluation, which included a randomly selected control group that allowed the effects of individual participant characteristics to be separated out from the effects of the demonstration, the evaluation laid to rest, at least temporarily, the debate about the cost-effectiveness of home- and community-based care relative to institutional care.

#### E. THE DADE COUNTY POPULATION AND SERVICE ENVIRONMENT

Dade County, which contains Miami and Miami Beach, is one of the largest counties in Florida, covering 1,955 square miles. With 1,769,500 residents, it contains 15 percent of all Florida residents: (See Table II.1, which summarizes the statistics discussed in this section and their sources.) Dade County is also home to 13 percent of the state's population age 65 and older and 14 percent of the state's residents age 75 and older. Although the distribution of elderly residents for Dade County is roughly similar to that of the rest of the state, it has a disproportionate share of both minority and poor, residents. Dade County contains 62 percent of the State's Hispanic

**TABLE II.1**  
**POPULATION AND HEALTH CARE SUPPLY AND SERVICE USE**  
**FOR FLORIDA AND DADE COUNTY**

	Florida	Dade County	Dade County Percent of Florida
<b>Population<sup>a</sup></b>			
Total (1986)	11,675,000	1,769,500	15
65 and older (1984, 1986)	2,019,775	263,656	13
75 and older (1984, 1986)	805,575	116,787	14
Hispanic (1980, 1986)	1,027,400	632,419	62
Nonwhite (1984, 1986)	1,745,413	370,710	21
SSI beneficiaries (1986)	189,217	69,446	37
Social Security beneficiaries (1985)	2,310,223	257,750	11
<b>Inpatient Hospitals (1988)<sup>b</sup></b>			
Number of hospitals	293	32	11
Number of hospital beds	62,527	8,821	14
Occupancy rate (percent)	64.2	65.7	
Number of admissions	1,767,108	278,278	16
Total days	14,681,428	2,121,884	14
Average length of stay (days)	7.0	7.6	
Inpatient days/1,000 residents	1,258	1,199	
Emergency room visits	4,336,296	592,561	14
<b>Physicians (1985)<sup>c</sup></b>			
Number in patient care	20,002	4,540	24
Number of office-based GPs	2,630	675	26
Physicians in patient care/1,000 residents	1.7	2.8	
<b>TEFRA HMOs (1988)<sup>d</sup></b>			
Number of plans	9	7	77
Number of members	54,675	45,485	83
Members/1,000 Social Security beneficiaries	23.6	176.5	
<b>Nursing Homes (1986)<sup>e</sup></b>			
Number of facilities	1,246	148	12
Number of beds	70,578	8,383	12

TABLE II.1 (continued)

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<sup>a</sup>Population data come from Table B, U.S. Department of Commerce (1988).

<sup>b</sup>Hospital data come from Tables 5C and 6, American Hospital Association (1989); Miami-Hialeah metropolitan area data appear in Dade County column.

<sup>c</sup>Physician data come from Tables 11 and 12, American Medical Association (1986).

<sup>d</sup>TEFRA HMO data come from the March 1988 GHPO File. Miami market-area data appear in Dade County column; other Florida TEFRA HMO market areas at that time were Jacksonville and Daytona, with 1 HMO each and 2,710 and 6,430 members, respectively.

population and 21 percent of the state's nonwhite population. Dade County also contains 37 percent of the state's Supplemental Security Income (SSI) beneficiaries, reflecting a level of poverty above that of the rest of the state. Due to the relatively high level of SSI receipt combined with a somewhat lower-than-average level of Social Security eligibility (and concomitantly lower level of Medicare eligibility), Da& County contains relatively more elderly Medicaid recipients who may not have Medicare as the first payor for covered services than the state as a whole.'

Acute health care providers appear to be in ample supply in Dade County. According to the American Hospital Association 1988 annual survey, the county contained 32 (or 11 percent) of the state's 293 hospitals and 14 percent of the hospital beds. Although the county had just over 15 percent of the state's total hospital admissions and just under 15 percent of the state's total hospital days of care, it had a slightly lower hospital use rate per resident: 1,199 days per 1,000 residents, compared with 1,258 days per 1,000 residents for the entire state. A relatively high proportion of the state's physicians practice in Dade County. According to the American Medical Association, at the end of 1985 the county had 24 percent of the state's practicing physicians, yielding 2.8 physicians in patient care per 1,000 residents, compared with 1.7 per 1,000 residents for the state as a whole. In 1988, Dade also had a high concentration of the state's TEFRA HMOs (i.e., HMOs certified to serve Medicare beneficiaries), with 7 of the state's 9 HMOs and over 80 percent of the state's 54,675 Medicare-covered HMO members. Thus, the HMO penetration rate among the elderly in Dade County far exceeded the rest of the state, with 176.5 HMO members per 1,000 Social Security beneficiaries, compared with 23.6 members per 1,000

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<sup>1</sup>Medicaid may purchase Medicare B coverage for Medicaid beneficiaries who, by virtue of their ineligibility for Social Security Benefits, are ineligible for Medicare A. An individual may be enrolled in the Medicare B program if he is 65 or older, is a resident of the U.S., and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the five years immediately prior to the month he applies for enrollment. He must file a written request for enrollment, signed by him or on his behalf, with the Social Security Administration. If such an individual is also Medicaid-eligible, Medicaid will pay for his Part B premiums.

Social Security beneficiaries for Florida as a whole, thus yielding an acute-care service environment for the elderly that is heavily influenced by prepaid, managed care.

Dade County contains a somewhat smaller-than-average proportion of the state's nursing facilities, with only 148 (12 percent) of the state's nursing homes and 12 percent of the total number of nursing-home beds. However, according to **DHRS**, only 47 nursing homes in Dade County were **certified** for Medicaid reimbursement as of January 1990.<sup>2</sup> DHRS operates a statewide nursing-home preadmission screening program called CARES (Comprehensive Assessment and Review Services) out of its office of Aging and Adult Services. CARES screening is performed free of charge for any individual contemplating nursing-home placement, but is mandatory for Medicaid beneficiaries. A primary goal of CARES is to **familiarize** its clients with community-based alternatives to nursing-home placement when such alternatives are **medically** feasible. CARES provides an initial assessment carried out by a multidisciplinary team using the GATES assessment instrument, develops a plan of care for clients, and conducts periodic **followup** to re-evaluate the client's condition and to assure service delivery. If a client has been **assessed** as requiring a nursing-home-level of care, but has been judged to be able to remain in the community with sufficient support, CARES provides information and referral to community-based service **programs**.<sup>3</sup>

For Medicaid beneficiaries, community-based options include the three programs that operate under Medicaid 2176 waivers in Dade County: **ElderCare**, Channeling, and TEACH. Exhibit IL2 compares the eligibility **criteria** and **services** offered by the three programs. TEACH and

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<sup>2</sup>In 1990, the nursing homes **received** per-diem Medicaid reimbursements of between \$42 and \$82, with an average per diem of \$67.

<sup>3</sup>DHRS operates another program to **assess** Medicaid **beneficiaries** for **home-and** community-based services that parallels the CARES screening program. However, clients using the **DHRS** assessment tend to be less frail than those using **CARES** screening since clients using CARES screening are considering nursing home placement, while those using **DHRS** assessment are not.

EXHIBIT IL2

ELIGIBILITY CRITERIA FOR AND SERVICES COVERED BY TEACH, CHANNELING, AND ELDERCARE

	TEACH	Channeling	ElderCare
<b>Eligibility Criteria</b>	<ol style="list-style-type: none"> <li>1. Reside in Alachua, Marion, or Dade counties</li> <li>2. Be 65 years old or older</li> <li>3. Meet SSI or ICP income cutoff</li> <li>4. Require a nursing-home level of care</li> <li>5. Have an informal caregiver</li> </ol>	<ol style="list-style-type: none"> <li>1. Reside in Dade County</li> <li>2. Be 65 years old or older</li> <li>3. Meet SSI or ICP income cutoff</li> <li>4. Require a nursing-home level of care</li> <li>5. Have two unmet needs requiring case management</li> </ol>	<ol style="list-style-type: none"> <li>1. Reside in Dade County</li> <li>2. Be 65 years old or older</li> <li>3. Be eligible for Medicaid by virtue of SSI eligibility</li> <li>4. Require a nursing-home level of care</li> </ol>
<b>Services Covered</b>	<ol style="list-style-type: none"> <li>1. Nursing case management</li> <li>2. Caregiver health support training</li> <li>3. Respite care</li> <li>5. Escort services</li> <li>6. Health support services</li> <li>7. Home management/homemaker services</li> </ol>	<ol style="list-style-type: none"> <li>1. Case management</li> <li>2. Homemaker/personal care</li> <li>3. Skilled nursing</li> <li>4. Home-delivered meals</li> <li>5. Physical, occupational, and speech therapy</li> <li>6. Housekeeping/chore service</li> <li>7. Minor structural modification of home</li> <li>6. Adaptive equipment and consumable medical supplies</li> <li>9. Home health aide</li> <li>10. Companion and respite services</li> <li>11. Mental health services</li> <li>12. Medical alert/response</li> <li>13. Caregiver training</li> <li>14. Financial education</li> <li>15. Protective services</li> </ol>	<ol style="list-style-type: none"> <li>1. Inpatient and outpatient hospital care</li> <li>2. Physician, nurse practitioner, and emergency services</li> <li>3. Independent lab and X-ray services</li> <li>4. Prescription drugs</li> <li>5. Skilled home health services</li> <li>6. Transportation</li> <li>7. Visual, hearing, and dental services</li> <li>8. Adult day health care</li> <li>9. Case management</li> <li>10. Respite and personal care</li> <li>11. Home management services</li> <li>12. Health support and placement services</li> <li>13. Escort services</li> </ol>

SOURCE: CARES unit, Aging and Adult Services Program, Florida Department of Health and Rehabilitative Services.

Channeling are available to clients whose incomes are higher than those served by **ElderCare**.<sup>4</sup> Channeling was by far the largest of the three programs; TEACH was allocated **250** of the state's wavered slots to serve Dade County residents, and Channeling was allocated 750 slots, compared with 200 for **ElderCare**.<sup>5</sup> In addition, TEACH **requires** that the client have an informal caregiver, **since** a primary objective of that program is to train clients and caregivers to provide care **in** the home. Channeling does not **require** that clients have an informal **caregiver** and provides a broader range of services than does TEACH, but does not integrate acute and long-term care services as does **ElderCare**. **Medicaid-covered services** arranged by TEACH and Channeling are reimbursed on a fee-for-service basis; Channeling also has a sliding-scale client copayment

Medicaid also funds home- and-community-based **services** through the state's Aging Waiver program. In addition the state funds a number of other programs with general revenues for which Medicaid beneficiaries are **eligible**. Both types of programs are less comprehensive than Channeling, TEACH, and Elder-care.

## F. SUMMARY

Florida's Frail Elderly Project, **ElderCare**, was designed and implemented in the mid- to **late-1980s**, a period during which the already **sizeable** health care needs of the state's elderly population and the projected growth of those needs had been recognized and met with considerable alarm. DHRS did not have the option of implementing the Frail Elderly Project in more than one location in the state, because only Mt. Sinai Medical **Center** expressed an interest in the experiment. Thus, the **specific** characteristics of Dade County (the high concentration of poor and minority residents, and the above-average concentration of physicians and **HMOs**) are likely to

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<sup>4</sup>In 1989, the Aging and Adult **Services** Institutional Care Program (**ICP**) **income-level** cutoff was \$900 per **month**, compared with the SSI cutoff of approximately **\$368**.

<sup>5</sup>**Between** September 1987 and June 1989 CARES recommended 990 **nursing-home-eligible** Medicaid beneficiaries for diversion to community **services**. Of those, just under half were recommended to Channeling, a **fifth** to TEACH, and a **tenth** to **ElderCare**.

influence **ElderCare** and its effectiveness in ways that cannot be fully **separated from the** characteristics of the plan **itself**.

**The** mid- to late-1980s was also a period characterized by substantial **experimentation** with the delivery of case management and home- and community-based **services** to the frail elderly, as well kwith the prepaid, capitated **financing** of acute health care. The **final** results of the National Long Term Care Demonstration, which appeared for the **first** time in 1986, underscored the **difficulty** of identifying individuals who will subsequently go into nursing homes. Thus, its evaluators concluded that home- and community-based care was not a leas expensive alternative to nursing-home care and would have to be justified based on the **increased** satisfaction derived by the elderly and their caregivers. On **Lok** and **the** National S/HMO Demonstration have revisited the issue of the **cost-effectiveness** of case-managed community care when provided as part of a continuum with acute care and when **financed** on a capitated basis. Florida's Frail Elderly Project, **ElderCare**, has joined these programs in attempting to find a rational, **cost-efficient, high-** quality alternative to institutional care for the **frail** elderly.



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### III. THE ORGANIZATION AND OPERATION OF ELDERCARE

The ability of Elder-Care to provide a full range of acute, **long-term** care and case management services to its **frail** elderly target population within the financial limitations of a prepaid, risk-based contract with the Florida Department of Health and Rehabilitative Services (**DHRS**) depended on its ability to:

- o Attract and retain a caseload of adequate size
- o Attract and retain providers of direct **services** and monitor the quality of **services** provided
- o Manage service delivery in a manner that prevents or delays permanent institutional placement without compromising the health of its clients
- o Provide clients with the requisite covered **services** within the limits of the **capitation** payment

**In** this chapter we discuss the findings from a case study of **ElderCare**, the purpose of which was to inform our assessment of its capabilities along these dimensions. The case study describes the organizational structure of Elder-Care and **its relationship** to its host institution, Mt. Sinai Medical Center, and the implementation of **ElderCare**. In particular, the case study documents and assesses the operational facets of **ElderCare** as they pertain to the issues of specific interest to the evaluation:

- o The access of potential clients to plan application and enrollment procedures and the access of clients to plan services, as well as whether barriers exist in outreach procedures that may restrict access to application or **enrollment** procedures and plan **services**
- o The types of marketing techniques used and the relative **effectiveness** of **different** techniques for various segments of the target population
- o The satisfaction of providers with plan participation, and **constraints** against their satisfaction

- o The perceptions of **ElderCare** staff about (1) the satisfaction of informal caregivers and clients with enrollment **incentives** and plan **services**, (2) constraints against their satisfaction, and (3) the effect of plan participation on decisions to enter nursing homes
- o The adequacy of recordkeeping systems to support the range of functions performed by **ElderCare** (e.g., administration, reporting to the State, enrollment and **disenrollment**, quality assurance, utilization review, cost containment, case management, and **grievance** processing)

In this chapter, we first **describe** the methodology underlying the case study. We then discuss the specific **aspects** of the organization and operation of **ElderCare** that illustrate the plan's capacity to provide the requisite services to its **frail** elderly caseload: the history and organizational structure of **ElderCare**; outreach activities; intake and termination procedures; case management and the provision of direct services; quality assurance and utilization review procedures; and the recordkeeping and reporting systems. **The final** section of this chapter **describes ElderCare's** ability to meet its operational and service goals.

#### **A. METHODOLOGICAL APPROACH FOR THE CASE STUDY**

Data for the case study were derived from three major **sources: in-depth, in-person interviews** with **ElderCare** staff and the liaison for the demonstration **from** DHRS; telephone conversations with the state actuary responsible for the **capitation** methodology, as well as follow-up telephone conversations with other **staff**; and documents that **described** the operational components of the demonstration.

In-person interviews were conducted during a site visit to **Mt. Sinai** Medical Center in Miami Beach by two members of the evaluation team on July **20 and 21, 1989**, several months before the end of the cooperative agreement between DHRS and HCFA. At that time, **ElderCare** had been operating for nearly two years and was serving **approximately** 110 clients.

The in-person interviewing began with an initial meeting with both the vice president at Mt. Sinai responsible for overseeing the development of **ElderCare** and its operation at the corporate

level and the Director of Mount Sinai Medical Health Plans (including Elder-Care). The **purpose** of this meeting was to acquaint these administrative staff with the site visit team, to reiterate the objectives of the site visit interviews, and to answer any of their questions about the nature and scope of the interviews, as well as to obtain general information about the plan and its relationship to the Medical Center.

The team then subsequently **interviewed ElderCare's** case management staff, the case manager **responsible** for marketing, the **financial** manager, and the medical director. A representative of an externally contracted provider and the Senior Human **Services** Program **Specialist** for the Medicaid Alternative Health Plan Unit of DHRS, who served as the liaison between the State and **ElderCare**, were also **interviewed**. An exit interview with the vice president, the **ElderCare** director, and the state liaison concluded the site visit.

Interviews were guided by a detailed **interview** protocol, the contents of which are summarized in Exhibit **III.1**.<sup>1</sup> Although the protocol was used as a point of departure for **discussion** rather than as a formal **survey** instrument, it helped ensure that questions were asked consistently by the interviewers and that all topics were covered completely and accurately. As reflected in Exhibit **III.1**, several respondents were asked the same questions to ensure that a variety of viewpoints were represented, to facilitate identifying patterns of **consensus** (or disagreement), and to cross-check the quality of **information received**. Respondents were also asked about their **responsibilities** within **ElderCare**. Respondents were sent an abbreviated version of the protocol prior to the site visit to prepare them for the discussions.

Each interview was conducted by the two-person evaluation team and lasted from 45 minutes to 2 hours. Both team members were present at each interview in order to **minimize** the influence of personal differences and styles that can affect the ability of interviewers to ask questions and to listen to responses objectively. In addition, the presence of two team members also **allowed** one

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<sup>1</sup>The complete protocol is contained in **Schore** and Nelson (1989).

EXHIBIT III.1

INTERVIEW TOPICS FOR THE SITE VISIT MEETINGS

Topics	Meeting						Telephone Conversation State Actuary
	Initial	Financial/Data Processing	Marketing	Case Managers	Medical Director	State Liaison	
<b>Organizational and Operational Characteristics</b>							
Structure and History	X						X <sup>a</sup>
Participation Decision	X					X	X
Service Package/Enrollment Incentives	X			X			X
Service Contracting	X						X
Case Management	X			X			X
Quality Assurance	X						X
Utilization Review/Cost Containment	X	X			X		X
Integration of the Demonstration	X	X	X	X			X
Summary	X	X	X	X	X	X	X
<b>Specific Evaluation Issues</b>							
Access			X	X	X	X	
Marketing			X	X		X	X
Capitation Rate	X	X			X	X	X
Recordkeeping		X		X		X	X
Provider Satisfaction				X		X	X
Client and Informal Caregiver Satisfaction				X		X	X

<sup>a</sup>Structure and history of the external organization.

person to guide the discussion and the other to record the responses. (The **conversations** were also tape-recorded to serve as backup to the written notes.)

The second data source for the case study consists of telephone interviews with persons who were not available for an in-person interview during the site **visit.**<sup>2</sup> In August, a telephone **interview** was conducted with the former **actuary** for DHRS about the rate-setting methodology used for **ElderCare**. Telephone **calls** were also made to **staff interviewed** in-person to follow up on issues that required resolution.

Following the site visit and the telephone calls, a summary of the site visit was prepared and sent to the state liaison, the **ElderCare** director, and HCFA to review its accuracy. **The** summary was revised on the basis of their comments, and then redistributed.

The third data source consists of various documents that had been made available to the evaluator by **HCFA**; additional documentation was requested **from** the state and **ElderCare**. These documents included:

- o The revised Operational Protocol for the Alternative Health Plans Project for the Frail Elderly
- o **The** contract between DHRS and **Mt. Sinai**
- o Quarterly progress reports and service use and **financial** reports for the project
- o Memoranda and letters **from** DHRS that **describe** the planning phase of **ElderCare**
- o Information from the Aging and Adult **Services** unit of DHRS about other Dade County programs offering **Medicaid-waivered** home- and community-based **services**
- o Enrollment and disenrollment forms
- o **Grievance procedures**

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<sup>2</sup>A telephone interview was planned for an external provider who had made some inquiries about participating in **ElderCare**, but who **ultimately chose** not to participate. The purpose of that interview was to identify the reasons that the provider decided not to participate. However, the staff members from that provider who had made the initial **inquiry** and the decision not to participate were no longer with the provider when the case study was conducted, and were thus unavailable for an interview.

- o The quality assurance program **plan**
- o Marketing literature
- o The job descriptions of case managers
- o Organizational charts for Mt. Sinai **Medical** Center and **ElderCare**

**These** documents were reviewed prior to the site visit in order to familiarize the evaluation team with the program and to guide the development of the site interview **protocol**.

## B. INSTITUTIONAL HISTORY AND ORGANIZATION OF **ELDERCARE**

This section discusses the decision of Mt. Sinai Medical Center to initiate the **ElderCare** program, its ongoing relationship with **ElderCare**, the organizational structure **developed** for **ElderCare**, and the manner in which **lines** of communication between **staff** members were established.

### 1. **Initiating the ElderCare Program**

Mt. Sinai **Medical** Center is south Florida's **largest** private not-for-profit **health** care facility, encompassing patient care, research, medical and paramedical education, and community outreach. Its service area encompasses **all** of Dade County, with secondary service areas in Broward and **Palm** Beach counties. In 1986, **approximately half** of **all** admissions were for residents of Miami Beach. **The** Medical Center includes a **700-bed** acute-care teaching **hospital**, comprehensive outpatient services, and an ambulatory care facility. Emergency services are provided to over **25,000** patients a year. To promote noninstitutional care, Mt. Sinai, in cooperation with **several** community organizations, provides a range of services to the community, **including** transportation, personal emergency response, in-house and **community social** and medical care, home assessment, and **health** education and prevention training. The Medical Center **also** has an **extensive Social** Work Department whose **staff** are experienced with case management. The **Medical** Center has

contractual relationships with four of the six **HMOs** in the area and has been active in the **area's** movement toward Preferred Provider Organizations.

Mt. Sinai's interest in **ElderCare** stems **from** its longstanding interest in programs for **the** elderly. Twenty years ago, Mt. Sinai established a major outpatient clinic from which a number **of geriatric** programs subsequently **evolved**. As shown in **Exhibit III.2**, Mt. Sinai expressed initial interest in operating a program for the frail elderly as part of the **Florida** Alternative Health Plan project in **1984**, two years after the project had been approved by **HCFA**. However, it was another three years before **ElderCare** began operations, following the resolution of a number of disagreements **concerning** features of the demonstration waivers and the demonstration budget among **HCFA**, DHRS, and the Medical Center. For example, the Operational Protocol submitted by DHRS to HCFA in **1984** proposed that the **frail** elderly demonstration use an income cutoff at the Institutional Care Program (**ICP**) level, while HCFA was calling for the substantially lower Supplemental Security Income (**SSI**) cutoff **level**. (In **1989**, the ICP **cutoff** was \$900 per month, compared with the SSI cutoff of approximately \$368.) In **1984**, the DHRS protocol was rejected by **HCFA**. In **1986**, a revised protocol was submitted and accepted, in which the SSI income cutoff was adopted; in addition, **the** revised protocol used a huger base group upon which **the capitation** payment for the plan was computed. A year of contract negotiations between DHRS and Mt. Sinai followed. On September **1, 1987**, the **first** client was enrolled in the **plan**.

## **2. ElderCare's Relationship to Mt. Sinai Medical Center**

Although **ElderCare** was **affiliated** with Mt. Sinai Medical **Center as** a nonprofit subentity, its **daily** operations were relatively autonomous. However, **Mt.** Sinai provided Elder-Care with various types of support at no cost to the plan, including office space **ElderCare's** accounting system, quality assurance program, and utilization review committee were integrated with **those** of Mt. Sinai. Mt. Sinai also provided the plan with some of its **transportation services** at no cost. In addition, Elder-Care **negotiated** favorable rates for inpatient services at Mt. Sinai. These

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**EXHIBIT IIL2**

**SUMMARY OF ACTIVITIES IN THE EVOLUTION OF ELDERCARE**

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- 1982 HCFA **approves** funding for the Medicaid **Competition** Demonstrations, including the Florida Alternative Health **Plan**
- 1984** **Operational Protocol** submitted to HCFA by DHRS, but **not** approved  
Proposal for Frail Elderly module **received** by DHRS **from Mt.** Sinai Medical Center
- 1986 HCFA approves revised Operational Protocol submitted by DHRS  
Contract negotiations begin between DHRS and Mt. Sinai
- 1987** Contract with Mt. Sinai signed midyear  
First client **enrolled** as of September 1
- 1988** Establishment of automated MIS for **ElderCare**
- 1989 End of **cooperative** agreement between DHRS and HCFA (originally September 30, extended to December 31)
-

**contributions** were not **directly** reimbursed by the **capitation** payments, **Thus**, Mt. Sinai provided the state with considerable subsidies to the care provided through **ElderCare**, **in the** expectation that the investment in **ElderCare** would provide returns to the Medical **Center** in the future.

Mt. Sinai's historical commitment to providing care for the elderly and its **desire** to maintain and expand **its** market share in an increasingly competitive environment were the **primary motivations** for **its** strong institutional support for **ElderCare**. **In** addition, the **commitment** of individual **staff** members and the **small size** of the plan and the fact that all **staff** members were able to communicate with each **other** daily allowed the plan to **identify**, discuss, and **find solutions** to problems as they arose-whether with **specific** clients, **plan benefits**, or **external** factors. **The** institutional commitment and the commitment of the **ElderCare staff** to the success of the plan and the **flexibility** of the plan at addressing problems (such as the addition *of off-site physicians*) engendered a high degree of satisfaction among **clients** with their **plan** participation, **as will be described** in Chapter VI.

At the time the case study was conducted, the State's cooperative agreement with WCFA for the Alternative Health Plan demonstration was due to end on October **1, 1989**. The end date of **the** agreement was later extended **through December of that year, while Mt. Sinai made plans to** continue **ElderCare** through its Medicaid Prepaid Health Plan (**PPHP**). Mt. Sinai planned to expand **ElderCare** into **Broward** County within a year **as** part of the Medical **Center's** Medicaid PPHP, and **possibly** into Palm Beach **County** within the ensuing three **years**. **Thus**, Mt. Sinai's participation in the **Alternative Health Plan** demonstration provided the **hospital** not **only** with a way to **fulfill** its institutional commitment to **the** elderly and an opportunity to garner **favorable publicity in the community, but also with the opportunity to expand its market share with long-term care services in neighboring counties in the future.**

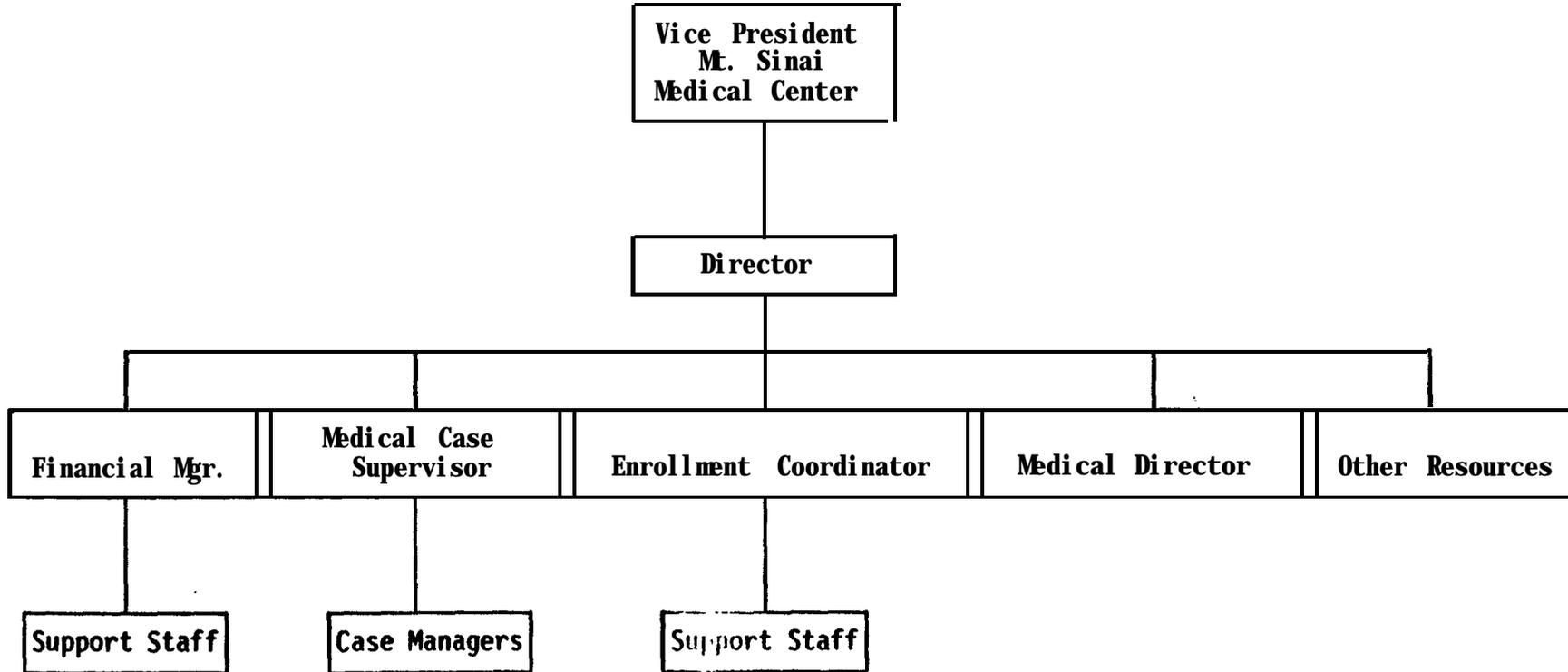
### **3. The Organization of ElderCare**

At the time of the case study, **ElderCare's staffing** structure consisted of a **plan director**, three **case** managers, a medical director, a financial manager, an **enrollment** coordinator, and several support staff. **Mt. Sinai** provided corporate oversight through a Medical Center vice president, **As indicated** by the organizational chart in Figure **III.1**, the plan **director** reported to the Medical Center vice president, while other **staff** reported either to the **plan** director or to a **function-specific** supervisor. While delegating authority to the plan director for day-to-day management, Mt. Sinai was ultimately accountable for the **fiscal viability** and successful operation of the plan. **The** plan director was responsible for **managing** the operational performance of the plan and for making **final** recommendations about policy and other decisions to **Mt. Sinai**.

**The plan** had three case managers, one of whom acted **as a supervisor** and **directed** marketing. Case management activities encompassed the following integrating and coordinating long-term **services** for each client with primary acute care; providing personal counseling to clients and support counseling to clients' families; arranging for ongoing meetings with the client's care team; visiting and assessing the client's home environment; serving as an ombudsman for the client; and integrating community resources into the client's plan of care. **Two** of the case managers were registered **nurses**; the third had worked with the Medicaid elderly population in a public welfare agency and had acquired case management expertise while working at **ElderCare** in other official capacities. At the time of the case study, **two** of the case managers had been in their positions for slightly less than a year. The third case manager had been with the program for **approximately a year and a half and had replaced a case manager who was with the plan from September 1987 to December 1987**. **The** case management **supervisor** was also the **director** of marketing. Her **responsibilities** included **developing** and **disseminating** marketing plans and **materials**, providing public relations, and overseeing **enrollment** procedures.

FIGURE III. 1

ORGANIZATIONAL STRUCTURE OF MOUNT SINAI ELDERCARE



ElderCare's financial manager had been with the plan since February 1988 and was responsible for automating the plan's MIS. **The financial manager's responsibilities** entailed budgeting, accounting, implementing **financial** controls, processing claims, preparing and submitting **financial** and statistical reports, and overseeing the plan's insurance **coverage**. An enrollment coordinator **was** responsible for data-entering enrollment information, producing **enrollment** and **disenrollment** reports for the State, mailing out marketing literature, and issuing identification cards.

ElderCare's medical director was responsible for managing the **fiscal** aspects of acute care services, implementing the prior authorization of acute services, and participating in the utilization review and quality assurance programs. He also served as the primary care physician for many of the plan members. A second, bilingual physician was **added** to the **ElderCare staff** to serve the needs of Spanish-speaking clients. **Two** other staff physicians provided backup coverage for the two physicians. All four physicians were on-site at the Mt. Sinai Medical **Center**.

Several off-site physicians also served clients. **Off-site** physicians were added to the plan because a large **number** of clients were **disenrolling from ElderCare** in order to return to their original primary care physicians. In order for an off-site physician to participate in **ElderCare**, he or she had to accept the Medicaid fee-for-service reimbursement as payment in full for care and had to agree to cooperate with the case managers and the plan's prior authorization process for referrals to specialists and other acute care.

### C. OUTREACH: THE USE OF **REFERRAL** SOURCES AND **MARKETING** ACTIVITIES

When **ElderCare** began operations in late 1987, it had approval to serve 200 clients under Medicaid waivers and had projected that it could serve 400 clients. By the **final** quarter of the **first** year of operation, only 57 **clients** had enrolled, and another **20** clients had already enrolled and **disenrolled**. **The lower-than-expected enrollment** and **higher-than-expected disenrollment** were considered to be serious problems, because they called into **question** the assumptions underlying

the level of unmet need in the frail elderly community, thus prompting **ElderCare** to rethink its marketing strategy.<sup>3</sup>

The Comprehensive Assessment and Review Service (**CARES**), the statewide nursing-home preadmission screening program, was originally envisioned as the primary referral source for **ElderCare**. **CARES** assesses all Medicaid beneficiaries who are considering nursing-home placement, and determines whether or not they require nursing-home care at the skilled or intermediate level. Dade County Medicaid beneficiaries who received “a level-of-care determination” were then assessed to determine whether they might remain in the community if sufficient support could be provided under one of the Medicaid waiver programs serving the county (**ElderCare**, Channeling, **TEACH**, and the state’s Aging Waiver program)? If the beneficiary’s physician was willing to accept the “level-of-care determination” and if the beneficiary and his or her family accepted community diversion, the beneficiary was referred to one of the waived Programs.

However, even though **ElderCare** clients were required to undergo a **CARES** assessment and be recommended for community diversion in order to be considered eligible, referrals to **ElderCare** did not generally come from **CARES**. According to plan staff, 9 of 10 applicants approached **ElderCare** prior to a **CARES** assessment. **DHRS** also initially perceived that Channeling and **TEACH** were operating at capacity, and that the overflow from these programs would be sufficient to fill the **ElderCare** caseload. However, Channeling expanded the number of its waived slots,

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<sup>3</sup>High rates of disenrollment were a particular problem because **ElderCare** lost one of its waived slots for each disenrollment. However, slots lost due to Medicaid ineligibility or death (i.e., due to involuntary disenrollment) could be recovered. The request to recover waived slots was made to **HCFA**, and any slots that were reallocated went back to Florida’s Aging and Adult Services (**AAS**) program. If **ElderCare** were still operating under Medicaid waivers when the slots were returned to **AAS**, **ElderCare** could then request the slots back from **AAS**. At the time of the case study, **ElderCare** had not recovered any of its lost slots.

<sup>4</sup>The Channeling and **TEACH** Medicaid waiver programs are described more fully in Section ILE

thus reducing its overflow, **and slots in TEACH** were in fact available. Thus, neither of these programs proved to be a source of referrals as originally envisioned.

A number of the earliest plan clients were rolled into **ElderCare** from **Mt. Sinai's** Medicaid Prepaid Health Plan. Other early referral sources included the Social Work Department at Mount **Sinai**, Jackson Hospital's Medicaid health plan, and other organizations serving the elderly. Plan **staff** attributed the slow growth of the caseload during the **first** year of operations to several factors: the amount of time required for word-of-mouth referrals to begin for a relatively unknown program; the reluctance of clients to change their primary care physicians; the reluctance of physicians to certify that clients required a nursing-home level of care; the reluctance of physicians to lose clients (or, for those offered the opportunity to **serve** their clients **from** within **ElderCare**, to lose their autonomy to the plan's case management and prior authorization procedures); a general fear of **HMOs** by both the elderly and their physicians in the wake of a number of HMO scandals in south Florida; and the **lower-than-expected** number of referrals **from CARES**, Channeling, and TEACH just **described**.

Early marketing activities were low key, consisting largely of a brochure mailed out to social service agencies that **serve** the elderly, a single appearance by an **ElderCare staff** member on a health-related television program on a local station, and presentations made by **staff** at meetings of **CARES staff**, local **service** providers, and government agencies that **served** the elderly. This conservative approach was intentional, since planners felt that **sufficient** unmet demand existed for Elder-Care's **services**. Furthermore, a conservative marketing **strategy was** adopted by Mt. Sinai and DHRS because they were concerned about the ability of the **capitation** payment to cover those **services frequently** used by the **frail elderly** (particularly home- and community-based care). However, after one year, the approach was deemed to be too **conservative** to **fill** the 200 slots.

**The** elderly of the Miami Beach area come primarily **from three ethnic/racial** groups: black Hispanic, and Jewish. Social programs in the Miami Beach area often come to be **identified** "as

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belonging to" one of these three groups. **Initially** it was thought that **ElderCare** might be identified as a "Jewish" program, in **view of** the **Medical** Center's **longstanding** ties **with** the Jewish community. However, plan **staff** felt that **ElderCare** had avoided being labeled as belonging to a particular group, despite the fact that the majority of the plan's caseload was Hispanic and a **relatively small** proportion was black.

**ElderCare's** success at enrolling elderly Hispanic clients was due to a revised marketing plan that targeted the large Spanish-speaking elderly population of Miami Beach and included programming on Spanish-language radio and television. **Staff believed** that media served as a major source of referrals for Spanish-speaking clients. **They** also indicated that **television** was more effective than radio as a marketing tool, and that news shows yielded a greater telephone response than did talk shows. **Staff** estimated that one television news show had generated 150 telephone calls, yielding approximately 30 enrollees over a two- to three-month period. On the other hand, **staff** indicated **that the** elderly Jewish population were more likely to have learned about the program through adult day centers, hospital social workers, and newspapers. **Thus**, referral sources for later enrollees were more likely to include media, as well as word-of-mouth, as the program's reputation in the community grew. **Local** hospitals continued to be a **significant** referral source. In addition, at the time of the case study, **ElderCare** had just received approximately 15 referrals from TEACH, which was beginning to phase down its operations.

Due to the general mistrust of **HMOs** in South Florida in the wake of the IMC scandal, particularly among the elderly, the case manager responsible for marketing emphasized the difference between Elder-Care and traditional **HMOs** when **talking with** potential **clients**. **The** case manager also let potential members **know** in advance that the color **of their** Medicaid card would **change** from white (the color of the Medicaid card used by **beneficiaries in** the **fee-for-service** sector) to blue (the color of the Medicaid **card** used by **beneficiaries in** **prepaid** health plans). Early in the evaluation, plan **staff** indicated that anxiety about having to change Medicaid cards

from white to blue prompted some clients to **disenroll** from the **plan**. **In** addition, the change in card color became a particular problem when clients needed to **fill** prescriptions, **because** prepaid health plans do not usually use community pharmacies, though **ElderCare** did. Therefore, some pharmacies did not honor the cards of **ElderCare** clients **even** though **they** could have been reimbursed under the plan

In addition to appealing directly to consumers through the media, the revised marketing effort continued to include presentations to community groups, coalitions of social service agencies, and social service departments at various hospitals. In **1989**, the **Mt. Sinai** **public** relations department developed a new brochure for inclusion with SSI checks. An **English-language** videotape was also produced in **1989** for use with organizations that serve the elderly and could generate referrals (e.g., social work departments and physicians' **offices**). **The** videotape was being considered for presentation on television.

DHRS approved **all** marketing materials in **advance** and preapproved the content of marketing scripts before they were produced for television programs. According to DHRS rules, marketing materials could present **ElderCare** enrollment incentives only as those features of the plan that distinguished it from regular Medicaid coverage—the guarantee of a primary care provider, **fully** coordinated case management and health care, a greater variety of health care services, and an alternative to nursing-home placement. DHRS reported that its changes to materials were minimal, generally clarifying the distinction between a regular Medicaid benefit and an expanded **ElderCare** benefit. Marketing literature need not have contained information on the demonstration status of the **plan**.

#### **D. INTAKE AND TERMINATION PROCEDURES**

Intake and termination procedures adopted by a prepaid health plan that **serves** a **frail** elderly population have an important **effect** on the access of clients to and their **satisfaction** with **care**. The efficient, rational **flow** of eligibility **screening** and **enrollment** procedures **serve** to **minimize**

barriers to **access**. Equitable and well publicized grievance **procedures** serve to enhance **the** satisfaction of clients with the **plan**. **Eligibility screening**, enrollment, grievance, and **disenrollment** procedures for **ElderCare** were governed by the operational **protocol** for the **plan**. In this section, we briefly describe these procedures and the perceptions of **staff** about the problems that arose **with** them.

### 1. Eligibility Screening

Clients were **eligible** for **ElderCare** if they were:

- o Eligible for Medicaid by virtue of receiving monthly cash assistance from SSI
- o Age 65 or older
- o A Dade County resident, and
- o At risk of nursing-home placement

**ElderCare's** nurse case managers were responsible for screening potential clients. (Exhibit III.3 summarizes the steps in **ElderCare's** eligibility and enrollment **processes**.) Screening began when an applicant made an initial telephone **contact**. The client's Medicaid status, age, and place of residence were **verified** informally by the case manager during an **initial** home visit, which **occurred** within one to two weeks after the telephone **call**. During the home visit, the case manager administered a screening instrument to the client to **assess** his or her health status, level of impairment, unmet need, and **existing** support systems. **The** home visit also allowed the case manager to explain the program to the client and the client's family in greater detail and to provide them **with** a plan handbook\_

The risk of **nursing-home** placement was determined by CARES. CARES **performs an** initial comprehensive assessment to determine whether the applicant is **eligible for** nursing-home placement and at **what** level of care. Reassessments are conducted at **30-, 60-, 90-, and 180-day** intervals. A desk **review of each case** is subsequently **performed** annually by CARES.

**EXHIBIT III.3**

**STEPS IN THE ELDERCARE ELIGIBILITY SCREENING  
AND ENROLLMENT PROCESSES**

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**Potential client contacts ElderCare**

**CARES provides** a nursing-home **level-of-care** determination and recommendation for community **diversion**

Physician provides a referral that **confirms** the **need for** a nursing-home **level of care**

**ElderCare case** manager visits the client's home to present a detailed description of the plan, administer the screening instrument, and informally verify Medicaid **eligibility**, age, and county of residence

**ElderCare submits** enrollment forms to DHRS

**DHRS notifies ElderCare** of Medicaid **eligibility verification** and formal **enrollment**

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Site staff interviews indicated that the **SSI** income cutoff restricted access to **ElderCare--a** viewpoint that had been expressed by its **Mt. Sinai** planners over the three-year **period** in which **ElderCare** was developed. **Staff** indicated that the SSI cut-off level (\$368 per month in **mid-1989**) was too stringent, effectively denying **ElderCare services** to a large group of people with incomes **slightly** above the cut-off (at the institutional care, or **ICP, level**) who needed the services provided by the plan and whose nursing-home placement and spend-down to Medicaid might be delayed by participation. (The case managers noted that they referred higher-income applicants to the Channeling program.)

## **2. Enrollment Procedures**

After the home visit and screening assessment were completed, a referral form was requested **from** the individual's physician which stated the physician's belief that the individual required a nursing-home level of care. If the applicant had not already been **assessed** by CARES, the referral form was sent to CARES along with information **from** the home visit. CARES then determined the level of care required by the patient and assessed the appropriateness of community diversion for the individual--a determination that was valid for six months. **Formal** validation of Medicaid eligibility, age, place of residence, and enrollment in **ElderCare** was performed monthly by DHRS.

Enrollment procedures took from four to six weeks. **The** completed enrollment forms had to be received by the DHRS by the 15th of the month in order **for the client** to start receiving services on the **first** of the following month. When enrollment in the demonstration began to increase, the State liaison had to intervene manually in the **enrollment** process for applicants for whom the state's records on Medicaid **eligibility** appeared to conflict with information given to **ElderCare**; three to five cases each month required the **manual** intervention of the **state** liaison. Other delays in the enrollment process were attributed to **difficulties** in contacting the client and to **difficulties** in getting the physician to complete the physician referral form, due both to physicians' busy **schedules and** to a general **unwillingness** to **certify** that an individual requires a

nursing- home level of care. In **cases** of extreme need, a privately funded emergency home care program (STEMS) provided emergency **services** to applicants awaiting formal enrollment in **ElderCare**. More **frequently**, **ElderCare** provided **services** to a client at its own **financial** risk before DHRS completed formal enrollment, so as not to lose the client **from the plan**.<sup>5</sup>

• **The case** managers felt that the length of the enrollment process restricted access to the plan, although the plan director was not convinced that clients were discouraged by the delay, since emergency services were provided in the interim through STEMS or by **ElderCare**. **The** State liaison felt that, while **his** manual intervention in the enrollment process had not yet become too burdensome, the enrollment **process** would take even longer if the size of the plan **increased**, and greater number of cases required his manual intervention. He also noted that the risk to **ElderCare** increased as it provided **care** to a greater number of clients not formally enrolled. (At the time of the case study, it was projected that, **in** the month of August, **ElderCare** would assume the risk for 11 clients awaiting formal enrollment in the plan)

### 3. Grievance Procedures

**ElderCare** instituted both informal and formal grievance **procedures** that were **described** for clients in the plan handbook which was provided at enrollment. The **objectives** of both types of procedures were to promote communication and positive relationships among members, health providers, and plan managers, as well as to provide **systematic** feedback to management to help it revise and **refine** the plan as appropriate. **The** informal procedures were designed to **resolve** problems by promoting direct communication among the persons involved. If the problem could not be **resolved** at this **level**, then plan members were encouraged to **contact** their case managers, who had the authority to help members **resolve** their complaints. **If** the situation could not be **resolved** by the case managers, **formal grievance** procedures could be initiated by the client by

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<sup>5</sup>**ElderCare** was liable for the costs of care delivered to clients **before** DHRS completed formal enrollment if the client died prior to formal enrollment or if the client's record of Medicaid eligibility was never found **on** the DHRS **files**.

submitting a written complaint to the **plan**.<sup>6</sup> Although the formal grievance procedures were in place, none had been filed.

#### 4. Disenrollment Procedures

**Disenrollment from** the plan may have been voluntary or involuntary. Plan members could **disenroll** voluntarily at any time. **The** voluntary disenrollment process began when the client submitted a written application to **disenroll**. **The** disenrollment application contained information that **identified** the client, his or her expressed reason for disenrollment, and the signature of the client or his or her legal guardian. **This** request was submitted to **ElderCare** and then forwarded to DHRS. If the request was submitted to DHRS by the 15th of the month, the client was **disenrolled** as of the **first** of the following month. **The** State need not have approved voluntary **disenrollments**. A disenrollment summary report was prepared each month to indicate the number of **disenrollments from** the plan by **reason**.

As discussed in **staff** interviews, some clients **disenrolled** voluntarily because they were confused by the change in the color of their Medicaid card once they were enrolled, and opted to leave the plan in order to get their white card back. Earlier in the demonstration, some clients **disenrolled** due to the physician lock-in **feature**, which, however, became less of an issue as clients were later allowed to retain their cnyv physician if arrangements **could be worked** out with the particular doctor. **Disenrollment** due to the physician lock-in **feature** was not attributed by **DHRS**

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**The grievance form collected** information on the incident in question, including the date and location, the date on which **the** plan was **first** made aware of the problem, the person who was not&d, and the action that was taken at that time. **Clients were** required to complete and **file** a grievance form within one **year** after the complaint. Case managers **were** responsible for reviewing the grievance and informing management of the **problem**. Medically related grievances were **forwarded** to the medical director. **ElderCare reviewed** the **grievance** and sent the member a written Ending and conclusion after the **complaint was received**, depending on whether or not information had to be collected outside the service **area**. If the member was **still** dissatisfied, then **he or she could have appealed the decision by submitting a written request for an appeal to the** plan's internal grievance committee. **Again**, a written Ending was sent to the member within 30 days. A member who **was**, still dissatisfied with the **findings** was entitled to take the appeal to **DHRS**.

to how **ElderCare** was marketed but rather was **seen** as a problem with **HMOs** in **general**. **That is, the** State liaison indicated that when potential members first heard about the **plan they** were **likely to** have remembered the positive **features** of the plan, but to have missed some of the aspects of the plan that were unattractive.

• Clients may have been **disenrolled** involuntarily because they were ineligible for **Medicaid**, moved out of Dade County, used the plan **identification** card **fraudulently**, missed three consecutive appointments within a continuous six-month **period**, exhibited disruptive behavior, failed to follow the recommended plan of medical care, or resided in a long-term care facility for six months. According to site visit **interviews**, the primary reason for disenrollment **from ElderCare** (either voluntary or **involuntary**) was the death of the client. **The** second most frequent reason for disenrollment was reported to be the client's moving out of Dade County.<sup>7</sup>

#### **E. SERVICES COVERED BY ELDERCARE AND SATISFACTION WITH CARE**

In addition to the **services** covered by regular Medicaid benefits in Florida, **ElderCare** provided case management and home- and community-based (**HCB**) care. Case management and some of the **HCB services** (namely, homemaker, home health aide, personal care, and respite care) were suggested by the Medicaid 2176 waiver under which the plan operated. However, a number of other **services** were added, sometimes on a **case-by-case** basis, to meet the **specific** needs of clients. In this section we **describe** the services **covered** by **ElderCare** and present the perceptions of staff about the satisfaction of clients and caregivers with **services**. We conclude this section by **describing** the relationship between **ElderCare** and one of its **externally** contracted providers of home health care, Home Advantage.

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<sup>7</sup>**Disenrollment forms indicated an error in staff** perceptions about the reasons for disenrollment. The percentage of enrollees by reason of **disenrollment, as** recorded on disenrollment forms, are **presented** in **Chapter IV**. **According** to the **forms, 45 percent of the 46 disenrollments** that occurred between September 1987 and June 1989 were due to the desire of the client to see another physician; 33 percent of the **disenrollments were** due to the death of the client.

## 1. Case Management

Case management in **ElderCare** consisted of the traditional functions of **assessment**, reassessment, care planning, and service coordination and monitoring. In addition, case managers furnished emotional and psychological support for clients and caregivers, and the two nurse case managers provided direct nursing services when required. **ElderCare's** model of **case** management is similar in many respects to that of On **Lok's** integrated approach, in which case managers plan care **with** initial and ongoing input **from** the plan's physicians. The small size of **ElderCare** permitted this input to be informal rather than **routinized** through regularly scheduled meetings **between** case **managers** and physicians. **The** small **size** of the plan also permitted frequent contact between case managers and clients and between case managers and home care workers, both of whom could and did suggest **changes** to care plans.

Care planning was the responsibility of the nurse case managers. A health care assessment was conducted during the screening home visit **from** which a care plan was **developed**. The screening instrument was also used to develop the plan. **The** written plan of care documented the following: the client's problems and **needs** (such as acute and chronic medical conditions, the level of impairment in performing activities of daily living, and the need of clients and caregivers for psychosocial support, transportation, equipment, **disposables**, supplies, and case management); the services to be provided (including medical care, home care, **caregiver** respite, and transportation); the specific **service** providers; and the results of the intervention. Care plans and **progress** notes were updated monthly, but **ElderCare's** case managers were in daily contact with the plan's medical director about the use of services, acute symptoms, supplies, and other health-related problems. **The** frequent contact with the medical **director** and clients obviated **the need** for formal care plan vents. Case managers did not **use individual or caseload spending caps to prepare care plans**, but were **expected to maintain a cost-conscious approach**.

**ElderCare** employed three case managers at the time of the site visit, one who acted as a case management supervisor and managed marketing, and two who maintained caseloads of between **50** and 60 clients. **The** case managers had one clerical support **person**. Caseload assignments were made alphabetically according to the last name of the client. The case managers felt that caseloads **of 50 to 60 clients, while** manageable, may have been an upper limit for this population. The optimal size of a caseload for **a frail** elderly program of this sort continues to be a matter of debate. During the design of the Medicare Alzheimer's Demonstration, caseload estimates of between 30 and **100** clients were considered to be workable by the Technical Advisory Panel for the demonstration design. The practicality of the relatively larger caseloads depends on the type and degree of support available to case managers for handling paperwork and service arrangements, the need of clients for in-person attention, and the location of clients relative to the case managers.

Home visits by **ElderCare** case managers after enrollment were **infrequent**, although they were made if a particular problem arose or if abuse of the client was suspected. Routine, ongoing contact with plan members was maintained predominantly by telephone. Telephone contact occurred at least once every two **weeks**. Some clients called their case **managers** several times a day. However, case managers called clients when they did not hear **from** them for more than a week or two. Home health **aides** also monitored clients and reported problems to the case managers.

Most contacts with clients focused on medical problems. The case managers served as a liaison between the client and the doctor and the client's **family**, and accompanied the client to medical appointments. Case managers worked with family members to build on, maintain, and **improve informal caregiving abilities, although working with families was not viewed as a focus of** their work. Rather, their aim was to arrange for **necessary** care not **already provided** by the

informal caregiver. Case managers also provided **counseling** to family members after the death of a client.

Acute-care hospitals assumed **responsibility** for case management when clients were admitted to the **hospital, although ElderCare's** case managers visited and monitored **clients** during their **hospital** stays. ElderCare's case management responsibility **formally** resumed with discharge **planning**.

The case managers monitored the quality of care provided by all providers. Providers were dropped from the plan either when the case managers felt that the **services from** that provider were inadequate or when they received multiple **complaints** about a provider **from** clients. Clients were instructed to report problems with providers to the case managers and, according to the case managers, were not hesitant to do so. **Formal** authorization procedures allowed case managers to monitor the ongoing **receipt** of **all home-** and community-based services and to evaluate changes in service needs.

## **2. Direct Services**

The services offered through **ElderCare** were determined jointly by the State and Mt. Sinai Medical Center. **Services** included those covered by the regular Medicaid program plus those covered under the Medicaid 2176 waiver. A **full list** of services offered by **ElderCare** and relevant limits are presented in Exhibit **III.4**. The **following** services were covered under the 2176 waiver: respite care, personal care, specialized home management (e.g., housekeeping and chore services), placement (to residential facilities other than skilled or intermediate nursing facilities), health support (to facilitate the provision of preventive, **emergency**, and health maintenance **services**), and **escort** services to **medical** appointments (for which interpreters were provided for hearing-impaired and **non-English-speaking** individuals).

A number of services were not originally offered by the plan, but were added to fill the unmet needs of clients. They included the provision of medical **supplies**, durable medical equipment,

## EXHIBIT III.4

### SERVICES OFFERED BY ELDERCARE AND LIMITATIONS ON THEIR UTILIZATION

<b>Services</b>	<b>Limitations</b>
Inpatient <b>hospital</b>	<b>Covers</b> the 45 <b>days</b> per year per recipient maximum covered by <b>Medicaid.</b> <sup>a</sup>
Outpatient hospital	<b>Blood products may be limited to first 3 pints</b> per service occasion if client has <b>Medicare.</b> If not, blood products must be covered as needed.
Emergency <b>services</b>	None
Physician <b>services</b>	None
<b>Laboratory</b> and X-ray <b>services</b>	None
Home health <b>services</b> <sup>b</sup>	Durable medical <b>equipment (DME)</b> may be limited to one issuance of <b>each type</b> of <b>DME</b> during a <b>lifetime.</b>
Transportation	All nonemergency <b>transportation</b> must <b>previously be authorized</b> in the plan and should <b>be</b> the <b>kast</b> expensive method <b>available.</b>
Vision, denture, and hearing services	<b>One examination every 2 years.</b>
Advanced registered nurse practitioner	Services limited for <b>each</b> professional to the <b>services</b> permitted for the <b>particular certification</b> of the Advanced <b>Registered Nurse Practitioner.</b>
Nursing-home <b>services</b>	<b>If a client remains</b> in the nursing home at <b>the end of the contract period or for a period of 12 consecutive months,</b> whichever is <b>longer,</b> and <b>nursing-home</b> placement is <b>permanent and not temporary,</b> the <b>DHRS</b> may approve <b>disenrollment.</b> All <b>disenrollments</b> for <b>institutionalized clients</b> must have the <b>prior written approval</b> of the <b>DHRS.</b> <sup>c</sup>

EXHIBIT III.4 (continued)

services	Limitations
Adult day <b>health care</b>	As <b>prescribed</b> by the primary care physician in consultation <b>with other</b> members of the <b>case management team</b>
Case <b>management</b> <sup>d</sup>	None
Respite <b>care</b> <sup>e</sup>	14 days in a <b>6-month</b> period
Personal <b>care</b> <sup>f</sup>	N o n e
Home management <b>services</b> <sup>g</sup>	None
<b>Health support services</b> <sup>h</sup>	None
Placement <b>services</b> <sup>i</sup>	None
<b>Escort services</b> <sup>j</sup>	None

**NOTE:** Information for this exhibit comes from The Revised Protocol for Module C: Alternative Health Plans for the Frail Elderly, Florida Department of Health and Rehabilitative Services, August 1986.

<sup>a</sup>May cover days in **excess** of the **limit** if necessary.

<sup>b</sup>Home health **services** are **defined** as intermittent or part-time nursing **services** and medical items or **supplies**, appliances, and durable medical equipment (**DME**).

<sup>c</sup>Although the **Protocol** stated a **12-month limit** on **nursing-home coverage**, a **6-month** limit was **actually in effect**.

<sup>d</sup>Case management is a method **used** to **identify** individual client needs, develop intermediate and long-term goals and arrangements, and monitor services **through** multiple **resources** for as long as **necessary** to meet established goals for the client.

<sup>e</sup>Respite care includes **supervision**, companionship, and/or personal care, the **purpose** of which is **to relieve the primary caregiver from the stress and demands associated with providing daily care**.

<sup>f</sup>Personal care is a **service** to **assist** with bathing, dressing, **ambulation**, **housekeeping**, **supervision**, and eating, and to supervise self-administered **drugs** and **medication**.

<sup>g</sup>Home management **services include housekeeping-oriented and** chore tasks **provided** by a trained **individual**.

EXHIBIT III.4 (continued)

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**Health** support services include activities to help persons secure and **utilize necessary** medical treatment, as well as preventive, emergency, and **health** maintenance services.

Placement services involve activities to help **place** clients in residential care settings, including foster homes, adult congregate living facilities, and other settings, in order to **avoid** institutional placement

**Escort** services involve the personal accompaniment of individuals to and from service providers, including **interpreters** for persons who speak a **foreign language** or have a speech or hearing impairment.

disposable supplies (such as incontinence products), nutritional supplements, and intravenous therapy. Heavy housecleaning services and the delivery of medications to the homebound were also added to the plan's benefits. **Staff** reported that **ElderCare** also had **the** flexibility to meet many individual needs on a one-time or limited basis, such as paying for a client's dental work or providing respite care beyond the 14day per six-month limit, although such coverage was not required of **the** plan. Staff felt **that** any services required by clients were made available under the plan, and that all services provided were important and that none should have been excluded\_

Plan members had access to medical care 24 hours per day, 7 days per week at Mt. Sinai Medical Center. Emergency visits **could** be made at any area hospital emergency room Nonemergency physician visits were scheduled with the two on-site **physicians** at the **ElderCare** clinic at Mt. Sinai within 7 days after the request for an appointment As noted earlier, arrangements were also made **with** several off-site physicians to serve clients closer to home or to **serve** clients who preferred their own primary care physicians. Limitations on the availability of specialists to clients of prepaid **health** plans can restrict access to services, since prepaid health plans generally prefer to use physicians who are willing to accept a predetermined fee **from** the plan **as** payment in full. However, **ElderCare staff** reported no problems in enlisting specialists who would **accept the** Medicare/Medicaid fee as payment in full from the plan, although, as with other prepaid health plans, **ElderCare** would have paid a higher fee if a client **required** services that could not be purchased at that fee.

Florida Medicaid has a **45-day-per-year** limit on inpatient **hospital coverage**, which applied to **ElderCare** as **well**. Staff reported that clients would not be denied coverage if they **exceeded that** limit, although none did The plan **also** covered up to 6 months of nursing-home care if **the** placement was not deemed to be permanent **If** placement was permanent or **exceeded** 6 months, the plan could **disenroll** the client with the prior authorization of DHRS. No such **disenrollments** occurred.

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### 3. The Perceptions of Staff about the Satisfaction of Clients with ElderCare Services

ElderCare staff believed that the plan features most attractive to clients and informal caregivers were those services that allowed the client to remain at home and the financial arrangement whereby no payment was required for services, which is not always the case with traditional HMOs. The case managers indicated that homemaker services, personal care services, and the provision of consumable products were the most attractive services from the clients' perspective. The case managers felt that informal caregivers were attracted by the availability of day care and respite services. The services deemed to be the most valuable at limiting the risk of institutionalization were expanded home health, personal care, and homemaker services. Staff believed that case management was a much-valued plan feature once the individual was enrolled, but one that clients tended not to perceive as a benefit prior to enrollment.

Staff indicated that transportation was perceived to be a crucial service that was difficult to arrange and involved intensive coordination. This was due to several factors, including the large size of Dade County and the poor quality of the local taxi system. The difficulties surrounding the availability of transportation were compounded by the fact that ElderCare sometimes had to arrange for transportation with very little advance notice. Despite these difficulties, it was recognized as an important program component.

The case managers felt that both plan members and informal caregivers were very satisfied with the services they received. This belief was consistent with the fact that no formal grievances had been filed against the plan. Staff believed that ElderCare helped maintain the clients' quality of life, as well as their independence and dignity, and that many clients would have been in nursing homes in the absence of the program. Staff believed that the level of impairment exhibited by ElderCare clients was similar to that of nondemonstration frail elderly Dade County residents, and thus felt that neither favorable nor adverse selection prevailed for the plan. However, the

representative **from** Home Advantage noted that clients in **managed-care** programs generally had lower incomes and tended to be more **frail** than the **agency's** private-pay clients. "

The DHRS liaison reported that the State had not heard anything directly about the **satisfaction** or dissatisfaction of clients. Nor had **DHRS** received any complaints about the plan from its district office. DHRS does not routinely monitor the satisfaction of individual PPHP clients but looks primarily at enrollment and **disenrollment** as measures of the satisfaction of members with their plans. Although **ElderCare** experienced a high disenrollment rate, because most voluntary **disenrollments** were due to objections to the physician lock-in **feature**, DHRS did not believe that high **disenrollment** was indicative of an unusual level of client dissatisfaction.

#### 4. Externally Contracted Service Providers

Mt. Sinai provided some services **directly** to some **ElderCare** clients (e.g., pharmacy, transportation, and inpatient services). clients also used community pharmacies, private transportation companies, and other inpatient facilities to expand their **access** to services. Other inpatient facilities that **served ElderCare** clients were generally reimbursed by **ElderCare** at their fee-for-service Medicaid per diem

**Formal** arrangements were established with external providers of such **services** as adult day care, home health care, and respite care. **ElderCare** followed established Mt. Sinai **practices** for contracting with external **providers**. Mt. Sinai Medical Center had **extensive experience** in **contracting with** external providers through its Medicaid Prepaid Health Plan and other endeavors. Some providers for **ElderCare** were selected because they performed well on previous contracts with Mt. **Sinai**; others were chosen for their reputation in the community, while some were chosen **conditionally** and were maintained if they performed **satisfactorily** in the plan. **In** some instances (e.g., adult day care), the choice of providers was restricted due to their limited m&ability in the community. At the time of the case study, **ElderCare** had service contracts with home health agencies, supply **companies** for durable medical **equipment** and **disposable** products, **day care**

facilities, transportation companies, nursing-home and inpatient respite facilities, and a maintenance company for heavy cleaning (**Exhibit III.5** provides a list of **ElderCare's** external providers in mid-1989.)

**The** plan was able to negotiate favorable rates with providers by shopping around. Thus, the **cost** of services to **ElderCare** were in line with or below prevailing **community rates**. The staff believed that **ElderCare's affiliation** with **Mt. Sinai** carried substantial weight in gaining and maintaining the participation of providers and negotiating rates, and that on its own **ElderCare** may not have been able to attract the same providers at those rates, particularly in light of the relatively small size of the program.

**ElderCare staff** felt that external providers were satisfied with their contracts. Contracts were discontinued only at the initiation of **ElderCare**, rather than at the initiation of the provider. A small number of providers that showed some initial interest **in** the plan chose not to participate due to low reimbursement rates. **The** State liaison reported that DHRS had not received any complaints from providers and felt that providers experienced unhappiness only about not having been given the opportunity to participate.

**During** the site visit, an interview was conducted with a **representative** of Home Advantage, a home health agency owned jointly by **Mt. Sinai Medical Center** and **Miami Jewish Home and Hospital**. Home Advantage's contract with **ElderCare** outlined the types of **services** to be provided by job title. Home Advantage provided **primarily** home health aide and homemaker **services** for clients for approximately two to four hours, several days per week. Home health aides provided personal care, light housekeeping, and meal preparation, ran errands for clients, and escorted them to medical appointments. Nursing visits by Home Advantage were not made as **frequently** as visits by personal care and home care workers because **ElderCare's** nurse case **managers** generally provided this **service** to clients; physical and occupational therapy **services were** provided

**EXHIBIT IIL5**

**ELDERCARE'S EXTERNALLY CONTRACTED PROVIDERS**

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**HOME HEALTH AGENCIES**

**Primary:**

Home Advantage  
Special Care

**Secondary:**

Best Care  
VHS  
Tender Loving Care  
Upjohn

**DME AND DISPOSABLES**

American Medical Supply  
Bell Medical  
Senior Health Care Products  
Glassrock

**DAY CARE**

Legion Park  
Villa Maria  
Greenbriar  
JCC of Miami Beach

**TRANSPORTATION**

Central Cab  
Diamond Taxi  
Florida Medi Van

**HEAVY CLEANING**

H&C Maintenance

**NURSING HOME & INPATIENT RESPITE**

Miami Jewish Home & Hospital  
Greenbriar  
Southpoint Manor  
Treasure Isle  
Meadowbrook

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**infrequently.** In addition to the care plan developed by **ElderCare**, Home Advantage prepared a care plan and nursing assessment as part of the agency's licensing requirements.

**ElderCare's** contract with Home Advantage **specified** all **services** to be authorized by **ElderCare**. Thus, the **ElderCare** case managers sent an initial request for services, and Home Advantage provided the appropriate staff to **fill** that **request**. Feedback from the home health aides and supervisory visits made by Home Advantage indicated to **ElderCare's** case managers whether clients required a **different type** or level of care. Home Advantage **staff** generally found that **ElderCare's** assessments and referrals were accurate and appropriate. **The** Home Advantage representative indicated that not enough communication initially existed with the **ElderCare** case managers, but that the problem was recognized and remedied. **The** representative noted that the **ElderCare** case managers were receptive to the feedback provided by the home health aides. (The **ElderCare** case managers also reported that home health aides provided them with valuable information on clients.)

Home Advantage billed **ElderCare** and was reimbursed monthly through Mt. Sinai's accounting system. This arrangement sometimes created delays in payment even if **ElderCare** submitted its paperwork to the Mt. Sinai accounting department on time. Other than monthly billing, Home Advantage had no reporting requirements as part of its contract with **ElderCare**.

**ElderCare** was viewed as a breakeven enterprise for Home Advantage. Compared with its other contracts, the agency provided Elder-Care with smaller units of service for more clients, which required more staff and coordination. The Home Advantage **representative** indicated that its contract with **ElderCare** was similar to any of its other contracts, with the exception that prior authorization for services was **required** under **ElderCare**. In general, Home Advantage was satisfied with its contract with **ElderCare** and would participate in a similar program in the future. However, Home Advantage reported that, since it does not operate on a high-profit margin, its overall participation in managed **care** programs may have to be limited in the future.

## F. QUALITY ASSURANCE AND UTILIZATION REVIEW

Quality assurance (QA) plans and utilization review (**UR**) are important mechanisms used by providers of **acute** care to control the costs of care while ensuring the accessibility and quality of **services**. **ElderCare's** formal QA and **UR** plans focused **primarily** on acute **services** and were based on those developed by the Medical Center.

### 1. Quality Assurance

The goal of the **ElderCare** quality assurance program (QAP) was to identify and remedy medical, administrative, or fiscal **deficiencies** in order to enhance the satisfaction of clients with the plan, while attempting to serve as a mechanism that assures quality of care. The **ElderCare** QAP was integrated with the QAP of **Mt. Sinai**, although the Medical Center maintained a separate Quality Assessment and Peer Review Committee for **ElderCare**. This committee **included** the **ElderCare** plan director, medical director, and case managers. The committee's **responsibilities** were to:

- Direct and review all quality assurance and peer review activities
- Develop new or improved quality assurance **activities**, including evaluation and study **design procedures**
- Review the practice methods and patterns of physicians and health care professionals and **evaluate** the appropriateness of care
- Review the lower of 10 percent or **50** medical and related social records once per quarter
- Review allegations of inappropriate **services** and grievances pertaining to medical treatment or social **services**
- **Publicize** Findings to appropriate staff and departments and implement **corrective** action when necessary

Medical records were selected at random for quarterly review. However, at the time of the case study, Mt. Sinai was developing a procedure whereby records could also be selected according to diagnosis or procedure.

Elder-Care was also reviewed on a quarterly basis by the State as part of its contract **compliance** review for Medicaid prepaid health plans. The areas covered by the compliance review included administration, marketing, quality of care, service access, grievances, enrollment, **disenrollment**, fiscal management, and quarterly reporting. In addition, a sample of **ElderCare's** medical records were reviewed on an annual basis by the Florida Peer Review Organization-the Professional Foundation for Health Care, Inc.-in order to ensure that the medical practices of the plan were appropriate.

## 2. Utilization Review

**ElderCare's** utilization review committee was also integrated with that of Mt. Sinai. The goal of the utilization review committee was to assess whether patients were receiving appropriate inpatient care. The committee consisted of approximately 10 nurses. The utilization review committee examined admissions and discharges on a prospective and retrospective basis, as well as evaluating cases with specific problems. **According** to staff, a good deal of overlap existed between the quality assurance and utilization review functions, since both closely monitor the quality of care delivered by physicians.

In addition to the formal utilization review committee, several **mechanisms** were in place to ensure that covered services were being used appropriately. In **ElderCare**, as in traditional **HMOs**, the primary care physician (in particular, the medical director) served as a "gatekeeper" to medical services, while case managers served as gatekeepers to home- and community-based services. Prior authorization procedures used by the medical director and case managers **were** not believed to impede the timely **receipt** of care, largely because the program was small and not highly bureaucratic. **The** overuse of emergency room **services**, frequently **cited** as a problem encountered

with Medicaid beneficiaries in the fee-for-service sector, was not reported to be a problem, due largely to the close contact between plan members and case managers and physicians.<sup>8</sup>

### G. RECORDKEEPING AND REPORTING

Exhibit III.6 summarizes the flow of reports and records between Elder-Care, DHRS, Mt. Sinai, and external providers, as well as reports prepared by ElderCare for internal use. ElderCare operated an automated recordkeeping system that tracked plan enrollment and service use and costs. However, during the first nine months of operation, service use and cost records were kept manually. The State required that ElderCare submit financial and service utilization reports quarterly and annually. (These quarterly reports were also used by the evaluation in assessing the adequacy of the capitation payment.) ElderCare was required to submit to DHRS a monthly file reflecting enrollment changes covering the period from the 18th of one month to midnight on the 17th of the next month. This file was submitted to DHRS by ElderCare by the 20th of each month on the same tape used to provide DHRS with enrollment-change data for Mt. Sinai's Medicaid Prepaid Health Plan. After comparing the ElderCare file with its Medicaid eligibility files, DHRS sent ElderCare a monthly enrollment report that the plan used to update its enrollment records. ElderCare also provided input to DHRS in the preparation of HCFA-472 reports. In general, staff felt that the State's reporting requirements were time-consuming but not burdensome; in turn, the State felt that ElderCare's reporting was timely.

The plan maintained a recordkeeping system to track the payment of claims for services provided by external contractors. The plan was also required to maintain client-level service use and cost data for the evaluation. The system generated claim payment reports that were used to identify billing errors by providers, such as incorrect charges (which was particularly a problem with

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<sup>8</sup>The financial manager did note that, at one point, disposable incontinence products were being used heavily, with requests for items coming from clients on a daily basis. At the time of the site visit, ElderCare was attempting to implement a system whereby disposable products would be ordered twice a month, and a limitation placed on the total number of cases purchased.

EXHIBIT III.6

RECORDKEEPING AND REPORTING

	Produced By	Submitted To
<b>Financial and service utilization (quarterly and annually)</b>	Eldercare	<b>DHRS</b>
<b>Enrollment/disenrollment tape (monthly)</b>	Eldercare	DHRS
<b>HCFA-472 (quarterly)</b>	<b>Eldercare, DHRS</b>	HCFA
Enrollment report (monthly)	<b>DHRS</b>	<b>ElderCare</b>
Service use and reimbursement records	<b>Eldercare</b>	Mt. Sinai for payment of <b>external</b> providers  Evaluator
Accounting reports	<b>Mt. Sinai</b>	<b>ElderCare</b>
Claim payment reports (monthly)	<b>ElderCare</b>	<b>Internal</b>
<b>Enrollment/disenrollment reports by capitation group (monthly)</b>	Eldercare	<b>Mt. Sinai, internal</b>
<b>Service use and reimbursement reports by service type and capitation group (quarterly)</b>	<b>ElderCare</b>	<b>Internal</b>

providers of transportation services). **ElderCare** also produced a number of reports for **internal** use. *These* reports included a list of enrollments and **disenrollments** by month, a capitation group report, and quarterly reports on utilization and expenditures by type of service. Monthly **capitation** reports were submitted to **Mt. Sinai**. **Staff** felt that these reports provided the plan with useful **feedback** for reviewing utilization patterns by capitation group.

**ElderCare's** accounting system was integrated with that of **Mt. Sinai**; **accounting** reports for the plan were generated by the Medical Center. **Staff** reported that while this arrangement worked well, a separate accounting system would have enabled **ElderCare** to exercise greater control over the accounting process, improve its payment tracking capabilities, and pay providers more promptly.

At the time of the case study, all case management recordkeeping was **manual**. **ElderCare** would have liked to upgrade its **MIS** in general, and adopt an automated case management MIS in particular. **Staff** felt that a case management MIS would have **facilitated** the recordkeeping process for the case managers and prevented paperwork problems and duplication as the plan expanded

#### H. CONCLUSIONS

The planning phase of **ElderCare** took **five** years from the start of **HCFA's** contract with the **Florida** DHRS for the Alternative Health Plan Project in **1982** until the **first** client was enrolled in the plan in **1987**, considerably longer than its developers had **originally** foreseen. The plan also experienced **slower-than-expected** growth during its **first** year of operation and took longer than anticipated to **fill** the 200 Medicaid 2176 waiver slots that it had been allotted. The lengthy period of development and slow growth could be attributed to the **shortcomings** of DHRS and Mt. Sinai Medical Center, or, perhaps more appropriately, could be due to the fact that the complexities of setting up a program like **ElderCare** were not foreseen, and that other Alternative Health Plan modules competed for the attention of DHRS in the early days of **ElderCare's** development. **ElderCare** was not unusual **in** its slow startup. **Difficulties** in reaching consensus on plan features

and reimbursement rates were **common** among all the Medicaid Competition Demonstration programs. Furthermore, both the national S/HMO plans and San Francisco's On **Lok** program experienced slow caseload growth early on, underscoring the **difficulties** in starting plans like **ElderCare**, even when the institutional host is well known in the elderly community.

However, once operational, **ElderCare** was able to **serve** its clients with the full range of coordinated, case-managed acute and long-term care services in its mandate and to identify and resolve specific problems in implementing the plan in terms of access, marketing, provider and client satisfaction, and **recordkeeping**.

#### 1. Barriers to Access

Barriers to the accessibility of health care services offered by prepaid health plans can arise in three areas: restrictive eligibility criteria for the receipt of services, daunting enrollment procedures, and **difficulty** in obtaining covered services. **ElderCare staff** indicated that the eligibility requirements for the plan (in particular, the requirement that an applicant have an income at or below the SSI cut-off) were a barrier to access, in the sense that a large group of individuals with just slightly higher incomes needed the services provided by the plan, including beneficiaries who were eligible for Medicaid by virtue of "medically **needy**" criteria, and frail elderly individuals who would quickly spend down their assets to Medicaid **eligibility** if faced with a long nursing-home stay. However, despite repeated discussions between Mt. Sinai and DHRS about the efficacy of raising the income cut-off for the plan, DHRS held **firm** to its commitment to serve only **SSI-eligibles**.

Two factors were **identified** as barriers to access in **enrollment** procedures: (1) the length of time required to process applications; and (2) difficulties in obtaining the physician sign-off on referral forms. To alleviate the lengthy enrollment process, **DHRS** made efforts to hasten the process by intervening **manually** in problematic cases, and **Eldercare** served some **clients** prior to their completing **formal enrollment** procedures. However, the DHRS liaison believed that such

efforts as manual intervention are workable only with a plan at **ElderCare's** relatively small size, manual intervention by **DHRS** would be too time-consuming for a larger plan. Furthermore, **ElderCare** staff believed that assuming the concomitantly greater **financial** risk for clients awaiting formal enrollment in a larger plan might not be **economically** feasible. The timely receipt of **paperwork** from physicians to declare their willingness to release patients to **ElderCare** was also a problem, although the magnitude of this problem diminished as **ElderCare** became better known and accepted among community physicians.

Plan **staff** indicated that the primary barrier to service receipt was the change in the color of the Medicaid card issued to plan participants, from the white **fee-for-service** sector Medicaid card to the blue card used by prepaid health plans. Some community providers (particularly pharmacists) would not serve Medicaid beneficiaries with blue cards, even though, **unlike** other prepaid health plans, **ElderCare** would reimburse them. The case managers **intervened** in individual **situations** and later drafted a letter which clients could give to their pharmacists to explain the reimbursement policy of the plan. Thus, the color of the Medicaid card became less of a problem over time.

**Difficulties** in arranging for specialists to serve plan clients, often cited as barriers to the **accessibility** of acute-care services in prepaid health plans, were not apparent in **ElderCare**. Nor did the prior authorization of medical and home- and community-based services appear to act as a barrier to the receipt of **services** by **ElderCare** clients. Formal prior authorization procedures were minimal, due in part to the small size of the plan.

In conclusion, the small size of the plan **facilitated frequent**, informal communication between physicians and case managers and between clients and case managers (as well as between **DHRS** and plan **staff**). **This** type of contact facilitated identifying and resolving problems early, thereby improving the access of clients to plan **services**. **The** plan was **extremely flexible** at increasing **access by adding services as required, occasionally on a case-by-case basis**. **In addition, the plan**

added a bilingual physician on-site in response to its growing number of Spanish-speaking clients, and several off-site physicians in response to clients' preferences to remain with the primary care physicians with whom they had established relationships.

## 2 Marketing

The initial marketing strategy taken by **ElderCare** was quite conservative and not very successful. **Two** main reasons for the conservative approach were offered: (1) the lack of comprehensive, empirical information on the use of home and community-based **services** among the target population and thus some concern about immediate overextension by Mt. Sinai; and (2) the assumption that, due to the well-publicized needs of the population, a **sufficient** number of clients would enroll without much marketing. Both **ElderCare** and state **staff** had anticipated that Channeling and TEACH were running at capacity and would thus serve as referral sources for Elder-Care, and that CARES would furnish more referrals than it **did**. During the early months of **ElderCare**, other organizations that ultimately became important referral sources for **ElderCare** may not have known about **ElderCare** or may have been reluctant to direct clients to a program that they viewed as a relatively untested commodity, or they simply may have thought first of directing clients **to the** then better known Channeling and TEACH programs. In addition, in the wake of the IMC and other south Florida HMO scandals, the **ElderCare** case managers believed that potential clients viewed **ElderCare** as "just another HMO" and were thus reluctant to join; this attitude quickly prompted staff to focus their introductory presentations on the differences between **ElderCare** and traditional **HMOs**.

A more aggressive marketing approach evolved over time, and word-of-mouth communication among both potential clients and community referral sources (such as agencies and physicians) increased enrollment. The plan increased its use of radio and television coverage (in Spanish and English), and the marketing director continued to be very active in the community. Thus, as the

demonstration contract for the plan was ending, **ElderCare** was well established and well known in the community.

### 3. The Participation and Satisfaction of Providers

The evaluators of **the** Medicaid Competition Demonstrations (**MCD**) found that the ability to enlist organizations to act as demonstration plan hosts and to evoke the participation of other providers in plans varied with local market conditions. **Certainly, Mt.** Sinai Medical Center was motivated to host Elder-Care **from** its a desire to increase its market share in the highly competitive south **Florida** health-care market, in addition to its institutional commitment to serve the elderly. Potential MCD hosts were also often reluctant to participate if they had no prior experience with **capitated** programs, with case management, or with Medicaid beneficiaries (who often have irregular patterns of program **eligibility**). However, such was not the **case** with **Mt. Sinai**, which **from** earlier endeavors had acquired experience in all three areas. As noted with the **S/HMO** demonstration, the prior experience of institutional hosts with **capitation** greatly **simplified** the startup of the plan

**ElderCare** contracted out for a number of **services, including** home **health/personal** care services, transportation, durable medical equipment, consumable supplies, and day care. Mt. Sinai Medical Center had established relationships with many providers in the community, enabling Elder-Care to identify reliable providers and negotiate favorable rates for services. Some providers had initially shown some interest in **contracting** for **ElderCare** but **were** discouraged by **the low** reimbursement rates. None of the providers that entered into contracts with **ElderCare** terminated voluntarily, although **ElderCare** terminated contracts with some providers that did not perform to expectations (particularly providers of transportation **services**). **The** local **service** environment was such that a choice of providers was usually available to the plan (with adult day **care** the notable exception). **Qualified**, bilingual home care workers were in good supply, which was not always the ease in other areas **of the country**. **In contrast, nurses to provide home care were in short supply,**

which was true across the country. However, this shortage was not a major problem for **ElderCare**, because the plan's nurse **case** managers provided much of the skilled in-home care required by **clients**.

#### 4. The Perceptions of Staff about the Satisfaction of Clients and Informal Caregivers

**ElderCare** staff **believed** that clients and caregivers were highly satisfied with the plan and that the plan fostered a familial relationship between the case managers and the clients and caregivers. The scale of the plan allowed for close communication between the case managers and clients, some clients calling case managers several times a day. Case managers reported that clients monitored the services **received** from external providers and were not reluctant to complain if a problem arose.

One of the few sources of dissatisfaction with the plan for some clients (but a major one that ultimately led to a number of disenrollments) was the requirement that clients use plan physicians rather than remain in the care of their own physicians. The **MCD evaluators** found that the traditional physician lock-in feature of **HMOs** was a particular problem for a demonstration site that served a large number of permanently disabled Medicaid beneficiaries. Based on this and similar experiences at other MCD plans, the evaluators concluded that capitated health care might not be appropriate for the chronically ill and disabled and the **elderly**, who often have established relationships with primary care physicians.

However, **ElderCare** was able to address the dissatisfaction with the **lock-in** feature of plan clients in two **ways**, and thus to lower the rate of **disenrollment** due to this source of dissatisfaction. The **first** was the addition of a **bilingual** plan physician to meet the needs of a growing **Spanish-speaking** clientele. The second, a major departure **from** the usual practice of prepaid health plans, was to allow clients to retain their own physicians while in the plan. **ElderCare staff reported that** for some clients it was **sufficient** just to know that **they** could keep their own physician if **they** so desire& this fact alone **made** clients more comfortable about using plan physicians.

## 5. Recordkeeping

Difficulty in establishing and upgrading Management Information Systems\_ (**MISs**) was a universal, ongoing problem among the Medicaid Competition Demonstration plans. **MCD** evaluators noted that, while having an MIS did not ensure an effective program, its absence had profound negative consequences on such functions as eligibility and **enrollment** processing, provider payment, **financial** monitoring, **utilization review**, and quality assurance. **ElderCare** encountered only minor **difficulties** in establishing an MIS, in part because Mt. Sinai had institutional experience in this area. However, **ElderCare** did not establish an automated MIS until mid-1988, having processed claims from providers manually prior to that time, and did not need to incorporate prior authorization functions (which were handled manually) or quality assurance and utilization review procedures (which were handled by **Mt. Sinai**) in its MIS.

The recordkeeping requirements for the demonstration were met by Elder-Care to the satisfaction of all parties: plan **staff**, external providers, and, in particular, **DHRS**. Reports required by DHRS included quarterly **financial** and utilization reports and monthly enrollment and **disenrollment** reports. HCFA required that HCFA-472 reports be submitted on a quarterly basis. **The** plan used its MIS to track the payment of claims for services provided by external contractors. In addition, the plan maintained hard-copy records of the medical **histories** and **care** plans of clients. **DHRS** felt that reporting was performed in a timely and efficient manner; the external contractor, Home Advantage, felt that **ElderCare processed** its monthly bills promptly. Although recordkeeping was adequate, **ElderCare** staff agreed that they would have preferred a more sophisticated MIS, but that the demonstration status of the plan had prevented them from **investing** in one.

## 6. Summary

**Flexibility** appears to have been the hallmark of **ElderCare's** ability to **resolve** problems in implementing its **plan**. **ElderCare** and **DHRS** were **successful at minimizing access and service**

**barriers** by intervening manually to keep enrollment procedures moving efficiently and **by** keeping the required formal prior authorization procedures from becoming overly bureaucratic. The marketing approach was made more aggressive when it appeared that the original conservative approach was not **sufficient**, targeting the Spanish-speaking elderly of Miami Beach and actively using the media, particularly television, while continuing outreach to organizations that served as referral sources for the plan. Providers seemed to be satisfied with their contractual arrangements and the open **lines** of communication with **ElderCare staff**, and thus **ElderCare** did not have to endure extensive problems with provider turnover. **Staff perceived** that clients and caregivers were highly satisfied with the plan, having made a number of **specific** changes to plan parameters to ensure their satisfaction, such as adding covered **services** and making arrangements for clients to keep their community physicians. Though it encountered numerous problems, **starting with** its slow development and continuing through its **27** months of operations, the commitment of Mt. Sinai Medical Center and the **ElderCare staff** and their ability to identify and **resolve** problems produced a program that was able to meet its original service goals.

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#### IV. ELDERCARE: CLIENT CHARACTERISTICS AND COSTS

This chapter **describes** the characteristics of the **ElderCare** caseload, the **costs** of providing them with **services**, and the degree to which those costs were covered by the capitation payments **to** the plan. We begin by discussing the patterns of enrollment into the plan and the characteristics of the clients at enrollment in order to document the growth of the caseload (which was slower than some **planners** expected), **as** well as the demographic **features** of the caseload, their level of **frailty**, and the informal supports available to them. A knowledge of the caseload buildup process and the characteristics of clients will enhance our understanding of the **service** delivery process of the plan and inform comparisons with other programs whose goals were similar to those of the Frail Elderly Project. We then document the methodology used by the Florida Department of Health and Rehabilitative Services (**DHRS**) to establish capitation rates for the **plan**, and the risk management techniques used by the plan to **protect** itself **from** the costs of catastrophic illness and to maintain costs within the limits of the capitation payments. A knowledge of the rate-setting methodology and risk management techniques will enhance our understanding of the **financial** constraints under which the plan operated and, again, will inform comparisons with other programs. Finally, we compare expenses for the plan with capitation payments in order to assess whether the capitation payment was adequate at covering the plan's operating **expenses**; we also examine the relative cost of providing **different types** of services and compare **service** use and costs for **ElderCare** with those of other, similar plans, within the constraints of their different operational features and client **characteristics**.

##### A DATA SOURCES AND **METHODOLOGICAL** APPROACH

Our discussion of **enrollment** patterns and client **characteristics** is based on client-specific enrollment and disenrollment dates **from** the **ElderCare** Management Information System (**MIS**) and **client-specific** screening **questionnaires**, respectively. Reasons for **disenrollment** were available

at the plan, rather than at the client, level and were transmitted on summary forms prepared by the plan. The screening questionnaires, which provided socio-demographic data and data that described the level and type of impairment exhibited by clients and the informal supports available to them when they enrolled in the plan, were transmitted in hardcopy and dataentered. Screening questionnaires were available for 150 of the 156 clients enrolled in the plan between September 1987, the first month of enrollment, and June 1989, the last month for which a full paid-claims history would be available for the evaluation and six months before the end of ElderCare's contract.<sup>1,2</sup> Our discussion of ElderCare enrollment and client characteristics is descriptive. We also use published data to compare the characteristics of ElderCare clients with those of On Lok clients and treatment group members for the National Long Term Care Demonstration.

Our descriptions of the capitation methodology and risk management techniques were drawn from a number of sources: the Operational Protocol for the demonstration, numerous memos and letters exchanged between DHRS and HCFA, and case study interviews with state and plan staff. The methodological approach for this section is strictly one of documentation. The original design for the evaluation called for a comparison of Medicaid service use and reimbursement for ElderCare clients with those for the group of fee-for-service Medicaid beneficiaries upon whose Medicaid history the capitation payments for ElderCare were based. The Medicaid history of ElderCare clients prior to their enrollment in ElderCare was to have been compared with the Medicaid history of the fee-for-service beneficiaries prior to the point at which their history was selected for setting the capitation payment. The purpose of this comparison was to explain

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<sup>1</sup>Screening questionnaires were not available for six clients who were transferred from TEACH to ElderCare.

<sup>2</sup>The June 1989 cutoff was chosen to allow six months for ElderCare and Medicaid to process the claims required for an analysis of service use and reimbursement, which is presented in the next chapter. The evaluation schedule required these claims by January 1990, and experience with collecting Medicaid claims for other projects showed that six months was adequate to ensure that a reasonably complete claims history was available for each sample member.

**differences** (or the lack thereof) between the capitation payments received by **ElderCare** and the cost of supplying the **services** used by clients. For example, if the capitation payments made to **ElderCare** had consistently been below the cost of providing services, a comparison of the **fee-for-service** capitation group with **ElderCare** clients prior to enrollment might have revealed that the **fee-for-service** group had been substantially younger or in better health (as might have been indicated by a lower level of inpatient hospital care and other Medicaid-covered services). However, because Florida DHRS was unable to locate Medicaid identification numbers for the **fee-for-service** capitation group, claims for the group could not be **extracted**. Thus, the evaluation could not address whether the Medicaid history of the fee-for-service capitation group adequately represented the service use of individuals who later enrolled in **ElderCare**.

**Finally**, our assessment of the adequacy of the **capitation** payment and the relative costs of services is based on **service** utilization data and data on plan revenues and expenses **from** quarterly reports prepared by **ElderCare** for DHRS, covering the fourth quarter **of** 1987 through the second quarter of 1989.<sup>3</sup> These aggregate data reflect the utilization of and expenses and revenues for services reimbursed in a particular quarter, not **necessarily** for **services** rendered to clients in that quarter. However, these data reflect the financial activity of the plan each quarter and, as such, are appropriate for our discussion of the adequacy of the **capitation** payment and the ultimate financial viability of the plan. **The** methodological approach of this section is descriptive; we compare the revenues with the **expenses** of the plan, and, in a limited way, service use and cost data for **ElderCare** with published data on service use and costs for On **Lok** clients and S/HMO expanded care recipients.

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<sup>3</sup>One client was enrolled in September 1987; however, the beginning of **service** delivery for the plan was effectively October 1987.

## B. ENROLLMENT PATTERNS AND CLIENT CHARACTERISTICS

**ElderCare** enrolled its **first** client on September 1, 1987. As reflected in Table IV.1, the plan filled its **200 waived** slots slowly, having used only 156 slots by the end of June 1989.<sup>4</sup> During the first quarter of operations, 27 clients enrolled in the plan, a level of new **enrollments** that was not reached again until early 1989. The relatively high enrollment early on was due **partially** to the fact that some **frail** elderly members of Mt. Sinai's existing Medicaid Prepaid Health Plan were rolled over into **ElderCare**. During 1988, **enrollment** ranged between 10 and 18 new members per quarter.

Disenrollment rates through 1988 were relatively high. Nearly 30 percent (or **25**) of the 87 clients who had joined **ElderCare** between September 1987 and December 1988 died (5 clients, or 6 percent) or disenrolled (20 clients, or 23 percent) **during** that period. 'Two of the **20 disenrollments** were involuntary, due to loss the of Medicaid eligibility; 16 clients **disenrolled** voluntarily to **return** to private physicians. Thus, 18 percent of the 87 clients enrolled between September 1987 and December 1988 **disenrolled** because **they** "wished to see a private M.D. or practitioner or attend another clinic." **The** other 2 voluntary disenrollments were for clients who **expected** to move out of the plan's **service** area

With the hiring of a new marketing director at the end of 1988, enrollment picked up in 1989: 30 new clients joined the plan during the **first** quarter of that **year**, and 39 **new clients** joined in the second quarter, increasing the **size** of the previous caseload by approximately 80 percent. During the first half of 1989, 11 clients died and 10 **disenrolled** (**5** involuntarily because **they** lost their Medicaid eligibility or moved out of the service area and **5** voluntarily to return to private physicians). Thus, 4 percent of the 129 clients enrolled **between** January and June 1989 disenrolled to return to private physicians, a noteworthy decline in the proportion of **disenrollments** for this

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<sup>4</sup>The 200 slots made available to **ElderCare** under the state's Medicaid 2176 **waiver** were meant to limit to 200 the total number of **enrollees** in the plan regardless of whether **they disenrolled** prior to the termination of the demonstration. However, as was **described** in Chapter III, the state could assign new enrollees to the plan slots vacated by members who **were disenrolled** involuntarily.

TABLE IV.1

## ENROLLMENT OF ELDERCARE CLIENTS BY QUARTER, OCTOBER 1967 TO JUNE 1989

	Quarter 1 10/87-12/87	Quarter 2 1/88-3/88	Quarter 3 4/88-6/88	Quarter 4 7/88-9/88	Quarter 5 10/88-12/88	Quarter 6 1/89-3/89	Quarter 7 4/89-6/89	Total	Quarterly Average
Number of New Enrollees	27 <sup>a</sup>	16	18	16	10	30	39	156	22
Number of Terminations	3	3	6	8	5	9	12	46	7
Number Enrolled for at Least Part of the Quarter	27	40	53	63	65	89	119	--	65
Number Enrolled at End of Quarter	24	37	47	55	60	80	107	--	59
Number of Client Months <sup>b</sup>	51	93	139	164	177	222	298	1,144	163

SOURCE: Data for this table are based on client enrollment and disenrollment dates from the ElderCare MIS.

<sup>a</sup>Includes one client enrolled in September 1987.

<sup>b</sup>Client months are the total number of months in which clients were enrolled in the plan during the quarter. The average length of enrollment during the analysis period for all clients was 7.6 months; the average for those who terminated prior to the end of the analysis period was 5.5 months.

reason over the previous 15 months. As indicated in Chapter **III**, this **decline** is likely to have been precipitated by the change in **ElderCare** policy which gave a number of clients the option of keeping their original primary care physicians while remaining plan members.

The net result of the enrollment and termination of plan clients during the analysis period for the evaluation was that 156 clients had enrolled and 46 (just under 30 percent) had died or disenrolled, either involuntarily or voluntarily. On average, the plan served 65 clients for at least some part of each quarter; the actual number of clients served ranged from only 27 during the first quarter of operations to 119 during the quarter from April to June 1989. Naturally, not **all** clients were enrolled in the plan for the full three months of each quarter; on average, clients were enrolled two and a half months of each quarter. Thus, the plan provided an average of 163 client months of service each quarter; the actual number of client months of service each quarter increased steadily from **51** during the last quarter of 1987 to 298 during the quarter **from** April to June 1989. The average length of enrollment in the plan for all clients was just over 7 months; for those who terminated prior to the end of June 1989, it was 5.5 months. However, the analysis period necessarily truncated estimates of the length of enrollment with its endpoint of June 1989, since 107 clients remained in **ElderCare** after June 1989.

Table IV.2 presents selected characteristics of 150 of the 156 individuals enrolled in **ElderCare** during the evaluation reference period. Their mean age was 81 years; just over half were 81 years old or older and a quarter 86 or older. The oldest client was 98, the youngest 65. As is typical with groups of elderly individuals, most (**three-quarters**) were female. Just under 60 percent of enrollees during this period descrii themselves as Cuban or of other Hispanic origin, reflecting the high concentration of Hispanics in Miami Beach and Dade County more generally? and likely reflecting the successful use of the Spanish-language media for outreach Thirty-two percent of the caseload were married, but only 24 percent reported living with their spouses, possibly because

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<sup>5</sup>In 1980, 36 percent of Dade County residents were Hispanic (U.S. Department of Commerce, 1988).

TABLE IV.2

**CHARACTERISTICS OF ELDERCARE CLIENTS AT ENROLLMENT**  
 (Percentage with Characteristic **Unless** Otherwise **Noted**;  
 Absolute Sample Size in Parentheses)

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<b>Age</b>	
<b>Mean age (years)</b>	<b>80.5</b>
<b>Age distribution</b>	
<b>65-75</b>	<b>22.7 (34)</b>
<b>76-80</b>	24.0 (36)
81-85	28.0 (42)
86 and older	253 (38)
<b>Sex</b>	
Female	74.7 (112)
Male	253 (38)
<b>Race/Ethnicity</b>	
<b>White</b>	<b>22.5 (31)</b>
Black	<b>6.5 (9)</b>
Cuban	46.4 (64)
Haitian	1.4 (2)
Other Hispanic	<b>12.3 (17)</b>
Other	10.9 (15)
<b>Marital Status</b>	
Married	<b>32.2 (46)</b>
Widowed	54.5 (78)
Divorced	<b>6.3 (9)</b>
Other	7.0 (10)
<b>Living Arrangement</b>	
Lives alone	30.1 (43)
Lives with spouse	23.8 (34)
Lives with others	<b>46.2 (66)</b>
<b>Current Residence</b>	
Private home	98.6 (141)
Boarding house	1.4 (2)
<b>Unable To Perform Following Activity without Help:</b>	
Do housework	<b>99.3 (146)</b>
Do laundry	99.3 (143)
Shop	<b>98.6 (143)</b>
Prepare own meals	<b>97.2 (139)</b>
Get to places beyond walking distance	<b>96.5 (138)</b>
Walk outside	94.4 ( <b>135</b> )
use stairs	93.6 (131)

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TABLE IV.2 (continued)

Unable To Perform Following Activity without Help:		
<b>(continued)</b>		
<b>Bathe</b>	<b>83.9</b>	(120)
Dress/undress	<b>70.2</b>	(99)
Handle money	<b>64.3</b>	<b>(92)</b>
-Take medicine	60.7	<b>(85)</b>
Take care of personal appearance	57.1	(So)
Use telephone	<b>52.4</b>	<b>(75)</b>
Eat	<b>38.1</b>	(53)
Sometimes or Usually Unable To Get to Bathroom in Time	<b>38.1</b>	(40)
Vision (with Glasses) Poor or Blind	39.7	(46)
Hearing (with Aid) Poor or Deaf	<b>25.9</b>	(36)
Speech Poor or Nonexistent	<b>16.4</b>	(23)
<b>Walks Poorly or Is Bedbound</b>	43.7	(59)
Uses or Needs <b>the</b> Following <b>Medical Devices</b> :		
Wheel chair	373	<b>(56)</b>
Walker	320	<b>(48)</b>
<b>Cane</b>	26.7	<b>(40)</b>
<b>Oxygen</b>	10.0	<b>(15)</b>
<b>Lift</b>	53	<b>(8)</b>
Catheter	53	<b>(8)</b>
Colostomy equipment	13	<b>(2)</b>
<b>Artificial limb</b>	0.7	<b>(1)</b>
Other	213	<b>(32)</b>
Number of Hospital Stays in Last Year		
0	35.2	(32)
1	39.6	(36)
2 or 3	23.1	(21)
4 or more	<b>2.2</b>	(2)
Number of Nursing-Home Stays in Last Year		
0	91.6	(87)
1	<b>6.3</b>	<b>(6)</b>
2 or more	<b>2.1</b>	(2)
Number of <b>Visits</b> to the <b>Doctor</b> in the Last Year		
0	4.6	(4)
1 to 6	<b>31.0</b>	<b>(27)</b>
7 to 12	44.8	(39)
13 or more	<b>19.5</b>	(17)

TABLE IV.2 (continued)

Intellectual Functioning	
Sometimes or often appears confused	45.7 (58)
Sometimes or almost never willing to do things when asked	23.0 (28)
Age given is more than 5 Pears off	22.4 <b>(26)</b>
Sometimes or almost never reacts to own name	10.8 (14)
Health Insurance	
Medicaid only	113 (17)
Medicaid and Medicare B	427 (64)
Medicaid and Medicare A and B	46.0 (69)
Some other private insurance	5.4 (8)
support Services	
<b>Is</b> receiving help from family and <b>friends</b> only	48.7 <b>(73)</b>
<b>Is</b> receiving help from agency <b>only</b>	187 (28)
Is receiving help <b>from</b> family, friends, and agency	133 (20)
Is receiving help from neither family, friends, nor agency	193 (29)
Has a problem with transportation	86.7 (130)
Sample Size*	150

SOURCE: Data on age, **sex**, and Medicare coverage come from the **ElderCare** MIS. Other data for this table come **from** the Mt. Sinai **ElderCare** Plan **Screening** Questionnaire.

The total number of clients for whom screening questionnaires were available was 150. However, item **nonresponse** led to smaller sample sizes for **specific** table **entries**. **See** Appendix Table A1 for the number of missing items for each table entry.

some spouses were **institutionalized**. Almost a third of the caseload lived alone. Vii all lived in private residences; none lived in congregate facilities.

Almost **all** of the **ElderCare** clients who were enrolled during the reference period needed at least some help with tasks that required a degree of ambulatory ability, including shopping, preparing meals, doing housework, walking outside, or climbing stairs. Just over 40 percent were **assessed** by the plan case managers as walking poorly or being **bedbound**. Approximately **two-thirds** required a cane, a walker, or a wheel chair for ambulation (not shown in the table).

In addition to **difficulties** with mobility, the **ElderCare** caseload also suffered **from** relatively high levels of mental and other types of physical impairments. A half to two-thirds of the caseload required help with tasks that require some amount **of** mental dexterity, such as using the telephone, taking medicine, or managing money. Nearly **half** of the caseload were **described** by case managers as sometimes or often appearing confused; nearly a quarter either could not give their ages within five years or were sometimes or almost never willing to do things when **asked**. Ten percent sometimes or almost never responded to their own names, indicative of relatively severe mental impairment. Just over **80** percent needed help bathing, 70 percent needed help dressing, and almost 40 percent, those most physically impaired, needed help eating. Just under 40 percent had a notable problem with incontinence.

**Almost two-thirds reported** having been in the hospital at least once during the year prior to enrolling in the plan; a quarter had two or more hospital stays. Almost all clients had seen **a doctor at least once in the previous year; nearly a fifth had seen a doctor an average of at least once a month**. However, despite the **generally** high level of impairment of the caseload, only 8 percent reported having stayed in a nursing home in the year prior to enrolling **in** the plan.

Most of the clients in the **ElderCare** caseload appear to have had **substantial** social support networks in place when they enrolled. Despite these informal and **formal** arrangements, transportation was cited as a problem by over **85 percent**. **Seventy** percent of the caseload lived

with a spouse or some other person. Just over 60 percent reported receiving help from family or **friends**, while **nearly** a third reported receiving help **from** formal organizations. However, a **fifth** reported having neither **formal** nor informal supports. **Financial** support for health and **health-**related care was available for all clients **from** Medicaid, because Medicaid eligibility was a criterion **for** participation in **ElderCare**. Nearly 90 percent also had Medicare: 46 percent had Parts A and B, while 43 percent had Part B only? Only **5** percent reported having some type of private insurance.

Table IV.3 compares the characteristics of **ElderCare** clients with those of On Lok clients and treatment group members **from** the National Long Term Care Demonstration. **ElderCare** clients were similar to On Lok clients and Channeling sample members in terms of age and the predominance of females in the group, which comes with an aging population. All three groups appear to have been **highly** impaired, although caution must be used in rendering judgments about impairments, whose measurement tends to be somewhat subjective and **whose definitions** are not entirely consistent across programs. **ElderCare** had the largest proportion of clients with the most severe ADL impairment (that is, **difficulty** eating without assistance), as well as the highest proportions of clients who had **difficulties** with **dressing** and bathing. **Measures** of mental impairment across the three programs were too disparate to compare, although On **Lok** reported that just over 60 percent of its caseload had **difficulties** with “orientation,” almost **50** percent of the Channeling sample have been **described** as **suffering from** some level **of cognitive** impairment (**Coughlin** and **Liu, 1989**), while approximately 45 percent of the **ElderCare** caseload were descrii by case managers as “sometimes or often confused.” **ElderCare** clients, all of whom were **Medicaid/SSI-eligible**, clearly had the fewest financial resources of the three groups, since only threequarters of On **Lok** clients were **SSI-eligible** (not shown in the table), and only a **fifth** of Channeling clients were eligible for Medicaid at **all**. A sign&ant **difference** between **ElderCare**

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<sup>6</sup>As explained more fully in Chapter II, Medicaid is able to buy **Medicare** Supplemental Insurance (Part B) for Medicaid **beneficiaries** who would not **otherwise** be eligible for Medicare.

**TABLE IV.3**  
**COMPARISON OF THE CHARACTERISTICS OF CLIENTS AT ENROLLMENT FOR**  
**ELDERCARE, ON LOK, AND CHANNELING**  
**(Percentage with Characteristic Unless Otherwise Noted)**

	ElderCare	On Lok	Channeling Treatment Group
Mean Age (years)	80.5	81.8	79.7
Sex			
Male	25.3	34.0	28.8
Female	74.7	66.0	71.2
Race/Ethnicity			
white	22.5	14.0	73.3
Black	6.5	0.0	23.0
Other	58.7 (Hispanic) 12.3 (Other)	85.0 (Oriental) Lo (Other)	3.7
Current Residence			
Private home	98.6	60.0	n.a.
Boarding house	1.4	n.a.	
Congregate facility	0.0	34.0	
Inpatient facility	0.0	6.0	
ADL Impairment			
Bathing	83.9	73.0	x. 8
Dressing	70.2	51.0	60.6
Eating	38.1	18.0	23.0
Medicaid/Medicare Coverage			
Medicaid only	11.3	9.0	0.0
Medicaid and Medicare	88.7	80.0	22.1
Medicare only	0.0	11.0	n. 9
Sample Size	150	338	3,453

SOURCE: Data for ElderCare come from the ElderCare MIS and the ElderCare Plan Screening Questionnaire. Data for On Lok come from the On Lok Medicare 222 Waiver Continuation Application for July through December 1988. Data for Channeling come from Applebaum (1988, Tables 3 and 4).

and On **Lok** clients, with ramifications for the manner in which program **services** can be delivered and the costs of delivery, is the larger **number** of On **Lok** clients (approximately **one-third** of the caseload) who were living in On **Lok-operated** congregate facilities relative to **ElderCare** clients, all of whom live **in** private residences.

• Although **ElderCare** clients were very frail (consistent with its **eligibility** criteria) and possibly more **frail** than On Lok and Channeling clients, case study **interviews** with **ElderCare** case managers, the plan medical director, the representative of the externally contracted home health agency, and plan administrators consistently indicated that the impairment of the caseload was representative of the local population of **frail** elderly, and they thus believed that neither **favorable** nor adverse selection with respect to level of disability came into play for the plan. However, although plan staff did not perceive that selection bias was evident along dimensions pertaining to the frailty of clients, the attitudes of informal caregivers to **ElderCare** clients may not have **been** representative of all caregivers in the area. **In** fact, although the caseload was quite **frail**, clients had very little previous nursing-home use, and thus the caseload may be unlikely to have been representative of the attitudes of all informal caregivers -- **specifically, in fact**, informal caregivers in general may have been more willing than the **ElderCare informal** caregivers to **place** elderly family members in nursing homes.

### C. THE **CAPITATION METHODOLOGY** AND **FINANCIAL RISK REDUCTION** MECHANISMS

As **described** in Chapter II, plan reimbursement was one of the most controversial features of the Medicaid Competition Demonstrations. In some respects, the formulation of the capitation payment for the Florida Frail **Elderly** Project was **less controversial** than for other demonstration projects because DHRS relied on the HCFA-approved methodology used **for** setting capitation payments for its Medicaid **HMOs**. However, Mt. **Sinai Medical Center and DHRS** disagreed about **specific** components of the methodology, and Mt. Sinai **proposed** early in the planning phase of

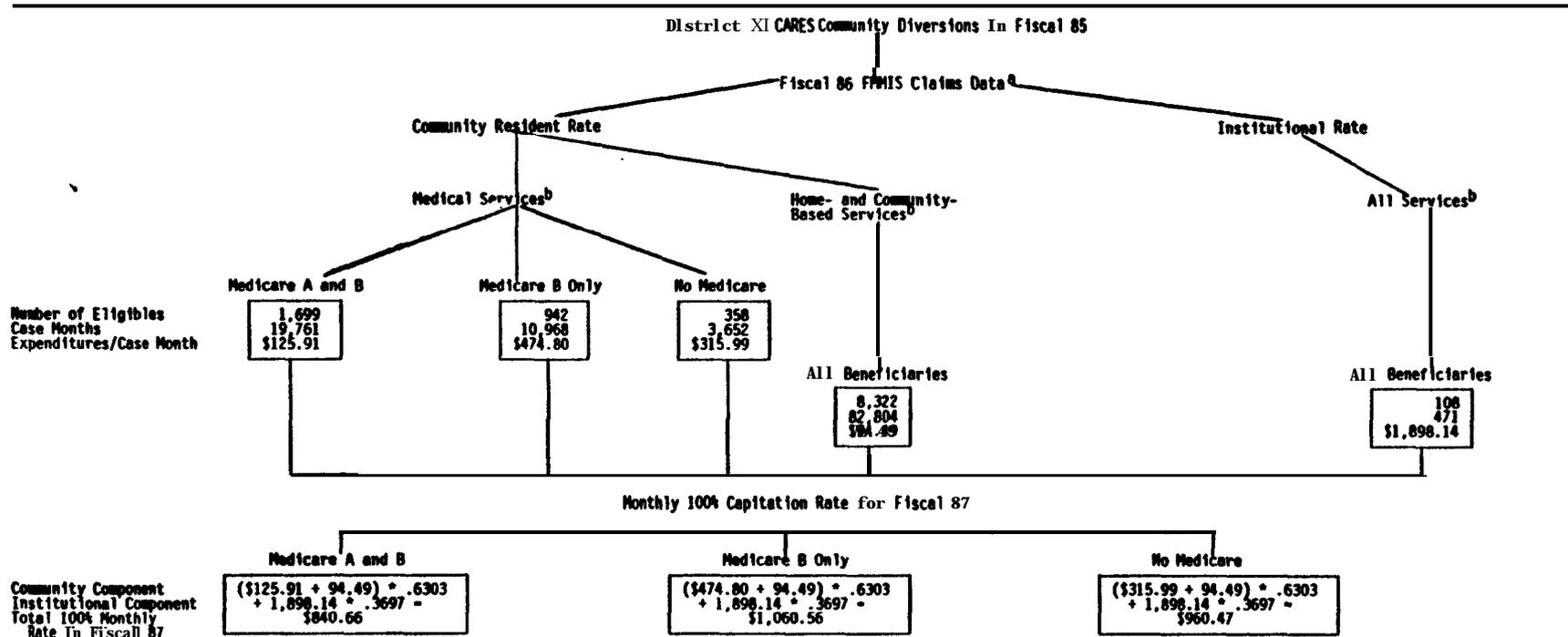
Frail Elderly Project (and later in the case study interviews for the evaluation) that the simpler approach of setting the capitation payment at 95 percent of Medicaid nursing-home reimbursement for the local market area would have been more rational and equitable. As **discussed** in this section, the methodology that was eventually adopted was more **complex**; indeed, a number of **formal** and informal risk reduction mechanisms were incorporated into **ElderCare's** structure both to ensure that **the** capitation payments would cover the **costs** of operating the plan and to protect against the event that the payments would not be adequate to cover the costs.

### 1. The Capitation Methodology

Figure IV.1 summarizes the method used by the Florida **DHRS** and approved by HCFA for calculating capitation payments for its Medicaid prepaid health **plans**. The method called for identifying a population that was believed to be "actuarially equivalent" to the target population of the prepaid plan. In the case of **ElderCare**, the population of interest consisted of Florida District XI Medicaid-eligible residents **age 65 and older who had participated in the state's nursing-home preadmission screening program (CARES) during fiscal 1985 (July 1, 1984 to June 30, 1985)**; thus, the population consisted of those who had been evaluated as requiring skilled or intermediate nursing care and had subsequently been recommended for diversion to community-based care. (This group is referred to as the **"CARES diversion"** group below.) In order to represent the different levels of expense to Medicaid after Medicare (the **first payor** for beneficiaries dually eligible for Medicare and Medicaid) contributes to the reimbursement for health services, the methodology then called for disaggregating the CARES diversion group into three mutually exclusive groups, referred to as capitation groups, according to their type of Medicare coverage: Medicare Parts A and B; Medicare B **only**; or no Medicare.

After this **actuarially equivalent group was identified**, DHRS then required a **review of fee-for-service Medicaid claims for the group for the year following preadmission screening (fiscal 1985 and 1986)** in order to provide actual service utilization and costs on which the capitation rates

FIGURE IV.1  
OVERVIEW AND RESULTS OF THE ORIGINAL CAPITATION METHODOLOGY



SOURCE: Information for this figure comes from "Protocol for Module C: Alternative Health Plans for the Frail Elderly," August 1986.

<sup>a</sup>In addition, data for the capitation calculation come from Brandeis S/HND study planning data: the proportion of time spent in nursing homes is based on the experience of Fiscal 85 CARES diversions.

<sup>b</sup>See Exhibit IV.1 for a list of included services.

would be based. The monthly capitation rate was computed in two stages. First, medical service and community-based service rates for community residents and institutional rates for institutional residents were calculated. These rates were **then** combined as a weighted sum in proportion to the time spent by the CAFES diversion group in the community and in nursing homes.

• In the initial step, separate rates were computed for beneficiaries who were residing in the community for at least 11 months of the year (community residents) and for beneficiaries who were institutional residents for at least one month of the year (institutional residents). The rate for community residents was broken down into a medical services rate (including, for example, physician services, inpatient and outpatient hospital services, pharmacy, and transportation) and a home- and community-based services rate (including such **waivered** services as case management, respite care, homemaking, and personal care), because the data available for different **types** of services differed Exhibit **IV.1** provides a complete list of services included in the community resident and institutional rates.

The medical services component of the community-resident rate, which was calculated separately for each of the three capitation groups, entailed a four-step process. **First**, the total number of case months of Medicaid **eligibility** (CM) represented by the sample was **determined**, as was the total number of service units used by the sample (**SU**) and total expenditures for the sample (**EXP**) for each individual **service** over the year. Second, for each medical **service**, the following were calculated in turn: a monthly utilization rate (SU divided by **CM**); an average cost per service unit (**EXP** divided by **SU**); and a **service-specific** capitation rate (utilization rate multiplied by average cost). Third, **service-specific** capitation rates for services for which reimbursement increased between fiscal 1986 and **fiscal 1987 (i.e.,** Medicaid inpatient, outpatient, **pharmacy**, and transportation services and Medicare **crossover** payments for physic& home health, laboratory, and X-ray services) were each multiplied by a **service-specific** inflation factor. Finally,

EXHIBIT Iv.1

SERVICES INCLUDED IN CAPITATION RATE COMPONENTS

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Community **Resident: Medical** Service

- Hospital Inpatient
- Health **Insurance Benefits**
- Hospital Outpatient
- Hospital Outpatient **Crossover**
- Physician **Services**
- Physician **Crossover**
- Prescribed** Medicine
- Nurse Practitioners
- Lab and X-Ray
- Lab and X-Ray **Crossover**
- Transportation
- Transportation **Crossover**
- Adult Dental
- Adult Vision
- Adult Hearing
- Home Health
- Home Health **Crossover**

Community Resident: Home- and **Community-Based Services<sup>a</sup>**

- Adult Day Health Care
- Case Management
- Respite Care
- Personal Care
- Specialized** Home Management **Services**
- Health Support Services
- Placement Services
- Escort Services**

Institutional: **All Services**

- Hospital Inpatient
- Health Insurance **Benefits**
- Hospital Outpatient
- Hospital Outpatient **Crossover**
- Skilled** Nursing-Home **Crossover**
- Skilled **Nursing** Home
- ICF I** Nursing Home
- ICF II** Nursing Home

**EXHIBIT IV.1** (continued)

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**Institutional: All Services (continued)**

Physician Services  
Physician **Crossover**  
**Prescribed** Medicine  
**Nurse** Practitioners  
Lab and X-Ray  
Lab and X-Ray Cmssover  
Transportation  
Transportation Cmssover  
Adult Dental  
Adult Vision  
Adult Hearing  
Home Health  
Home Health Crossover

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SOURCE "Protocol for Module **C**: Alternative Health Plans for the Frail Elderly," August 1986.

\*The recomputation of the **capitation** rates also included nursing-home services as a home- and community-based service.

the service-specific rates were summed to arrive at a monthly community-resident medical service total for each of the three capitation groups.

The home- and community-based **service** component of the community-resident capitation rate was calculated from the total utilization and average cost per service unit included in the statewide **projections** for the **fiscal** 1985 Section 2176 Extension Waiver Request.' However, because **the** 2176 Request did not contain data on case months, case months for home and community-based services were estimated from **the** South **Florida** database of 8,322 Medicaid-eligible **persons** age **65** and older in **fiscal** 1986, prepared for the **Brandeis** S/HMO study. As with the medical capitation rate, the capitation rate for each home and community-based service was calculated separately by multiplying the utilization rate (total units of **service from** the Waiver Request divided by case months from the S/HMO study) by the average cost for that service. **This** product was then multiplied by the **Florida** Price **Level** Index in order to adjust the statewide cost data to reflect costs in the Dade County area. **The service-specific** rates were **then** summed to arrive at a single community-resident home and community-based service **capitation** rate for all beneficiaries. Finally, the home- and community-based rate was added to the medical services rates of each of **the** three capitation groups to yield a total community-resident rate for each of the three capitation groups.

A similar **service-specific** institutional-rate computation was carried out for sample members who spent at least one month in a nursing home during the year. As with home and **community-**based services, only one rate was computed because the level of Medicare coverage was believed to have had very little effect on **the** level of Medicaid reimbursements for individuals in nursing homes.

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'One rate, rather than three **capitation-group-specific** rates, was computed for home- and community-based services because the cost of such **services** to Medicaid was **believed** to be largely independent of Medicare coverage.

The final step in computing the **capitation** rate entailed multiplying the proportion of **time** spent by the **CARES** diversion group **in** a nursing home in **fiscal** 1985 by the institutional-rate computation and then summing this product with the proportion of time **not** spent in a nursing home multiplied by the community-resident **rate, yielding** a weighted average of the institutional **and** community-resident rates. (The proportion of time spent in a nursing home was estimated to be 3697, or 4.44 months per year.) This weighted average yielded a **per-person, per-month** (100 percent) capitation rate for **ElderCare** for each capitation group; the 100 percent rates appear in the lower panel of Figure JV.1. After negotiation, DHRS then agreed to pay **Mt. Sinai** 97 percent of these capitation rates beginning in **fiscal 1988**. Thus, when **ElderCare** began serving clients **in** September 1987, **Mt. Sinai** received \$815 per member per month for **members with Medicare A and B**, \$1,029 per member per month for members with Medicare B only, and \$932 per member per month for members with Medicaid **only**.<sup>8</sup>

**Two** adjustments were made to the original capitation **rates**. The **first** adjustment, agreed to in December 1987, was made retroactive to October **1, 1987** and made **effective** through June 30, 1988. The proportion of the 100 percent capitation rate to be paid to **Mt. Sinai** was raised from 97 to 98 percent in lieu of a risk-sharing arrangement with the state, which **has** been under discussion since 1986. Under this adjustment, **Mt. Sinai** received \$856 per **member** per month for members with Medicare A and B, \$1,080 per member per month for members with Medicare B only, and \$977 per member per month for members with Medicaid only.

The second adjustment was agreed to in February **1988** and was again made **retroactive** to October **1, 1987** and effective through June **30, 1988**. **This** adjustment was meant to take into account legislatively mandated Medicaid reimbursement increases in **physician, home health, and nurse practitioner services** and the provision of adult dentures, as well **as** the additional coverage

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<sup>8</sup>The Medicare B-only capitation rate is higher than the **Medicaid-only** capitation rate primarily because the rate of inpatient service use by the Medicare-B subset of the **CARES diversion** group is nearly double that for **the Medicaid-only** group.

of adult health screening and an increase from \$500 to \$1,000 in the covered outpatient hospital maximum. Under this second adjustment to the original capitation rates, Mt. **Sinai** received \$910 per member per month for members with Medicare A and B, \$1,130 per member per month for members with Medicare B **only**, and \$1,031 per member per month for members with Medicaid **only**.

In late 1988, the capitation rates were completely recomputed based on a more recent data base-Medicaid claims data for **fiscal 1987** and 1988 for individuals receiving CARES diversions in **fiscal 1987**. **The** purpose of the recomputation was to reflect a major **increase** in Medicaid reimbursement for physician services (effective October **1, 1988**), as **well** as to provide more recent data for home- and community-based service use and costs. The methodology for the recomputation was the same as was used for the original computation, with two exceptions: (1) the institutional rate was computed separately for each capitation group in order to capture differences in Medicaid reimbursement among the three groups which had not been captured in the original computation, and (2) the home and community-based service component of the community resident rate was based entirely on data **from** the state's waiver extension request, rather than pieced together **from** two sources. As with the original capitation rates, the proportion of time spent in a nursing home was based on the experience of **fiscal 1985** CARES diversions.

Table IV.4 compares the total and **service-specific** components of the 100 percent capitation rate for the original and rebased calculations. **The** total 100 percent capitation payment rate increased by approximately **50** percent for **ElderCare** clients with no Medicare coverage, **from** \$960 to \$1,435, due **primarily** to a more than 150 percent increase in the **capitation** payment for medical **services** for community residents. The total 100 percent capitation payment for clients with Medicare B only also increased by approximately **50** percent (from \$1,061 to **\$1,604**), due to increases in both the medical services and institutional components, **while** the **increase** for clients with Medicare A and B was more modest, at just under **13** percent (from \$841 to \$948).

TABLE IV.A  
COMPARISON OF ORIGINAL AND RECOMPUTED 100% CAPITATION RATES

	Fiscal 85-Based 100% Capitation Rate (\$)	Fiscal 87-Based 100% Capitation Rate (\$)	Percent Increase
<b>Community Component Medical Services</b>			
Medicare A&B	125.91	148.17	16.9
Medicare B	474.80	835.18	75.9
No Medicare	315.99	795.09	151.6
<b>Home- and Community-Based Services</b>			
All beneficiaries	94.49	103.28	9.3
<b>Institutional Component</b>			
All beneficiaries	1,898.14	-	
Medicare A&B	-	2,135.37	12.5 <sup>a</sup>
Medicare B	-	2,738.85	44.3 <sup>a</sup>
No Medicare	-	2,349.36	23.8 <sup>a</sup>
<b>Total 100% Capitation Rate (Assuming 63.03% of Time in Community)</b>			
Medicare A&B	840.66	947.94	12.8
Medicare B	1,060.56	1,604.06	51.3
No Medicare	960.47	1,434.80	49.4

SOURCE: For the fiscal 85-based rates, "Protocol for Module C: Alternative Health Plans for the Frail Elderly," August 1986.

For the fiscal 87-based rates, a letter dated March 14, 1989 from DHRS to HCFA containing a portion of an amendment to contract with Mt. Sinai Medical Center.

<sup>a</sup>Percentage increase over the single fiscal 85 rate for all beneficiaries.

**ElderCare** received 95 percent of the rebased 100 percent capitation rates, **the** drop from 98 to 95 percent **reflecting** the assumption that the new rates represented the **current** costs of providing services more adequately than did the original rates. Thus, retroactive to July 1, 1988 through September 30, 1988, Mt. Sinai received \$901 per member per month for members with **Medicare** A and B, \$1,524 per member per month for members with **Medicare** B only, and \$1,363 per member per month for members with Medicaid only. Legislatively mandated **revisions** to Medicaid which increased physician reimbursement rates led to two minor adjustments in these rates which affected the Medicaid-only group. Thus, for the period **from** October 1, 1988 to December 31, 1988, Mt. Sinai received \$1,369 per member per month for members with Medicaid only (an increase of \$6). As a result of the second adjustment, from January 1, 1989 through June 30, 1989, Mt. Sinai received \$1,371 per member per month for members with Medicaid only (an increase of \$2). Table **IV.5** summarizes the capitation payments received by **Mt. Sinai** Medical Center from the inception of **ElderCare** (September 1, 1987) to the close of the evaluation analysis period (June 30, 1989).

## 2. Managing Financial Risk

The organization of **ElderCare** included a number of direct and indirect measures to protect Mt. Sinai Medical Center, Elder-Care, and its clients from the potential large-scale **financial** failure of the plan. One direct measure entailed establishing a risk **reserve** account of one percent of the total contract amount of the plan for the year (as estimated prospectively by DHRS) to which the plan had no direct access without DHRS agreement. The purpose of this account **was** to act as a cushion for the plan in the event of a **financial** loss stemming **from** the delivery of **services** for catastrophic care that exceeded **capitation** payments. **ElderCare** never had to draw on this reserve. A formal risk-sharing agreement between Mt. Sinai Medical Center and **DHRS** had **been discussed** during the planning phase of **ElderCare**, but none was **ever** implemented **for** the **plan**.

TABLE IV.5

CAPITATION PAYMENTS RECEIVED BY MT. SINAI MEDICAL CENTER FOR  
ELDERCARE CLIENTS BETWEEN SEPTEMBER 1, 1987 AND JUNE 30, 1989

Capitation Group	(1) 9/1/87-9/30/87	(2) 10/1/87-6/30/88	(3) 10/1/87-6/30/88 (Replaced Column 2)	(4) 7/1/88-9/30/88	(5) 10/1/88-12/31/88	(6) 1/1/89-6/30/89
Medicare A and B (\$)	815	836	910	901	ml	901
Medicare B Only (\$)	1,029	1,080	1,130	1,524	1,524	1,524
No Medicare (\$)	932	977	1,031	1,363	1,369	1,371
Capitation Database Fiscal Year	85	85	85	87	87	87
Percentage of 100% Capitation Rate (%)	97	98	98	95	95	95

SOURCE: Column (1) comes from "Protocol for Module C: Alternative Health Plans for the Frail Elderly," August 1986.

Column (2) comes from a letter dated 12/18/87 from DHRS to HCFA. Column (2) adjusts the rates for the increase from 97 to 98 of the 100 percent capitation rate.

Column (3) comes from a letter dated 2/19/88 from DHRS to HCFA containing a portion of a contract amendment. Column (3) adjusts the rates to account for legislatively mandated Medicare reimbursement increases for physician, home health, and nurse practitioner services, the provision of dentures, adult health screening, and an increase in the outpatient limit.

Columns (4) - (6) come from a letter dated 3/14/89 from DHRS to HCFA containing a portion of a contract amendment. Columns (5) and (6) adjust the rates to account for legislatively mandated Medicare reimbursement increases for physician services.

The Medicaid limit of **45 days** per year on hospital inpatient coverage also applied to **ElderCare** and directly limited the **financial** risk of catastrophic illness. If the 45day limit were exceeded, the providing hospital rather than the plan would have been **responsible** for the cost of care. Although none of the plan clients reached the **45-day** limit, plan **staff** said that the plan would have continued to cover clients if they did. Nursing-home coverage for the plan was limited to six months. Clients who exceeded **this** limit, or those whose placements were judged to be permanent, could have been terminated from the plan. However, no clients **exceeded** the limit, and thus, **ElderCare** did not terminate any clients for nursing-home stays that exceeded the plan limit.

**Indirect** measures were designed to provide incentives to the **plan to provide services** efficiently enough for the plan to operate within the capitation payments. Utilization and costs for physician and other medical practitioner services were controlled under a policy whereby the plan's medical director was reimbursed with a **capitated** payment. The medical director authorized all utilization of nonemergency medical services. The **capitated** payment to the medical director covered the cost of medical care provided by the medical director, his associates, and off-site physicians, as well as referrals to specialists. (Referrals for laboratory tests and X-rays were included under this capitation only for part of the demonstration.)

No formal measures were used to contain the costs of home- and community-based services. These services were authorized by the case managers prior to their use. Case managers did not have formal spending limits, either for individual clients or for the caseload as a whole. Rather, they were trained to adopt what was **described** during case study **interviews** as a "cost-conscious orientation."

**Finally**, an important aspect of managing the **finances** of the plan entailed developing contracts with external providers at rates consistent with the budget constraints **imposed** by the capitation payments. **As** noted in Chapter **III**, **ElderCare staff** believed that they successfully **identified** and

contracted with providers at favorable rates, attributing their success in some cases to the reputation of its host organization, Mt. Sinai Medical Center. In fact, **Mt. Sinai** was one of Elder-Care's providers, furnishing transportation, pharmacy, and inpatient services for some clients. In particular, Elder-Care negotiated an extremely favorable reimbursement rate with Mt. Sinai for inpatient hospital care. For clients with Medicare B only, **ElderCare** reimbursed **Mt. Sinai** the amount of the Medicare B coinsurance and deductible charges for the stay, while **ElderCare** reimbursed other inpatient hospitals at the Medicaid per diem for its Medicare-B-only clients. For clients with Medicaid only, **ElderCare** reimbursed Mt. Sinai at a daily rate that was approximately 20 percent below Mt. Sinai's Medicaid-approved per diem.

#### D. THE ADEQUACY OF THE CAPITATION PAYMENT

**As** noted in Section B, Elder-Care clients as a group were old and had varying living arrangements and levels of informal and formal support at **enrollment**. **ElderCare** clients had multiple physical and mental impairments and appear to have been at least as impaired as On Lok clients and Channeling treatment group members, two groups of elders recognized as quite **frail**. In addition, **ElderCare** clients were less well-off **financially** than their On **Lok** and Channeling counterparts, in light of the SSI income **eligibility** criterion for **ElderCare**. **Thus**, it can be **expected** that Elder-Care clients would have had a high rate of service utilization (and concomitant costs) and a particularly high rate of in-home service utilization, since, unlike On **Lok**, **almost** all **ElderCare** clients lived in private residences, and, unlike On **Lok**, **ElderCare** itself did not sponsor congregate housing, nor did it operate its own adult day health facility.

During the planning phase of the demonstration, the capitation methodology for **ElderCare** was a point of contention among DHRS, Mt. Sinai **Medical Center**, and occasionally HCFA, and, as **described** earlier, the payments were adjusted a number of times during the operational phase of the demonstration. An ongoing concern of Mt. Sinai was that the **physician** service component of the capitation payment substantially **underestimated** service use in light of the **fact** that Medicaid

fee-for-service physicians were not bothering to file claims for the low reimbursement to which they were entitled. Mt. Sinai was also skeptical that the piecemeal approach to estimating home- and community-based service use under the original calculation would reflect the actual use of ElderCare's clients. In addition, the capitation methodology did not explicitly take into account the administrative expense of operating the plan.

#### 1. ElderCare Expenses and Revenues

Despite the high degree of impairment of the caseload and the perceived shortcomings of the capitation methodology, Tables IV.6 and IV.7, which summarize the plan's quarterly expenses and revenues from October 1987 to June 1989, suggest that the capitation payment did cover the costs of operating the plan. During that period, the plan showed a small surplus of approximately \$23,000, or just 2 percent of total revenue. Surpluses were shown during three of the seven quarters, ranging from \$10,000 to \$52,000, and losses were shown in four quarters, ranging from \$4,000 to 42,000. Thus, the plan appeared to just about break even during the observation period.

The total cost of operating ElderCare over the seven quarters was just under \$1.2 million, \$.8 million (or 68 percent) of which was spent on direct services (labeled "medical and hospital expenses" in the quarterly reports and Tables IV.6 and JV.7, but which included all direct service expenses). The remainder (just under \$.4 million, or approximately a third of total costs) covered

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<sup>9</sup>The expense and revenue figures in Tables IV.6 and IV.7 include services paid for by the plan in each quarter plus an estimate of outstanding costs for the quarter. The service use figures in Table IV.8 include only services paid for by the plan in each quarter. Thus, variations from quarter to quarter reflect patterns in the flow of bills to the plan as much as they do service use by clients during the quarter. For example, the relatively high numbers for the last quarter of 1988 have been attributed by plan staff to the receipt of bills from providers that were attempting to bring accounts up to date at year end. However, the quarterly data presented in Tables IV.6, IV.7, and IV.8 accurately portray overall service expenses, revenues, and use for the plan. Thus, the discussions that follow focus on the two rightmost columns of the tables, which present the seven-quarter totals and quarterly averages. Perclient averages cited in the text were calculated by dividing totals by 156 (the number of clients enrolled in the plan during the 7-quarter observation period); per-client per-month averages were calculated by dividing totals by 1,144 (the total number of months during which all clients were enrolled in the plan during the period). The latter averages adjust for the actual length of enrollment by the client in the plan (which was on average, 7 months), while the former do not.

TABLE IV.6

## ELDERCARE EXPENSES AND REVENUE BY QUARTER OF OPERATION AND STATEMENT LINE ITEM, OCTOBER 1987 TO JUNE 1989

	Quarter 1 10/87-12/87	Quarter 2 1/88-3/88	Quarter 3 4/88-6/88	Quarter 4 7/88-9/88	Quarter 5 10/88-12/88	Quarter 6 1/88-3/89	Quarter 7 4/89-6/89	Total	Quarterly Average
<b>Medical and Hospital Expenses</b>									
Physician <sup>a</sup>	179	125	2,393	2,912	3,985	2,090	5,271	16,955	2,422
Other professional <sup>b</sup>	6,306	25,492	34,154	36,180	112,214	3,895	5,576	223,817	31,374
Emergency room	279	1,665	0	230	1,372	1,285	10,500	15,331	2,190
Inpatient	1,006	18,892	20,069	16,635	37,506	78,890	53,035	226,033	32,290
Other medical <sup>c</sup>	4,544	7,352	14,646	13,931	25,632	53,560	191,035	310,700	44,386
<b>Total medical and hospital</b>	<b>12,314</b>	<b>53,526</b>	<b>71,262</b>	<b>69,889</b>	<b>180,709</b>	<b>139,719</b>	<b>263,417</b>	<b>792,836</b>	<b>113,362</b>
<b>Administrative Expenses</b>									
Compensation <sup>d</sup>	34,431	35,419	43,013	36,298	37,946	40,761	69,334	301,202 <sup>e</sup>	43,029
Occupancy	0	1,378	1,378	1,378	6,278	1,378	1,378	13,168	1,881
Other <sup>e</sup>	4,269	5,347	8,351	2,998	4,854	1,823	10,228	37,870	5,410
<b>Total administration</b>	<b>42,700</b>	<b>42,144</b>	<b>52,743</b>	<b>40,675</b>	<b>49,078</b>	<b>43,962</b>	<b>80,940</b>	<b>352,242</b>	<b>50,320</b>
<b>Total Expenses</b>	<b>55,014</b>	<b>95,670</b>	<b>124,005</b>	<b>110,564</b>	<b>229,787</b>	<b>183,681</b>	<b>346,358</b>	<b>1,145,079</b>	<b>163,583</b>
<b>Revenue</b>									
Capitation payments	50,535	88,827	133,367	162,117	186,648	221,450	317,083	1,160,027	165,718
Interest	0	35	875	383	709	3,567	2,610	4,179	1,168
<b>Total Revenue</b>	<b>50,535</b>	<b>88,862</b>	<b>134,242</b>	<b>162,500</b>	<b>187,357</b>	<b>225,017</b>	<b>319,694</b>	<b>1,168,207</b>	<b>166,887</b>
<b>Total Revenue - Total Expenses</b>	<b>(4,479)</b>	<b>(6,808)</b>	<b>10,237</b>	<b>51,936</b>	<b>(42,430)</b>	<b>41,336</b>	<b>(26,664)</b>	<b>23,128</b>	<b>3,304</b>
<b>Number in Plan during Quarter</b>	<b>27</b>	<b>40</b>	<b>53</b>	<b>63</b>	<b>65</b>	<b>89</b>	<b>119</b>		<b>65</b>
<b>Number of Client Months<sup>f</sup></b>	<b>51</b>	<b>93</b>	<b>139</b>	<b>164</b>	<b>177</b>	<b>222</b>	<b>296</b>	<b>1,144</b>	<b>163</b>

SOURCE: Data for this table come from Report #2: Statement of Revenue and Expenses prepared by ElderCare for the Florida Department of Health and Rehabilitative Services.

<sup>a</sup> "Physician" expenses include the capitation payment to the medical director and reimbursements made by ElderCare for Medicare B coinsurance and deductibles.

<sup>b</sup> "Other professional" includes vision, hearing, and dental service and laboratory and X-ray expenses.

<sup>c</sup> "Other medical" includes transportation, supply, prescription drug, outpatient, home health, home- and community-based service, and nursing-home expenses.

<sup>d</sup> "Compensation" includes the payroll expenses of case managers and other plan staff.

<sup>e</sup> "Other" (administration) includes office supplies, equipment, and transportation.

<sup>f</sup> Client months are the total number of months in which clients were enrolled in the plan during the quarter.

<sup>g</sup> Total compensation includes \$140,606 for case management.

TABLE IV.7

## TOTAL ELDERCARE EXPENSES PER CLIENT PER MONTH

	Total Expense (\$)	Percent of Total (%)	Expense per Client per Month (\$)
Medical and Hospital Expenses			
Physician <sup>a</sup>	16,955	1.5	15
Other professional <sup>b</sup>	223,817	19.6	1%
		<b>1.3</b>	<b>13</b>
Emergency room	<b>216,331</b>	<b>19.7</b>	<b>198</b>
Other medical <sup>c</sup>	310,700	27.1	272
Total medical and hospital	<b>792,836</b>	69.2	693
Administrative Expenses			
Compensation	<b>301,202</b>	<b>26.3</b>	263
Other <sup>d</sup>	37,878	3.3	<b>12</b>
			<b>33</b>
Total administration	352,242	<b>30.8</b>	<b>308</b>
Total Expenses	<b>1,145,079</b>	100.0	1,001

**SOURCE:** Expense data for this table come from Report #2: Statement of Revenue and Expenses prepared by ElderCare for the Florida Department of Health and Rehabilitative Services. Data on client months are based on client enrollment and disenrollment dates from the ElderCare MIS. Expense per client per month is estimated by dividing total expenses by 1,144, the total number of months of service provided for all clients.

<sup>a</sup>"Physician" expenses include the capitation payment to the medical director and reimbursements made by ElderCare for Medicare B coinsurance and deductibles.

<sup>b</sup>"Other professional" includes vision, hearing, and dental service and laboratory and X-ray expenses.

<sup>c</sup>"Other medical" includes transportation, supply, prescription drug, outpatient, home health, home and community-based service, and nursing-home expenses.

<sup>d</sup>"Compensation" includes the payroll expenses of case managers and other plan staff.

<sup>e</sup>"Other" (administration) includes office supplies, equipment, and transportation.

the cost Of plan administration, including case management. Direct services averaged just over **\$690** per client per month. Direct service expenses were dominated by a **category of service described** as “other medical,” which combines expenses for home- and community-based services, transportation, prescription drugs, supplies, and transportation; these services represented **40** percent of direct costs. As reflected in Table IV.8, the plan paid for nearly 25,000 hours of personal care, home management, escort services, and in-home respite **care** over the reference period, approximately 156 hours per client, or 21 hours per client per month enrolled. **The** plan paid for 5,600 **hours** of adult day health care, approximately 36 hours per client, or **5** hours per client per month. Consistent with the goals of the Alternative Health Plan Project, relatively little nursing-home care was used. **The** plan paid for a total of 178 days of care, or approximately one day per client (or just under 2 days per client per year)?

**The** next largest categories of direct **service** were for inpatient care and “other professional” services, each of which accounted for just under 30 percent of direct costs. The plan paid for a total of 525 inpatient days of care—just under 3.5 inpatient days per client, or 5.5 days per client per year. “Other professional” services included **services** related to vision and hearing, dental services, and laboratory and X-ray services. Physician and **emergency** room **services** were responsible only for 4 percent of **direct** costs.

Administrative costs were dominated by compensation **for** plan staff, totaling \$3 million, or approximately 85 percent of total administrative costs. Compensation to the case managers totaled **\$.14** million. The remaining 15 percent of administrative **expenses** covered a **contribution** to the cost of space and a proportion of the cost of **supplies** and equipment provided to the plan by the Medical Center. Total administrative **costs** averaged \$308 per client per month, including the cost of case management, which averaged \$123 per client per month.

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<sup>10</sup>**Respite** care provided in nursing homes was sometimes included under nursing-home days and sometimes under respite care hours.

TABLE IV.8

## ELDERCARE SERVICES REIMBURSED BY QUARTER OF OPERATION AND TYPE OF SERVICE, OCTOBER 1987 TO JUNE 1989

Type of Service (unit)	Quarter 1 10/87-12/87	Quarter 2 1/88-3/88	Quarter 3 4/88-6/88	Quarter 4 7/88-9/88	Quarter 5 10/88-12/88	Quarter 6 1/89-3/89	Quarter 7 4/89-6/89	Total	Quarterly Average
Hospital Inpatient (days)	50	78	0	117	164	29	87	525	75
Outpatient Center (visits)	0	6	0	0	12	13	6	37	5
Emergency Room (visits)	4	0	1	3	4	8	0	20	3
Practitioner (visits)									
Physician	48	65	102	108	144	187	147	801	114
Podiatrist	0	2	0	0	1	0	0	3	0
Dental	0	5	0	4	5	10	21	45	6
Vision	2	1	4	5	1	0	0	13	2
Hearing	0	1	1	0	1	0	1	4	1
Laboratory and X-Ray (orders)	36	27	47	110	101	182	98	601	86
Drugs (prescriptions) <sup>a</sup>	198	239	441	326	621	618	604	3,047	435
Home Health (hours) <sup>b</sup>	4	26	73	50	132	34	26	345	49
Transportation (one-way trips)	66	139	160	362	798	470	483	2,478	334
Home and Community-Based Services									
Nursing home (days) <sup>a</sup>	0	0	15	13	86	31	33	178	25
Adult day health care (hours)	128	430	34	1,367	1,370	1,224	1,040	5,593	
Personal care/Special home management (hours)	1,167	1,395	1,433	1,924	6,865	2,685	4,098	19,367	
Escort services (hours)	<sup>c</sup>	4	2	21	273	120	411	833 <sup>d</sup>	5
Respite care (hours) <sup>e</sup>	<sup>c</sup>	188	137	350	992	1,909	249	3,865 <sup>d</sup>	552 <sup>e</sup>
Number in Plan during Quarter	27	40	33	63	63	89	119		65
Number of Client Months <sup>f</sup>	51	93	139	164	177	222	298	1,144	163

NOTE: Data for this table come from the PHP/HMO Utilization Report prepared by ElderCare for the Florida Department of Health and Rehabilitative Services.

<sup>a</sup> Excludes prescription drugs provided by community pharmacies.

<sup>b</sup> Includes LPN services, with a visit as the unit of observation.

<sup>c</sup> Escort services and respite care not itemized in the Quarter 1 report.

<sup>d</sup> Total is exclusive of Quarter 1.

<sup>e</sup> Nursing-home respite care was sometimes recorded under "nursing home" and sometimes under "respite."

<sup>f</sup> Client months are the total number of months in which clients were enrolled in the plan during the quarter.

## 2. Comparison of the Service Use and Expense Rates of Elder-Care, S/HMO, and On Lok

It would be useful to place the financial experience of **ElderCare** into the context of other, similar programs for the frail elderly. However, comparisons of operating expenses and service use between **ElderCare** and other programs, such as the expanded long-term care component of the S/HMO demonstration and On **Lok**, are **difficult** to make, due to differences both within and between programs in the availability and quality of data and differences in the characteristics of clients.” These **difficulties** notwithstanding, this section compares **ElderCare** service utilization rates and costs with those of the S/HMO expanded care and On **Lok** programs in order to assess whether, given the characteristics of the clients **discussed** earlier, **ElderCare** appeared to be providing roughly the same level of service at the same level of expense as these programs. It should be emphasized that the purpose of these comparisons is **not** to draw conclusions about the relative cost-effectiveness of each program, which is beyond the scope of this evaluation.

In 1988, the S/HMO demonstration delivered expanded long-term care services to between 210 and 270 beneficiaries at each **plan**. Members were eligible for expanded care if they were **certified** as **nursing-home-eligible** (or, in one plan, at risk of becoming **certified** as **nursing-home-eligible**) according to state-specific nursing-home preadmission **screening** criteria. **Expanded** care included such services as personal care, homemaking, adult day health, transportation, and short-term nursing-home care. For the purposes of keeping track of expanded care use relative to spending limits on expanded care (of between **\$6,500** and \$12,000 per member per year), the plans distinguished between services covered under regular Medicare and those specific to the expanded care program. Table IV.9 presents estimated expanded care service use and costs rate for 1988 based on plan rates that were calculated for the full plan membership and were then adjusted for the proportion of members receiving expanded care that year. (These rates are not adjusted for

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<sup>11</sup>The quality of in-home **service** use records is particularly likely to be unreliable both because in-home services tend to be quite diverse and because it is **difficult** to convince in-home service providers of the importance of accurate recordkeeping.

TABLE IV.9

COMPARISON OF **ANNUALIZED** PER MEMBER SERVICE USE AND-MONTHLY PER MEMBER EXPENSES FOR **S/HMO** EXPANDED CARE, ON **LOK**, AND ELDERCARE

	<b>S/HMO</b>	<b>On Lok</b>	<b>Eldercare</b>
Annualized Nursing-Home Use (days)	16.0 - 43.4	123'	.7
Annualized <b>Skilled</b> In-Home <b>Care</b> Use (visits)	0 - 43	<b>10.9<sup>b</sup></b>	<b>1.3<sup>c</sup></b>
Annualized Unskilled In-Home Care Use ( <b>hours</b> )	112.3 - 768.7	<b>302.6<sup>d</sup></b>	<b>88.9<sup>e</sup></b>
Annualized Inpatient Care Use (days)	<b>n.a.<sup>f</sup></b>	24	1.9
Monthly Nursing Home, Skilled, and Unskilled In-Home Care <b>Costs (\$)</b>	310 - <b>685</b>	<b>n.a.</b>	<b>95<sup>g</sup></b>
Monthly Case Management <b>Costs</b> <b>(\$)</b>	81 - 174	<b>n.a.</b>	43
Number Enrolled	210 - <b>270<sup>h</sup></b>	317	<b>156</b>

SOURCE: Data from **ElderCare** come from quarterly Statements of Revenues and Expenses and **PHP/HMO** Utilization Reports prepared by **ElderCare** for the Florida Department of Health and Rehabilitative **Services**. Total-use data for seven quarters from Table IV.8 are divided by 1.75 to yield an **annual** average, then divided by 156 to yield a perclient annual average. **Total-expense** data for seven quarters from Table IV.6 are divided by 21 to yield a monthly average, then divided by 156 to yield a **per-client** monthly average. For consistency with S/HMO and On **Lok** data, these averages are not adjusted for the actual number of months in which clients were enrolled in the plan.

Data for the S/HMO plans for 1988 are estimated from **Luetz** et al. (1989) by adjusting **plan use and cost rates** for **all** plan members (*i.e.*, for **expanded** care recipients, as well as **"nonfrail"** members) by the percentage who **received** expanded long-term care. Rates are not adjusted for the actual number of months in which members were receiving expanded care. **The** ranges reported are the minimum and maximum values for the four plans in the demonstration

Data for On Ink come from the Quarterly Statistical Utilization and **Cost** Report for the fourth quarter of **1988**. Quarterly totals are multiplied by 4 to yield **annual** estimates, then divided by 317 to yield **per-client** averages.

**TABLE IV.9 (continued)**

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<sup>a</sup>**Nursing-home** days for On Lok reflect the **full-time** placement of 11 clients.

<sup>b</sup>**Skilled** visits for On Lok include visits that would normally be covered by Medicare and are not included in the rates for **ElderCare** and the S/HMO plans.

<sup>c</sup>**Skilled** in-home care for **ElderCare** comes from "home health" **service** use and combines hours for therapy with skilled nursing visits.

<sup>d</sup>**Due** to an error in the recording of hours by home care workers on the quarterly report, "**unskilled** hours" was estimated for this table by an On Lok **staff** member.

<sup>e</sup>**Unskilled** in-home care for **ElderCare** includes personal **care/special** home management, escort, and respite services.

<sup>f</sup>**The** inpatient utilization rate for the full S/HMO enrollment (**including** both **expanded** care and "**nonfrail**" members) ranged from 1.6 to 1.9 days per member.

<sup>g</sup>**Service dollars** for **ElderCare** come from "other medical," and include supplies and drugs that are not included in S/HMO figures.

<sup>h</sup>**Enrollment** numbers are based on December **1988** total plan **enrollment** and the average monthly percent of enrolled clients who received expanded care in **1988**.

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the number of months during which each member was receiving expanded care.) **The ranges** presented in the table are the minimum and maximum levels for the four **S/HMO plans. In 1988**, S/HMO members receiving expanded care used between 16.0 and 43.4 (expanded care) nursing home days per member, a **small** amount of (expanded care) skilled in-home care (that is, skilled nursing and therapy not reimbursed under regular Medicare) **of** 0 to 43 visits per member, and relatively more unskilled in-home care (for example, personal care and homemaking services, and other services not generally covered by regular Medicare) of 1123 to **768.7** hours per member (or approximately 9 to 64 hours each month).

Like **ElderCare** and the S/HMO expanded care program, On **Lok covers all** acute and chronic care services for its clients, **all** of whom are nursing-home **certified**; unlike **ElderCare** and S/HMO, On Lok does not **disenroll** clients who need long-term nursing-home placement. Nor does On Lok use **chronic-care-specific** client spending caps; thus, their service use estimates include services that are covered by traditional Medicare, in contrast to those presented for S/HMO and **ElderCare**.<sup>12</sup> Thus, it is noteworthy that On Lok clients appear to use less nursing-home care than do **S/HMO** expanded care beneficiaries (12.3 days per member in a year) even though, during the quarter upon which this rate was based, 11 of the 317 clients in the caseload were residing in nursing homes for **virtually** the **full** three- month period. However, On Lok had much higher rates of skilled in-home service use than the S/HMO plans, with an average annual rate of 10.9 skilled visits per member (including visits that would be covered by Medicare in the fee-for-service environment), but roughly equivalent rates of unskilled in-home care at 3026 hours per member (or just under 1 skilled visit and **25** hours per member each month). The level of in-home service

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<sup>12</sup>For **ElderCare** clients, **Medicare-covered** services are reimbursed directly by Medicare.

use **is also** noteworthy, since, **in** addition to in-home care, many of On **Lok's** services are delivered in adult day **health centers**.<sup>13</sup>

**Service use** appears to vary greatly among the S/HMO **plans** and between the **S/HMO plans** and **On Lok**, perhaps reflecting differences in service delivery philosophy and the level of client **impairment** and informal support, even among programs with broadly similar goals. For the sake of comparability with S/HMO and On **Lok** data, **ElderCare** service use and cost **rates** that appear in Table IV.9 and, in the discussion that follows, **have** not been adjusted for the actual length of enrollment by clients as they were in the previous section. It should be noted **that, like** the S/HMO rates, **ElderCare** rates exclude services covered by Medicare and for whom Medicare is thus the first **payor**. **Service** use rates at **ElderCare** are **generally** lower than those for the S/HMO plans or On Lok. **ElderCare** clients used only **.7** nursing **home-days** per **client** per year. (Indeed, as will be **discussed** in Chapter V, only 5 **ElderCare** clients were admitted to nursing homes over the 21 months of the analysis **period**.) However, the annual rate of skilled in-home care use by **ElderCare** clients (at 13 visits per client) was within the range of the other two programs. **The** use of **unskilled** in-home care at **ElderCare** was noticeably lower than the other two programs, at 88.9 hours of service per client in a year (or 7.4 hours per **client** in a month).

The cost of providing nursing-home and in-home skilled and unskilled care can be compared only for the **S/HMO** plans and **ElderCare**, since no cost data were available for On **Lok**. Furthermore, these estimates will overstate the cost of in-home care for **ElderCare** relative to the **S/HMO** plans because **ElderCare** quarterly reports combine supply and drug costs with the costs of in-home care as "other medical" **expenses**. Despite this overstatement, **S/HMO** costs for expanded care appear to be substantially higher (with a monthly average of **between** \$310 and **\$685** per S/HMO expanded care member, compared with \$95 per **ElderCare** member), consistent with

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<sup>13</sup>An On **Lok** **staff** member attributed the high level of in-home **service use to a high level** of client **disability** combined with the **unavailability** of an informal support system, saying that some clients required in-home **services** to prepare them to go to **adult** day health centers in the morning and to prepare them for **bed at night**.

generally higher rates of service use by the **S/HMOs, particularly** for nursing-home care and **unskilled** in-home care. The cost of case management was **also substantially** higher for the S/HMO plans at a monthly cost of \$81 to \$174, compared with **ElderCare** at \$43 **per member**.

**ElderCare generally** had lower rates of service use, and **concomitantly** lower expenses, than the S/HMO expanded care programs. However, beyond the fact that both **ElderCare** and S/HMO expanded care participants were certified as nursing-home **eligible** by their state screening criteria, no data were available to compare the characteristics of members. Thus, it is **difficult** to assess the comparative frailty of **ElderCare** and S/HMO **care** beneficiaries and the degree to which their frailty might have influenced service use and casts. The **generally** lower service use for **ElderCare** relative to On Lok does not appear to have **been** a function of the relative level of impairment of **enrollees**. The comparison of client **characteristics** presented in **Table IV3** suggests that **ElderCare** and On Lok clients are **equally frail**. However, inpatient service use was somewhat higher at On Lok (at 24 days per client per year, compared with 1.9 days for **ElderCare** clients), suggesting either somewhat poorer health of On Lok clients or differences in the management of acute care between the two programs or some combination of the two." However, a substantial difference in the level of informal support available to On **Lok** clients might have accounted for the greater need of On **Lok** clients for in-home **services**, much of which was delivered to clients **in On Lok-sponsored** congregate housing.

#### E. CONCLUSIONS

After operating for 21 months, the net effect of operating expenses and **plan** revenue left **ElderCare** with a small surplus: \$23,128, or 2 **percent** of total revenue. **However**, this surplus was so small that it could have been obliterated by a catastrophic **illness** requiring **40** days of inpatient care (reimbursed at a per diem of \$570, the rate paid to **Mt. Sinai Medical Center** for **Medicaid-**

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"As a point of **comparison**, it should be noted that the average rate of inpatient care for all Medicare beneficiaries in 1988 was 3.0 days per enrollee (U.S. Department of Health and Human **Services**, 1989).

only clients) or two nursing-home stays with durations of just under six months, the limit for the program (reimbursed at \$65 per day, the average rate paid by **ElderCare** for nursing-home care).

**ElderCare** long-term care service use rates were broadly consistent with the rates of other similar programs. That **ElderCare's** service use rates appear to have been somewhat lower may be due to the relative level of impairment and informal support of clients of other programs or to the more stringent budgetary constraints implied by the **ElderCare** capitation methodology and more efficient care management. However, although **ElderCare** quarterly reports show that it was financially viable, it should be recognized that Mt. Sinai Medical Center subsidized **ElderCare** in a number of ways, by providing, for example, the physical **ElderCare** facility at a favorable rental fee, and by purchasing some of the equipment used by the plan, alluded to earlier. The Medical Center also processed and paid provider bills for the plan (although the plan received and tracked bills itself) and provided backup administrative support through their personnel and public relations departments. In addition, the Medical Center provided transportation for some clients at no cost to the plan, and the plan negotiated a very favorable reimbursement rate for client inpatient stays at Mt. Sinai.

Therefore, it can be concluded that the capitation payment was adequate to cover the budget line item costs of operating Elder-Care, possibly due in part to efficient service delivery and the ability to limit the use of nursing-home care. However, these costs are likely to substantially underestimate the "true" cost of operating the plan, since it received a substantial subsidy from Mt. Sinai Medical Center.

## V. ELDERCARE: COMPARISON OF SERVICE USE AND REIMBURSEMENTS WITH OTHER FRAIL ELDERLY

The analysis of aggregate service use and cost data presented in Chapter IV suggested that ElderCare met two of the objective of the Frail Elderly Project-it provided a continuum of acute and long-term care within the budget constraints of the capitation payments, albeit with subsidization from Mt. Sinai Medical Center, and it kept the use of nursing-home services at a very low level. However, several questions remain about the manner in which these objectives were met. Specifically, did ElderCare provide roughly the same patterns of services at the same or lower cost as those received by other frail elderly in the Medicaid fee-for-service sector? And did the level of nursing-home use by ElderCare clients differ markedly from the level of nursing-home service use by other frail elderly Medicaid beneficiaries assessed as requiring a nursing-home level of care, but recommended for community diversion?

In order to address these questions, this chapter compares the service utilization patterns of and reimbursements for ElderCare clients with those of other Medicaid beneficiaries who, like ElderCare clients, participated in the CARES nursing-home preadmission screening program and who were assessed as nursing-home-eligible, but were recommended for community diversion. However, it must be emphasized that, while these comparisons provide partial answers to the questions at hand, they cannot be interpreted as the impacts of ElderCare per se, since ElderCare clients and other CARES clients differed along a number of measured dimensions and are likely to have differed along a number of other dimensions prior to CARES assessment that were either unmeasured or for which measures were unavailable for the evaluation. In turn, these differences are likely to have affected the services available to them, their choice of services, and their level of service use.

The chapter begins with a description of the data available for the comparisons made in this component of the evaluation and the statistical methodology used for these comparisons.

## A. DATA SOURCES, LIMITATIONS, AND METHODOLOGICAL APPROACH

As summarized in Exhibit V.1, our comparison of the use of and reimbursement for **ElderCare services** and Medicaid-covered services in **the fee-for-service** sector relies primarily on data from **two sources: individual-specific** service use and reimbursement data **from** the **ElderCare Management Information System (MIS)** and **individual-specific** service use and reimbursement data from the Florida Medicaid Management Information System (**MMIS**) Adjudicated Claims File. The **ElderCare MIS** data were available only for **ElderCare** clients while they were enrolled in the plan.<sup>1</sup> The **MMIS** data were available for a sample of **frail** elderly Medicaid beneficiaries in the fee-for-service sector who, like **ElderCare** clients, participated in the statewide nursing-home preadmission screening program (CARES), were **assessed** as requiring a nursing-home level of care, but were recommended for community care with support **from** Medicaid-funded programs, other state- or county-funded programs, or existing informal supports. This group is referred to in the remainder of this chapter as the CARES diversion sample.

The CARES diversion sample was **identified** for the evaluation by the CARES unit of the Florida Department of Health and Rehabilitative Services (**DHRS**) Aging and Adult Services (**AAS**) program. CARES clients were selected according to the following criteria. Sample members had to be DHRS District XI Medicaid beneficiaries who **received** a nursing-home level of care determination and were subsequently recommended for diversion to the community between September 1, 1987 and June 30, 1989.<sup>2</sup> The sample drawn by CARES included 936 Medicaid beneficiaries, 120 of whom were in the **ElderCare** analysis sample; Medicaid **identifiers** were supplied for each sample member. Medicaid claims whose service dates were between September 1986 and June 1989 were requested from the **MMIS** Adjudicated Claims File for the

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<sup>1</sup>The Elder-Care **MIS** data included both hardcopy data for claims **processed** before the plan's automated MIS was developed (July 1988) and which were **data-entered** as part of the evaluation contract and machine-readable data for claims **processed** after the MIS was **established**.

<sup>2</sup>**DHRS** District XI includes Dade and Monroe counties.

**EXHIBIT v.1**

**DATA AVAILABLE FOR THE COMPARISON OF THE USE OF AND REIMBURSEMENT  
FOR COVERED SERVICES FOR ELDERCARE CLIENTS WITH  
THE CARES DIVERSION SAMPLE**

	<b>In-Program Period</b>	<b>Preprogram Period</b>
<b>Eldercare</b>		
Time Frame	From date of enrollment to the <b>earlier</b> of the date of <b>disenrollment</b> or June 30, 1989	Year prior to the date of enrollment
Data Source	<b>ElderCare hard-copy</b> and <b>MIS</b> claims data plus <b>MMIS pharmacy claims</b> data	<b>MMIS</b> demographics and claims <b>history</b> ; CARES referral source and placement <b>recommenda-</b> <b>tion</b>
Sample Size	156	156
<b>CARES Diversion Sample</b>		
<b>Time</b> Frame	From date of recommenda- tion for community diversion to June <b>30, 1989</b>	Year prior to the date of recommendation for community diversion
Data Source	<b>MMIS</b> claims <b>history</b>	<b>MMIS</b> demographics and claims history; CARES <b>referral source and</b> placement recommendation
Sample Size	<b>816</b>	816

936 beneficiaries identified by CARES plus the 36 Elder-Care clients not included in the CARES list.<sup>3</sup>

Medicaid-covered service use and reimbursements for Elder-Care clients were compared with those of the CARES diversion sample during two time periods. One period is referred to as the "in-program" period in the discussion that follows. For ElderCare clients, the in-program period begins with the date of enrollment in ElderCare and ends with June 30, 1989, or the date of disenrollment if a client disenrolled prior to June 30, 1989.<sup>4</sup> The ElderCare analysis sample included 156 clients who enrolled in the plan between September 1, 1987 and June 30, 1989. An analogous period for the CARES diversion sample was defined as beginning with the date on which the beneficiary was recommended for diversion from nursing-home care to home- and community-based services (referred to by the CARES program as the "staffing date") and ending with June 30, 1989.<sup>5</sup> The CARES diversion sample included 816 Medicaid beneficiaries who were recommended for community diversion between September 1, 1987 and June 30, 1989, inclusive.

The second, earlier period is referred to as the "preprogram" period and is defined as the year prior to the start of the in-program period- Medicaid service use and reimbursement data during the preprogram period, as well as demographic data available from the MMIS claims file and data

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<sup>3</sup>Approximately 156,000 claims were received (4,000 institutional, 51,000 medical, and 101,000 pharmacy). A small number of unpaid claims and claims for CARES clients younger than age 65 were deleted, as were a larger number of claims whose service dates were outside the analysis period for specific sample members, leaving approximately 3,000 institutional, 38,000 medical, and 67,000 pharmacy claims. At least one paid claim was received for each ElderCare client. However, paid claims were received only for 680 of the 816 CARES diversion sample members, even though all 816 had Medicaid identifiers.

<sup>4</sup>June 30, 1989 was chosen as the end of the in-program period to allow six months for the administrative processing of claims and the transmittal of a relatively complete Medicaid claims history for each analysis sample member in January 1990, as required by the evaluation schedule.

<sup>5</sup>For ElderCare clients, the date of enrollment in the plan, which mark the start of the in-program period, was usually within 3 weeks of the date on which they were recommended for community diversion.

from CARES, were compared for the two groups in order to **describe** the degree to which **ElderCare** clients and CARES diversion clients differed prior to the in-program **period**.

Comparisons between the **ElderCare** and CARES diversion **samples** were made along individual-specific variables that capture Medicaid-covered service use and reimbursement during **the** preprogram and in-program periods. The variables for each sample member were constructed by allocating each claim to the preprogram or in-program period based on its start date of se&e; reimbursement and **service** units for claims that spanned the start or end dates of one of the periods were prorated according to the proportion of time during which the claim overlapped with the period. Total use and reimbursements were accumulated by type of **service** for each sample member and divided by the number of months in the period to yield average monthly use and reimbursement per individual. This method adjusted for **sample-member-specific** differences in the length of the in-program period. (For the preprogram period, which was a year in length for all sample members, totals were always divided by twelve. For the in-program period, which varied in length by sample member, the divisor varied.) For two-thirds of the **ElderCare** clients, the number of months in the in-program period was the number of months between their date of enrollment and June **30, 1989**. For one-third of the clients, who disenrolled prior to June 30, the number of months in the in-program period was the number of months in which they were in the plan. For CARES diversion sample members, the number of months in the in-program period was the number of months **between** the dates on which they were recommended for community diversion and June **30, 1989**. It is important to note that data were not available on the **dates** of Medicaid eligibility or the dates of death for the CARES sample. (**These** dates were implicitly contained in the **disenrollment** dates for the **ElderCare** sample) **Thus**, for the CARES sample, the length of the in-program period was likely to be somewhat inflated, and monthly Medicaid

service use and reimbursement during the in-program period are thus understated to the extent that CARES sample members died or lost their Medicaid eligibility prior to June 30.<sup>6</sup>

Our data are **also** limited **because** a diverse set of home-andcommunity-based service options were available to the CARES sample that were not restricted to **Medicaid-covered** services. The **services** chosen by the CARES sample **affected** both their level of service use during the in-program period and the degree to which Medicaid, as opposed to other agencies, was **financially** responsible for those services. Home- and **community-based** service options for the CARES sample included the Medicaid waiver programs-ElderCare, Channeling, and **TEACH-as** well as more limited **Medicaid-covered** services provided as part of the state's Aging Waiver program. A variety of **less** comprehensive service programs were also available, typically with long waiting lists, funded by Aging and Adult Services, county government, and **private** organizations. Clients could also have been referred to **foster** homes, Adult Congregate Living Facilities (**ACLFs**) (**which** require that residents be ambulatory yet need assistance with **activities** of daily living and instrumental activities of daily living), or programs geared toward individuals with mental **illness**. **The** client and his or her family and physician also had the option of declining the recommendation for community diversion and could have chosen nursing-home placement instead **Thus**, the CARES sample had a wide variety of service options available to them during the in-program period. In addition, the extent of Medicare coverage among individual sample members **affected** the degree to which Medicare rather **than** Medicaid paid for **certain services**. Thus, in **reviewing** their service use and reimbursements during that period, the reader must remember that the data for this evaluation capture **only Medicaid-covered** services, and that **services** funded by other programs are not represented

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<sup>6</sup>**The** average length of enrollment for **ElderCare** clients (and thus the average **length** of the in-program period) was 73 months for the sample **overall**; the average length of enrollment for those who **disenrolled** prior to June 30 was 5.5 months. **The** average length of the in-program period for the CARES sample was 12.2 months.



particular staff who members operated the plan, of Mt. Sinai Medical Center as a provider and coordinator of services, or of the Dade County service area.

## B. THE ELDERCARE AND CARES DIVERSION SAMPLES DURING THE PRE-PROGRAM PERIOD

Both **ElderCare** clients and **CARES** diversion sample members were similarly assessed as requiring a nursing-home level of care but as being able to remain in the community with support services. In this section we compare the characteristics along which the two samples may have differed prior to the enrollment of **ElderCare** clients and prior to the community diversion recommendation for the **CARES sample**.<sup>7</sup>

### 1. Medicaid Demographics and Claims History

As indicated in Table V.1, over 50 percent of both the **ElderCare** and **CARES** samples were 81 years old or older, although the **ElderCare** sample was nearly three years younger on average, (a significant difference), with a mean age of **80**, compared with 83 for the **CARES sample**. **Three-**

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<sup>7</sup>As noted earlier, all individuals identified by **CARES** (and **Elder-Care**) for the evaluation had been issued Medicaid identifiers. However, no paid claims were received for 136 (17 percent) of the 816 **CARES** sample members. Operating on the assumption that all were eligible for Medicaid at sometime in the year prior to that date and thus could have had Medicaid-covered services, we set Medicaid service use and reimbursements to zero for each beneficiary with no claims during the period in order to compute the means that appear in Table V.1. **That** 136 of the 816 **CARES** sample were on the Medicaid rolls but had no paid claims in a two-year period on average seems possible but is unlikely given the frailty of the sample. **However**, it was not possible to verify the proportion of **the** evaluation reference periods during which individuals were eligible for Medicaid, since no **eligibility** data were available for the evaluation. An alternative assumption is that, if a sample member had no paid claims in either the pre- or in-program periods, he or she was not actually eligible for Medicaid at any time during those periods (which is also **possible** but not likely to be true in all cases, since each had a Medicaid number). Mean values for the **CARES** sample presented in Table V.1, as well as in-program comparisons presented in Tables V.2 and V3, were recomputed under this assumption. These alternative mean values and statistical tests of comparison with the **ElderCare** sample are presented in Appendix Table A.2 (for the preprogram period) and Appendix Tables A3 and A.4 (for in-program reimbursements and use, **respectively**). The conclusions drawn from the results under the alternative assumption differ very little from the conclusions drawn under the assumption that those with no claims were Medicaid eligible even though **CARES** service use and reimbursement **levels** are higher under the alternative assumption and, as a result, some changes in the statistical significance of **ElderCare/CARES** differences occurred.

TABLE V.1

COMPARISON OF ELDERCARE CLIENTS AND CARES DIVERSION GROUP  
DATA DURING THE PREPROGRAM PERIOD, BASED ON MEDICAID DATA  
(Percentage with Characteristics Unless Otherwise Noted;  
Absolute Sample Size in Parentheses)

	Elder-Care		CARES
<b>Age at Enrollment/Community Diversion Date<sup>a,b</sup></b>			
Mean age (years)	80.4	•	82.8
65-75	23.1 (36)		17.5 (119)
76-80	24.4 (38)		19.6 (133)
81-85	26.9 (42)		25.9 (176)
86 and older	25.6 (40)		37.1 (252)
<b>Sex<sup>a</sup></b>			
Male	26.3 (41)		25.7 (175)
Female	73.7 (115)		743 (505)
Any Medicaid Claims in Preprogram Period	94.2 (147)	*	743 (606)
<b>Average Monthly Reimbursement for Medicaid-Covered Services (\$)</b>			
Total for all services	<b>406</b>	*	<b>292</b>
Inpatient	<b>228</b>		<b>182</b>
Nursing home	9		14
Outpatient/emergency room/ ambulatory surgery	16	•	7
Physician and other practitioner	4		4
Home- and community-based services	<b>50</b>		4
Transportation	17		6
All other types of <b>service<sup>c</sup></b>	83		75

TABLE V.1 (continued)

	ElderCare		CARES
Any Use of Medicaid-Covered Services During the Year			
Inpatient	39.7 (62)		43.9 (358)
Nursing home	<b>4.5 (7)</b>		3.1 (25)
Outpatient/emergency room/ambulatory <b>surgery</b>	<b>46.8 (73)</b>	*	<b>28.4 (232)</b>
Physician and other practitioner	<b>42.3 (66)</b>		48.8 (398)
Home- and community-based <b>services</b>	<b>21.8 (34)</b>	*	4.9 (40)
Transportation	<b>37.2 (58)</b>		31.1 (254)
Average Monthly Utilization of Medicaid-Covered Institutional Services			
Number of inpatient days	<b>.55</b>		<b>.61</b>
Number of nursing-home days	<b>.16</b>		<b>.25</b>
Sample Size	156		816

SOURCE: Data for this table come from the Florida **MMIS** Adjudicated Claims File.

<sup>a</sup>Age and **sex** data were missing for 17 percent of the CARES sample.

<sup>b</sup>The age distributions for **ElderCare** and **CARES** samples were **significantly different** at the 95 percent level of **confidence based** on a **chi-square test**.

<sup>c</sup>**"Other"** includes home health, pharmacy, HMO, laboratory, and X-ray services, durable medical **supplies**, hospice **services**, and claims with no "category or **service"** code entered on the **file**.

<sup>d</sup>**ElderCare/CARES difference** is statistically **significant** at the 95 percent level of **confidence** in a two-tailed **test**.

quarters of each sample were female.<sup>8,9</sup> Table V.1 also shows that 94 percent of the **ElderCare** sample had a paid claim during the preprogram period, while only 74 percent of the CARES sample had a claim during that period. Thus, not surprisingly, **ElderCare** clients had **significantly** higher total monthly Medicaid reimbursements than did their CARES counterparts, at \$406 per month, compared with **\$292** per month for the CARES sample, a **difference** of \$114.” The primary sources of this difference were different reimbursements for outpatient services and **home- and community-based care services**.

However, the use of **Medicaid-covered** institutional services by the **ElderCare** and CARES samples was similar. The **ElderCare** sample had statistically similar levels of inpatient reimbursement (at between \$182 and \$228 per month) and inpatient service use (at between 40 and 44 percent with a stay during the year). Both **ElderCare** and CARES sample members had relatively low nursing-home service reimbursement and **use** during the preprogram period. Nursing-home reimbursements were less than \$15 per month for both groups, and fewer than 5 percent of either group had a nursing-home stay during the preprogram year.

**ElderCare** clients had significantly higher reimbursements for and use of outpatient services and home- and community-based **care**. Medicaid reimbursements for **ElderCare** clients during the

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<sup>8</sup>The racial composition of the two groups appeared to be more or **less similar**: 55 percent of each group were identified as white, less than 4 **percent were** black, and the remainder were Hispanic or “other,” although missing data impaired this comparison. However, the racial composition of the **ElderCare** sample based on **MMIS** data **differed** markedly **from its** composition based on **ElderCare** screening data. The latter **identified** a fifth of the clients as white and **three-fifths** as Hispanic. The **MMIS** identified many of CARES sample members with Spanish surnames as “other” or **“white,”** rather than **Hispanic**, calling the Medicaid coding of race into question

<sup>9</sup>A comparison of the level of Medicare coverage (i.e., no Medicare, Medicare B only, and Medicare A and B) for the **ElderCare** and CARES samples was attempted. However, the fields on the **MMIS** claims **file** that contained **these** data had coding inconsistencies, and attempts at creating the data from Medicare reimbursements for typical Part A and Part B **services** were not fruitful.

<sup>10</sup>When the **CARES** sample was restricted to **those** with at least one paid claim in either the pre- or in-program period, the average monthly reimbursement for all **services for the CARES** sample increased to \$350, and the **ElderCare/CARES** difference dropped to \$56. **This difference** was not significant.

year prior to their enrollment in the plan averaged \$16 and \$50 per month over the year for those services, respectively, while Medicaid reimbursements for the CARES sample averaged only \$7 per month for outpatient services and \$4 per month for home- and community-based care. Part of the difference was due to higher utilization rates among the **ElderCare** sample. **The** receipt of Medicaid-covered home- and community-based services in the preprogram period, particularly the relatively high rate of receipt among **ElderCare** clients, is **noteworthy**: 22 percent of the **ElderCare** sample, compared with 5 percent of the CARES sample, were receiving **waivered services** during the period. Consequently, over a **fifth** of the **ElderCare** sample were familiar with the Medicaid home- and community-based service system prior to their enrollment in **ElderCare**.

## 2. The Characteristics of the CARES Sample

Table V.2 compares data supplied by CARES that **describe** referral sources and placement recommendations for 120 **ElderCare** clients with similar data for the CARES diversion sample. Virtually everyone in both samples was a Dade County resident. **Two-thirds** of the **ElderCare** clients were referred to CARES by **ElderCare, confirming** the assertion of Elder-Care staff that, rather than clients' being referred to **ElderCare** by CARES, most clients first approached Eldercare and were then sent to CARES for the required level-of-care determination. Among the **remaining ElderCare** clients, most were referred to CARES by a DHRS **agency**, hospital, or other **agency**. A small number (8 percent of the 120) were referred by **family** and **friends**, and even fewer (5 percent) were referred **directly** by the **Channeling** and **TEACH** programs. In contrast, most of the **CARES** sample (60 percent) were referred to **CARES** by a DHRS **agency**, hospital, or other agency, with 27 percent by Channeling and **TEACH**, 2 percent by **ElderCare**, and 11 percent by family or friends.

**ElderCare** clients and CARES sample members were **assessed** as **requiring** roughly the same levels of nursing-home care. Among the **ElderCare** clients, the **fewest** (17 percent) required the lowest level of care (**ICF-II**), while 62 percent required the ICF-I level, and 21 percent required

TABLE V.2

COMPARISON OF **ELDERCARE** CLIENTS AND CARES DIVERSION GROUP,  
BASED ON CARES DATA(Percentage with Characteristic Unless **Otherwise Noted**;  
Absolute Sample Size in Parentheses)

	<b>ElderCare</b>	<b>CARES</b>
County of Residence		
Dade	100.0 (120)	99.8 (814)
Other counties	0.0 (0)	<b>0.2</b> (2)
Source of Referral to CARES		
DHRS and other agencies'	183 (22)	543 (443)
Channeling	1.7 (2)	22.2 (181)
Family or friends	<b>8.3 (10)</b>	11.0 (90)
Hospital	1.7 (2)	55 (45)
TEACH	<b>3.3</b> (4)	4.9 ( <b>40</b> )
<b>ElderCare</b>	66.7 (80)	20 (16)
Level of Nursing-Home Care <b>Required<sup>b</sup></b>		
ICF-II	16.7 ( <b>20</b> )	19.7 (161)
ICF-I	62.5 (75)	55.5 (453)
SNF	<b>20.8</b> (25)	24.8 (202)
Placement Recommendation		
Channeling	<b>3.3</b> (4)	553 (450)
TEACH	10.0 (12)	18.1 (148)
<b>Adult</b> congregate living facility or foster home	0.0 (0)	113 (92)
Private home, with <b>services</b>	<b>18.3</b> (22)	10.0 (82)
Private home, no services	0.0 (0)	23 (19)
<b>ElderCare</b>	683 ( <b>82</b> )	2.2 ( <b>18</b> )
<b>Other<sup>c</sup></b>	0.0 (0)	<b>0.8</b> (7)
First Date Recommended for Community <b>Diversion</b>		
September to December 1987	<b>18.3</b> (22)	22.9 ( <b>187</b> )
January to June 1988	22.5 (27)	303 (247)

TABLE V.2 (continued)

	<b>ElderCare</b>	<b>CARES</b>
First Date Recommended for Community Diversion (continued)		
July to December 1988	30.0 (36)	28.2 (230)
January to June 1989	<b>29.2</b> (35)	18.6 (152)
Sample Size	<b>120</b>	816

SOURCE: Data for this table come from a file that identified 936 Medicaid beneficiaries residing in DHRS District XI who were screened by CARES, given a "level-of-care" determination, and recommended for diversion to community-based services between September 1987 and June 1989. The file was prepared by the CARES unit of Aging and Adult Services, Florida Department of Health and Rehabilitative Services. Data were unavailable for 36 ElderCare clients included in the analysis sample.

<sup>a</sup>"DHRS and other agencies" include Aging and Adult Services, Economic Services, other DHRS units, and other state and local agencies.

<sup>b</sup>Nursing-home level-of-care determinations from least skilled to most skilled are ICF-II, ICF-I, and SNF.

"Other" includes adult day health programs and programs for the mentally ill.

skilled care, compared with 20 percent, 55 percent, and **25** percent at each level, respectively, for the CARES sample. Not surprisingly, the placement recommendations for **ElderCare** clients were weighted heavily toward **ElderCare**, with 68 percent receiving a recommendation to the plan. The remainder were recommended to Channeling, TEACH, or some other **service** provider by CARES, but ultimately became **ElderCare** clients. More than half of the CARES sample (55 percent) were referred to Channeling and 18 percent to TEACH. Another 2 percent were recommended to Elder-Care, but did not enroll. An additional 11 percent received recommendations for congregate housing or foster care, and most of the remainder were recommended to other service providers. Two percent received a recommendation that no formal services were required.

The distribution of dates of recommendation for community diversion for the **ElderCare** sample reflects an increase over time that is consistent with the growth of Elder-Care: 41 percent had recommendation dates between September 1987 and June 1988, while 59 percent had dates between July 1988 and June 1989. In contrast, the CARES sample had relatively earlier dates of recommendation for community diversion: 53 percent had dates between September 1987 and June 1988, while 47 percent had dates between July 1988 and June 1989.

### 3. Summary

The **ElderCare** and CARES diversion samples exhibited broadly similar levels of disability, as defined by their need for similar levels of nursing-home care and their subsequent recommendations for community diversion, albeit to **different** programs. **ElderCare** clients were nearly 3 years younger on average than CARES sample members. In **addition, ElderCare** sample members as a group were relatively more familiar with the Medicaid system in general, and the Medicaid-funded home- and community-based service system in particular, **than were** their CARES counterparts. Although all were believed to be Medicaid-eligible at the end of the preprogram period, almost all of the **ElderCare** sample had a record of at least some Medicaid-covered service

use during that period, while only threequarters of the CARES sample had records of such use. Moreover, the **ElderCare** sample showed a markedly higher use of Medicaid-covered home- and community-based services in the year prior to enrollment in Elder-Care than did the CARES diversion sample in the year prior to recommendation for **community** diversion.

However, the levels of inpatient service use for the two groups were close enough to suggest that **ElderCare** clients and CARES sample members may have **suffered from** roughly equivalent levels of acute illness. One could also speculate that because **ElderCare** sample members were more likely to seek out Medicaid-covered home- and community-based services during the pre-program period they may have suffered more frequently from the chronic, disabling conditions that require such care. However, since no data exist to describe the health status and specific disability level of the two groups, these comparisons of health status must remain speculative.

### C. **THE ELDERCARE AND CARES DIVERSION SAMPLES DURING THE IN-PROGRAM PERIOD**

In this section, we compare the use of plan services **by ElderCare** clients and the reimbursement of those services by the plan with the use of and reimbursement for **Medicaid-**covered services by CARES diversion clients in the fee-for-service sector. The purpose of these comparisons is to assess whether the type of case-managed, **capitated** system developed under the Frail Elderly Project and implemented by **ElderCare** proved **to** be less expensive for its clients than **was** the prevailing fee-for-service system for the CARES diversion sample. We also compare the rate of nursing-home use by **ElderCare** clients and the CARES sample, as well as the use of nursing-home **services** for those subsets of **ElderCare** clients and the CARES diversion samples who had a nursing-home stay during the in-program period, so as to gather evidence about whether **ElderCare** delayed nursing-home placement for its **clients**.

## 1. Patterns of Medicaid-Covered Service Use and Reimbursements

Table V.3 compares average monthly reimbursements for specific types of services used by **ElderCare** clients with Medicaid reimbursements for services used by the CARES sample. Because the **capitation** payment received by **ElderCare** was generally thought to be low relative to the **service needs** of a **frail** elderly population and because **ElderCare** managed to keep reported costs within the limits of those payments, it is somewhat surprising that the average monthly reimbursement for all services for the **ElderCare** sample (\$640) was more than double that for the CARES sample (**\$309**), a statistically significant **difference** of \$331.” Before **examining** the **service-specific** sources of this **difference**, we reiterate that this table (and Table V.4) includes the 136 CARES sample members who had no paid claims in the pre- or in-program periods and thus had zero Medicaid reimbursement and **utilization**.<sup>12</sup> (Tables A3 and **A.4** recompute average reimbursements and use excluding the 136 sample members from the CARES sample; Table A.3 shows an average monthly total reimbursement of \$371 for the CARES sample, generating a statistically significant **ElderCare/CARES** difference of \$269.) In **addition**, as noted in **Section V.A**, the length of the in-program period is overstated for the CARES sample because the dates of death or loss of Medicaid eligibility for CARES sample members who died or lost eligibility during the in-program period are missing, and thus monthly averages are understated for the **CARES** sample during the in-program period. As a result, differences between the **ElderCare** and CARES samples that indicate a higher level of **monthly** reimbursement (or monthly service use) for

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“Estimates of **ElderCare** spending in this chapter are based on **individual-specific** paid claims and, as such, will be lower than the estimates that appeared in Chapter IV, which are based on aggregate data that include both paid claims and estimates of outstanding costs.

<sup>12</sup>In addition, average monthly utilization estimates must be interpreted with **caution**, since **service units** on claims appear to be mixed within some types of services. In particular, hours, **days**, and visits all seem to be used to describe home- and community-based care, although hours predominated; items for equipment were **included** with visits **for** home health care on a **small** number of **claims**; days and visits were both used to **describe** outpatient care.

TABLE V3

**AVERAGE MONTHLY REIMBURSEMENT FOR ELDERCARE CLIENTS  
AND THE CARES DIVERSION SAMPLE BY TYPE OF SERVICE  
DURING THE IN-PROGRAM PERIOD**  
(Dollars per Client per Month)

	ElderCare		CARES
Reimbursement for All <b>Services</b>	640	•	309
Inpatient <b>Services</b>	280	•	90
Nursing-Home <b>Services</b>	10	•	83
Outpatient <b>Services<sup>a</sup></b>	3		6
Physicians and Other <b>Practitioners<sup>b</sup></b>	8		3
Home- and Community-Based <b>Services<sup>c</sup></b>	<b>229</b>	*	47
Transportation	31	*	7
Home Health <b>Services<sup>d</sup></b>	9		8
<b>Pharmacy<sup>e</sup></b>	48		<b>54</b>
<b>Other<sup>f</sup></b>	24	*	10
Average Number of Months in Observation Period	73	*	122
Sample Size	<b>156</b>		816

NOTE: For the **ElderCare** sample, data for this table come **from ElderCare** program records of reimbursements to providers and Medicaid Management Information System (**MMIS**) pharmacy records. For the CARES sample, data come **from the MMIS. Ninety-five** percent of the 156 **ElderCare** sample members had at least one **claim** to **ElderCare** during the **in-program** period. Seventy-eight percent of the 816 CARES sample members had at least one paid Medicaid claim during the **in-program** period. Those with no paid claims during the period had their **reimbursements** set to zero.

Individual reimbursement **values** are **formed** by **dividing** the total reimbursement for a sample member over his or her period of **observation** by the total number of months in his/her period of **observation**. For **ElderCare clients**, the period of **observation** begins with the month of **enrollment** in **ElderCare** and ends with the month of termination (or June 1989 for those who had not terminated). For the CARES population, the period of **observation** begins with the date of **recommendation for diversion** to community-based services and ends in June 1989.

**\*ElderCare** outpatient **services include** those **delivered** in an outpatient facility or emergency room. CARES outpatient services **include** those delivered in an outpatient facility, an **ambulatory surgery facility**, or a **community** mental health clinic.

TABLE V3 (continued)

<sup>b</sup>For ElderCare, reimbursement for physician visits includes the amount deducted from the medical director's capitation payment plus reimbursements made by the plan for Medicare deductible and coinsurance claims. The dollar value of the deduction from the medical director's capitation payment was not available on an individual-level basis prior to the establishment of the plan's MIS (July 1988). Thus, physician reimbursements for ElderCare are understated.

<sup>c</sup>For ElderCare, "home- and community-based services" include in-home respite, personal care, home management, adult day health care, and inpatient respite. For CARES, "home- and community-based services" include Medicaid 2176 waiver services, such as chore, homemaker, personal care, respite, case management, adult day health care, health support, and counseling

<sup>d</sup>Home health services include skilled care delivered at home by a nurse, therapist, or medical social worker.

<sup>e</sup>Pharmacy reimbursement for ElderCare includes payment for pharmacy services reimbursed direct@ by ElderCare plus payment for pharmacy services reimbursed by Medicaid and billed later to ElderCare.

<sup>f</sup>For ElderCare, "other" includes laboratory and X-ray and supply and equipment claims. For CARES, "other" includes laboratory and X-ray, supply and equipment, HMO and hospice claims, and claims with no category of service coded on the claim. The ElderCare/CARES difference in "other" service reimbursement was dominated by a difference of reimbursements for supplies and equipment.

- ElderCare/CARES difference is statistically significant at the 95 percent level of confidence in a two-tailed test.

TABLE V.4

SERVICE USE BY ELDERCARE CLIENTS AND THE CARES DIVERSION  
 SAMPLE BY TYPE OF SERVICE DURING THE IN-PROGRAM PERIOD  
 (Absolute Sample Size in Parentheses)

	ElderCare		CARES
Percent with Claims during Period	<b>94.9</b> (148)	*	<b>78.1</b> (637)
<b>Inpatient Services</b>			
Percent with any stay during the period	39.1 (61)	*	25.6 (209)
Number of days per month	1.19	*	030
Number of admissions per month	0.12	*	0.03
<b>Nursing-Home Services</b>			
Percent with any stay during the period	3.2 ( <b>5</b> )	*	11.9 (97)
Number of days per month	0.15	*	1.42
Number of admissions per month	0.01	*	0.05
<b>Outpatient Services<sup>a</sup></b>			
Percent with any use	17.9 (28)	*	<b>25.3</b> (206)
Number of days/visits per month	0.06	*	0.18
<b>Physicians and Other Practitioners<sup>b</sup></b>			
Percent with any use	64.1 (100)	*	25.9 (211)
Number of visits per month	0.67	*	0.09
<b>Home and Community-Based Services<sup>c</sup></b>			
Percent with any use	84.0 (131)	*	17.8 (145)
Number of hours per month	<b>26.80</b>	*	3.99
<b>Transportation</b>			
Percent with any use	71.8 (112)	*	<b>28.7</b> (145)
Number of one-way trips per month	1.72		<b>2.83</b>
<b>Home Health Services<sup>d</sup></b>			
Percent with any use	23.7 (37)	*	<b>3.1</b> (25)
Number of visits per month	<b>0.25</b>	*	<b>0.06</b>

TABLE V.4 (continued)

	ElderCare		CARES
<b>Pharmacy<sup>e</sup></b>			
Percent with any use	84.0 (131)	*	75.6 (617)
Number of prescriptions per month	219	•	273
Average Number of Months in Observation Period	73	•	122
Sample Size	156		816

**NOTE:** For the **ElderCare** sample, data for this table come **from ElderCare** program records of reimbursements to providers and the Medicaid Management Information System (**MMIS**) pharmacy records. For the CARES sample, data come **from** the MMIS. Ninety-five percent of the 156 **ElderCare** sample members had at least one Medicaid claim during the in-program period. Seventy-eight percent of the 816 CARES sample members had at least one paid Medicaid claim during the in-program period. Those with no paid claims had their service use set to zero.

Variables for individual units of service are formed by dividing the total units of **service** for a sample member over his or her period of observation by the total number of months in his/her period of observation. A binary indicator of any service use by type of service was also created. For **ElderCare** clients, the period of observation begins with the month of enrollment in **ElderCare** and ends with the month of termination (or June 1989 for those who have not terminated). For the CARES population, the period of observation begins with the date of recommendation for diversion to community-based **services** and ends in June 1989.

<sup>a</sup>**ElderCare** outpatient **services** include those delivered in an outpatient **facility** or emergency room and use visits as unit of **service**. **CARES** outpatient **services** include those delivered in an outpatient facility, an ambulatory surgery facility, or a community mental **health** clinic. **MMIS** outpatient claims include both days and visits as unit of service.

<sup>b</sup>For Elder-Care, the use of physician **services** includes visits covered under the medical director's capitation payment, as well as visits to outside providers for which the plan received claims for Medicare coinsurance and deductible payments. Unlike reimbursement, use data on individual-level visits covered under the medical director's capitation payment were available prior to July 1988.

<sup>c</sup>**ElderCare** "home- and community-based services" include in-home respite, personal care, home management, and adult day health care. Inpatient respite use is excluded from this table because the unit of **service** (days) was inconsistent with hours used for the **other** services. Elder-Care adult day health care claims used both days and hours as the unit of service, but hours predominated. CARES services include Medicaid 2176 waiver **services**, such as chore, homemaker, **personal** care, respite, case management, **adult day** health care, health support, and **counseling**.

TABLE V.4 (continued)

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<sup>d</sup>**Home** health services include skilled care delivered at home by a nurse, therapist, or medical social worker.

<sup>e</sup>**Pharmacy** use for **ElderCare** comes **from** claims for pharmacy services reimbursed directly by **ElderCare** plus claims for pharmacy services reimbursed by Medicaid and later billed to **ElderCare**.

- ElderCare/CARES **difference** is statistically **significant** at the 95 percent level of **confidence** in a two-tailed test.

**ElderCare** are somewhat overstated, while differences that indicate a lower level for **ElderCare** tend to be understated.<sup>13</sup>

The \$331 difference in total monthly reimbursement between the **ElderCare** and CARES samples is due primarily to large differences between **ElderCare** and CARES reimbursements for inpatient care and home- and community-based services. **ElderCare** reimbursed an average of \$280 per month for inpatient care for its clients while they were enrolled in the plan, while Medicaid reimbursed an average of only \$90 per month for **CARES** sample members, a difference of \$190.” The higher level of inpatient reimbursement for **ElderCare** clients was due at least in part to an increased likelihood of inpatient service use: 39 percent of the **ElderCare** sample, compared with 26 percent of the CARES sample, had a hospital stay during the period. However, the reduction in the likelihood of a hospital stay for the CARES sample from 44 percent in the year covered by the preprogram period to 26 percent in the 12 months (on average) covered by the in-program period (or a reduction in inpatient use for the **CARES** sample from 53 percent to 31 percent, if the sample is restricted to the 680 members with a claim) is suspect given the frailty of the sample, and raises questions about the completeness of the Medicaid data, although no systematic omissions from the Medicaid data were observed.

As in the preprogram period, reimbursement levels for **Medicaid-covered** home- and community-based care also differed considerably between the **ElderCare** and CARES samples: \$229

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<sup>13</sup>In order to estimate the magnitude of the problem posed by the lack of death or eligibility dates for the CARES sample, we recalculated the average monthly reimbursement for all **ElderCare services** using a June 30, 1989 end point for the in-program period for all sample members, simulating the lack of dates for the CARES sample. The result was that the average length of the **ElderCare** observation period increased from 73 months to 9.8 months, and the average monthly reimbursement for all services declined to \$495, or by 23 percent, thus reducing the difference between **ElderCare** and CARES from \$331 to \$186. The smaller difference was still statistically significant.

<sup>14</sup>Recalculating the **ElderCare** average monthly inpatient reimbursement using the June 30 end date for clients who actually disenrolled earlier reduced the **ElderCare** reimbursement to \$182 per month. Excluding from the CARES sample the 136 members with no claims increased monthly inpatient reimbursements to \$108. Both recalculations led to smaller but still sizeable differences between **ElderCare** and CARES inpatient reimbursements.

per month for **ElderCare**, compared with \$47 for **CARES**.<sup>15</sup> The difference in reimbursement levels was due primarily to the higher likelihood that **ElderCare** clients used such services: 84 percent of the **ElderCare** sample received home- and community-based care from the plan, while only 18 percent of the **CARES** sample received Medicaid-covered home- and community-based services. Because all **CARES** sample members were entitled to these services and were assessed as requiring a nursing-home level of care, it is possible that many of them were receiving the services through programs that were not funded by Medicaid and thus not captured by the database available to the evaluation. The relatively higher rate of home- and community-based service use among **ElderCare** clients during the in-program period is also likely to have been affected by their increased access to such services from participating in **ElderCare**, and their higher rate of use of, and thus familiarity with, such services before they were in **ElderCare**.

The higher overall level of reimbursement for **ElderCare** clients relative to **CARES** clients also stemmed from higher reimbursements for a number of other services. They included significantly higher reimbursements for transportation (\$31 per month for **ElderCare** clients, compared with \$7 for **CARES** sample members) and "other" types of services (\$24 for **ElderCare** clients, compared with \$10 for **CARES** sample members) and slightly (nonsignificantly) higher reimbursements for physician and home health services.<sup>16,17</sup>

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<sup>15</sup>Recalculating the **ElderCare** average monthly home- and community-based service reimbursement using the June 30 end date for the period reduced the **ElderCare** reimbursement only to \$209 per month. Excluding from the **CARES** sample the 136 members with no claims increased monthly home- and community-based service reimbursements to \$57. Both recalculations still generated large statistically significant differences between **ElderCare** and **CARES** home and community-based service reimbursements.

<sup>16</sup>The monthly average of \$31 for transportation services used by **ElderCare** clients does not include transportation services provided gratis to the plan by **Mt. Sinai Medical Center**, which averaged approximately 20 round trips per month in the first half of 1989. The higher rate of transportation use by **ElderCare** clients may reflect an increase in use for the purpose of receiving such **ElderCare** services as physician visits or adult day health care, as well as increased access to transportation services in light of the fact that **ElderCare** prior authorization procedures for transportation were probably less bureaucratic than those for Medicaid.

The higher level of reimbursement for inpatient and home- and community-based services for **ElderCare** clients relative to CARES sample members was offset somewhat by **significantly** lower reimbursements for nursing-home services. **ElderCare** reimbursed an average of \$10 per month for nursing-home services, compared with \$83 for CARES sample members, for a statistically **significant** difference of \$73 per month<sup>18</sup>. The difference in reimbursement level was due to a significantly lower level of nursing-home use by **ElderCare** clients: 3 percent of **ElderCare** clients, compared with 12 percent of the CARES sample, had a nursing-home stay during the in-program period. **ElderCare** clients also had **slightly** (but not **significantly**) lower outpatient and **pharmacy** reimbursements than did CARES sample members. (However, the use of outpatient services by the **ElderCare** sample declined from 47 percent during the preprogram period to 3 percent during the in-program period.)

The net result of these differences in reimbursement levels was that **ElderCare** paid more for the services used by their clients than Medicaid paid for a group of beneficiaries in the **fee-for-service** sector who, like **ElderCare** clients, were **assessed** as requiring a nursing-home level of care, but were recommended for diversion to community services. We know nothing about the relative quality of the **services** received nor about the existence of **remaining** unmet needs for services by each group (although both the case study and the client questionnaire suggested that **ElderCare** furnished its full complement of services in sufficient quantity and at a satisfactory level of quality). **Reductions in the use** of nursing-home and outpatient services for **ElderCare** clients were consistent with the goals of the Frail Elderly Project and led to modest reductions in reimbursements for those **services**, but did not **offset** increases for other types of services.

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<sup>17</sup>**ElderCare** clients had higher reimbursements for "other" types of services, which included laboratory and X-ray services and supplies and equipment for both samples and claims for services that were not coded with a service category on the **MMIS** for the CARES **sample**. The difference was dominated by higher spending on supplies and equipment for the **ElderCare** sample.

<sup>18</sup>**Excluding** the 136 CARES sample members with no paid claims **increased** monthly nursing home reimbursements for the CARES sample to \$100 per month, and the **ElderCare/CARES** difference to \$90.

Improved access to care for **ElderCare** clients **from** their participation in a program that coordinated both acute and long-term care **services** is likely to have played some part in the higher levels at which home- and community based services and inpatient care were used by **ElderCare** clients. Two additional factors were likely to have effected the large **difference** between the two groups in the use of home- and community-based care. First, it seems likely that CAFES sample members were **receiving** home- and community-based **services funded** by programs other than Medicaid. Thus, even though such services were not represented by **evaluation** data and were not an expense to Medicaid, they are likely to have occurred and represented an expense to state and local governments, as well as out-of-pocket expenses to sample members and **costs** to private organizations. Second, the familiarity of the **ElderCare clients** with Medicaid-covered home- and community-based care based on their preprogram experience is likely to have increased their use of such services during the in-program period.

Given that **ElderCare** appears to have spent more on providing services to ik clienk than Medicaid spent on the **CARES** sample, an additional question remains about the cost of **ElderCare** services relative to nursing-home care. When the **capitation** payments were recomputed, a month of nursing-home care for a Medicaid beneficiary in Dade County in **1988** was estimated at \$2135 (for those with Medicare A and B), \$2349 (for those with no Medicare), and \$2739 (for those with Medicare B only). Each rate is considerably more than the \$640 per month spent by **ElderCare** (or the \$1,001 per month, noted in Chapter IV, that includes both ouktanding **costs** and paid claims and administrative costs), indicating that **ElderCare services**, if not less expensive than a Medicaid fee-for-service, community-based alternative, were less expensive than what Medicaid typically pays for nursing-home care.

## 2 Patterns of Nursing-Home Use

A significantly lower proportion of **ElderCare clients** had a nursing-home stay during the in-program period than did CARES sample members: 3 percent of the **ElderCare** sample (**5 clients**),

compared with **12** percent of the CAFES sample (97 members), spent at least one day in a nursing home during the in-program **period**. For the **ElderCare** sample, this rate of nursing-home use is equivalent to that of the preprogram period. However, for the CARES sample, the in-program rate increased markedly.<sup>19</sup> As indicated in Table **V.5**, of those spending time in a nursing home during the in-program period, **ElderCare** clients spent fewer days on average: **31 days**, compared with **186** days for CARES sample members. This difference was due in part to the fact that all **ElderCare** clients had relatively short stays (that is, stays of 3 months or less), while nearly **two-thirds** of the CARES sample members with stays stayed 3 months or longer. Moreover, during the in-program period, **ElderCare** clients remained in the community for a longer time before entering a nursing home--on average, 7 months, compared with 3 months for CARES sample members.

Since no data on the relative health of or the availability of informal supports for the **two** groups were available for the evaluation, it was not possible to assess whether the apparent differences in nursing-home use were due to participation in Eldercare or to forces external to the plan. Nor was information available for the CARES sample to indicate whether the recommendation for community diversion was accepted by individual sample members. **Finally**, in interpreting outcomes that **describe** length of stay, the reader must remember that estimates of such outcomes are truncated by the reference period used by the evaluation and are thus likely to be particularly understated for those with relatively longer **stays**. The **effect** here is that CARES sample members may be experiencing even longer stays than are shown by these data. These caveats notwithstanding, the available data suggest that **ElderCare** met its goal of delaying the institutionalization of its clients.

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<sup>19</sup>As a point of reference, in 1985 in the United States, 6 percent of the population age 75 to 84 spent some time in a nursing home, compared **with 22** percent for those 85 and older (U.S. Senate, 1987-88). Among control group members for the National Long Term Care Demonstration (whose average age was **80**), 13 to 14 percent had been in a nursing home at some time during the year following **enrollment**, a level of nursing-home use that was lower than expected given the frailty of the sample (Wooldridge and **Schore, 1988**).

TABLE V.5

**PATTERNS OF NURSING-HOME USE BY ELDERCARE CLIENTS AND THE CARES DIVERSION GROUP DURING THE IN-PROGRAM PERIOD**  
 (Percentage with Characteristics Unless **Otherwise Specified**;  
 Absolute Sample Size in Parentheses)

	<b>ElderCare</b>		<b>CARES</b>
Percent with a Stay of Any <b>Length</b>	<b>3.2 (5)</b>	*	11.9 (97)
Of Those with at Least One Stay, Number of Days in Nursing Home	31		186
Of Those with at Least One Stay, Percent with Total Number of Days?			
1 to 14 days	40.0 (2)		103 (10)
<b>15 to 90 days</b>	60.0 (3)		26.8 (27)
91 days or more	0.0 (0)		629 (63)
Of Those with at Least One Stay, Number of Days between the Start of the In- Program Period and First Nursing Home Admission	223	•	103
Sample Size	156		816

NOTE: For the **ElderCare** sample, data for this table come from **ElderCare** program records for reimbursements to providers. For the CARES sample, data come **from** the **MMIS**.

The distribution of the number of days spent in a **nursing** home for **ElderCare** users and CARES users was **significantly** different at the 95 percent level of **confidence** based on a **chi-square** test.

\***ElderCare/Cares** difference is statistically **significant** at the **95** percent level of confidence in a **two-tailed** test.

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#### D. CONCLUSIONS

As noted earlier, this chapter has presented estimated **differences** in service use and reimbursements between the **ElderCare** and CARES samples in order to **describe** broad **differences in service** delivery patterns between the two groups that **affected** the cost to **ElderCare** of providing its services relative to Medicaid expenditures on the CARES diversion sample. Because differences are likely to have existed between the two groups prior to the in-program period that would have affected their **service** use during the period, differences between the two groups during the in-program period cannot be interpreted as having been caused solely by participation in **ElderCare**. In fact, the analysis of preprogram data indicated that **ElderCare** clients were slightly younger than CARES sample members, and that the two groups exhibited **different** levels of Medicaid-covered service use and, in particular, **different** levels of home- and community-based service use prior to the in-program **period**.

The two groups may also have differed along a number of personal characteristics for which measures were not available to the evaluation: health status, level of disability, the level and stability of informal support systems, personal preferences for the use of health care services, mortality rates, and length of Medicaid eligibility. Each of these factors could have a major effect on the use of plan or Medicaid-covered services (and thus reimbursements) in the in-program period. Furthermore, a variety of service options were available to the CARES sample, some of which were funded by Medicaid (and were thus captured by the data available to the evaluation) and some of which were funded from other sources (and were thus not captured by evaluation data).

Nevertheless, the available data suggest **differing** patterns of service use and **expenses** between the **ElderCare** and CARES samples. An objective of the Frail Elderly Project, as well as the larger Medicaid Competition Demonstration, was to **increase** access to requisite **services** for Medicaid beneficiaries while reducing **unnecessary** service use. **ElderCare** appears to have met this objective

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by reducing nursing-home and outpatient service use, while increasing the use of other **services** for **ElderCare** clients relative to CARES sample members. (In particular, **ElderCare** appears to have increased the use of home- and community-based services and, to a lesser extent, the use of inpatient services.) Due to this increased **service** use, **ElderCare** spent more serving its clients than Medicaid spent on the **CARES** sample.

The **analysis** found that nursing-home use by both the **ElderCare** and **CARES** samples was low, given that they had all been **assessed** as requiring a nursing-home level of care. The low level of use for both groups suggests that the use of home- and community-based care, in combination with a strong commitment by the elderly and their caregivers to stay in the community, may itself reduce nursing-home use. If the health status and informal supports of sample members from the two groups were comparable, one could conclude that **ElderCare** was particularly effective at reducing nursing-home use, as demonstrated by significantly lower rates of use, shorter **nursing-home** stays, and longer delays until nursing home entry relative to CARES sample members. However, we can conclude only that, while **ElderCare** managed to stay within the limitations of the capitation payments, **ElderCare** apparently provided more services to its clients and subsequently spent more on service provision than Medicaid spent on the CARES diversion sample, although its costs were well below the cost of nursing-home care.

## VI. THE ACCESS OF ELDERCARE CLIENTS TO AND THEIR SATISFACTION WITH PLAN SERVICES

The **final** component of the evaluation of the Florida Alternative Health Plan Project is an analysis of the results of a **survey** of plan clients which **addressed** their **access** to and satisfaction with plan services. The purpose of the analysis is to supplement the case study and the utilization and cost analysis by providing information on:

- Clients' reactions to marketing strategies
- Clients' perceptions about barriers to and incentives for **enrollments** and elements of their enrollment decisions
- The **accessibility** of plan se&es
- The level of clients' satisfaction with plan services
- Clients' perceptions about the ability of the plan to delay or prevent institutionalization.

In this chapter, we first discuss the approach taken to develop and administer the client survey. We then present the results of the survey, and discuss the results in the context of the rest of the evaluation.

### A THE DESIGN AND **ADMINISTRATION** OF THE **CLIENT** SURVEY

The purpose of the survey was both to address the objectives of this evaluation component descrii above and to provide plan **staff** with useful feedback about the satisfaction of clients.'

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'In the original statement of work for the evaluation, the approach for addressing the access of clients and caregivers to and their satisfaction with services called for conducting focus groups with plan clients, their caregivers, and nonparticipating **frail** elderly Miami Beach residents and their caregivers. Focus groups composed **in** this way would have enabled us to elicit the opinions of clients and caregivers separately, as well as afford us the opportunity to question nonclients and their caregivers about their access to and satisfaction with **services** not provided by Elder-Care. However, the level of effort allocated to this part of the **evaluation** did not **include** the translation of all focus group proceed@ into Spanish a process necessitated by the high proportion of Spanish-speaking clients who were enrolled in the plan, a fact ultimately brought to light as the  
(continued...)

To further these goals, the evaluation project **director**, a **survey** professional experienced in interviewing the frail elderly, and the **ElderCare** plan director developed the survey jointly. **The** case managers who administered the survey and HCFA **staff** reviewed and suggested changes to the survey instrument before it was administered. The survey instrument contained both English and Spanish versions of all questions to ensure that the questions were asked uniformly **regardless** of the language used by the respondent. Most **questions** had several numerically coded categorical responses for which the interviewer needed only to circle the response given by the client. However, the instrument also contained several open-ended questions (e.g., concerns about **ElderCare** prior to enrolling, and aspects of the introductory plan **description** that would have benefited from further clarification), which were reviewed after all the surveys had been returned to the evaluator and were then coded numerically. Completed **interviews** were transmitted to the evaluator by **ElderCare** along with other program data. (**The** survey instrument appears as Appendix B.)

The decision **to** have the case managers administer the survey was based primarily on the budget constraints of the evaluation. Having the case managers, rather than independent, professional interviewers, administer the survey was not optimal **from** the perspective of obtaining unbiased responses from plan clients, inasmuch as clients may have felt either that case **managers** **expected** particular responses or that their responses would **affect** their service receipt in the future. While there is no way to know the precise degree to which responses were biased because **the survey was administered by the case managers, we** feel confident that reasonable **measures** were taken to **minimize** the effects of such **bias—specifically**, the survey contained an introduction which **informed** clients that the purpose of the survey was to gather opinions, and thus that the **survey** should be viewed as an appropriate vehicle to air complaints about the plan, and the survey

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<sup>1</sup>(...continued)  
design phase of the evaluation **progressed**. In place of focus groups, a client survey administered by the plan's **bilingual** case managers was designed to meet the objectives of this component of the **evaluation**.

questions were worded in as neutral and nonthreatening a manner as possible. Prior to administering the survey, case managers received training in a one-hour session conducted by telephone **with** the survey professional who helped develop the instrument. The training focused on general survey interviewing techniques and instructions **specific** to the survey instrument. The case managers then **carried** out a pretest of the instrument with four clients, after which **they** suggested that additional changes be made to the instrument. During the approximately **10-week period in** which the **survey** was administered, case managers continued to discuss with the evaluation project director the problems **they** encountered in administering the **survey.**<sup>2</sup>

Despite the potential for bias, some benefits accrued to the sun9 effort by having case managers, rather than independent interviewers, approach plan clients. Because the clients were quite old and frail and naturally distrustful of strangers, it **is** likely that interviewers who were not familiar to the clients would have encountered great **difficulty** in persuading clients to talk with them. **By** contrast, clients spoke regularly with case managers (some spoke with their case managers several times a day) and were thus thoroughly **familiar** and comfortable with them. In addition, during the case study **interviews**, case managers **described** clients as quite willing to complain about the plan if **they** were dissatisfied with the services **they received**, suggesting that clients may not have been as disinclined as might be assumed to discuss the negative aspects of the plan with the case managers during the survey.

**The** sampling frame for the sun9 was the 112 clients who comprised the June **1989** plan roster. The June 1989 roster contained clients who were enrolled in the plan during that month, but excluded 44 clients who had died or disenrolled between September 1987 and May **1989**. An attempt was made to interview all 112 clients (or their proxies) during July and August **1989**. Clients were contacted in alphabetical order and interviewed either in person while waiting for a

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<sup>2</sup>The primary problem reported by **the** case managers was **the** length of time it took to administer the **interview**, given the tendency of clients to **digress from particular questions**. **This** problem was **addressed** by devising tactful strategies for **diverting** additional **conversation** until the end of the interview.

doctor's appointment at the Mt. Sinai clinic or by telephone. Table **VL1** summarizes the **survey** response rates and the types of responses made. Of those 112 June-roster clients, **interviews** were completed with 67 clients (or 60 percent of the sampling **frame**). **Interviews** were not completed for the following reasons: **mental confusion**, death, nursing-home placement, and **disenrollment** for other reasons (for 23 percent of the sampling **frame**), and time **constraints** in the survey analysis schedule (for 17 percent of the sampling **frame**).

Half of all the surveys were completed **entirely** by clients. Another 6 percent were completed by a combination of clients and caregivers, while the **remainder** (44 percent) were completed entirely by caregivers. Thus, responses **will reflect** the perceptions of **caregivers** nearly as often as they **reflect** the perceptions of clients. Most interviews (87 percent) were administered by telephone; the remainder were administered in person. Just under 7 **percent** of the interviews were completed despite some **difficulties** in communicating with the **respondent**.

Due both to the exclusion of 44 clients who **left** the plan prior to June 1989 and the noncompletion of surveys for another 45 clients, the respondent sample potentially was not entirely representative of the larger group of 156 **ElderCare** clients enrolled in the plan between September **1987** and June 1989. In order to assess the **representativeness** of the **survey** sample, we compared the characteristics of the sample who completed **interviews** with those of the remainder of the clients, as available on the **ElderCare** screening form used for **assessing** clients at enrollment. Screening data were available for 66 of the 67 **survey** respondents and **for** 84 of the 89 remaining clients. We carried out simple comparisons of means and **chi-square** tests in order to determine whether survey respondents **differed significantly** from other clients **included** in the evaluation in terms of the **characteristics** recorded on the **screening form**: demographics, physical and mental impairment, and existing social resources.

Table VL2 **compares** survey respondents with other clients. **The statistical** tests of comparison revealed that **survey** respondents **were** similar to the other clients in terms of all **characteristics**

TABLE VL1  
RESPONSE RATES AND RESPONSE TYPES

	Number	Percentage
June 1989 <b>Roster</b> <sup>a</sup>	112	100.0
<b>Interviews</b> Completed <sup>c</sup>	67	59.8
<b>Interview</b> Respondent <b>Types</b> <sup>b</sup>		
All clients	33	50.0
All <b>proxies</b>	29	43.9
Combination	4	6.1
<b>Interview</b> Mode <b>Types</b> <sup>b</sup>		
Telephone	54	87.1
In-person	8	12.9
Respondents Who Had <b>Difficulty</b> <b>Communicating</b> , but Who Completed an <b>Interview</b> <sup>b</sup>	4	6.6
Nonsurveyed Clients in <b>Roster</b> and <b>Survey</b> Nonrespondents		
Number not responding due to mental confusion, death, nursing-home replacement, or other <b>reasons</b> <sup>a</sup>	26	23.2
Number not surveyed due to survey schedule <b>constraints</b> <sup>a</sup>	19	17.0

<sup>a</sup> Percentages are the percentage of the June 1989 roster.

<sup>b</sup> Percentages are the percentage of completed interviews with **nonmissing responses**. **Response type** was missing on 1 questionnaire, **interview** mode was missing on 5 questionnaires; and **difficulty** communicating was missing on 6 questionnaires.

TABLE VL2

**COMPARISON OF QUESTIONNAIRE RESPONDENTS WITH  
ALL ELDERCARE CLIENTS**

(Percentage with Characteristic Unless Otherwise Noted;  
Absolute Sample Size in Parentheses)

	Questionnaire Respondents		All Other ElderCare Clients	
<b>Age</b>				
<b>Mean</b> age (years)	80.4		80.6	
Age distribution:				
65-75	27.3	(18)	19.0	(16)
76-80	19.7	(13)	27.4	(23)
81-85	<b>22.7</b>	(15)	32.1	(27)
86 and older	30.3	(20)	21.4	(18)
<b>Sex</b>				
<b>Male</b>	27.3	(18)	23.8	(20)
Female	72.7	(48)	76.2	(64)
<b>Race/Ethnicity</b>				
White	26.6	(17)	<b>18.9</b>	(14)
Black	7.8	(5)	5.4	(4)
Cuban	43.7	(28)	48.6	(36)
Haitian	0.0	(0)	2.7	(2)
Other Hispanic	10.9	(7)	<b>13.5</b>	(10)
Other	10.9	(7)	10.8	(8)
<b>Marital Status</b>				
Married	39.1	(25)	26.6	(21)
Widowed	50.0	(32)	<b>58.2</b>	(46)
Divorced	6.2	(4)	6.3	(5)
Other	4.7	(3)	8.9	(7)
<b>Living Arrangement</b>				
Lives alone	28.6	(18)	<b>31.3</b>	(25)
<b>Lives</b> with spouse	25.4	(16)	<b>22.5</b>	(18)
<b>Lives</b> with others	46.0	(29)	<b>46.2</b>	(37)
<b>Current Residence</b>				
Private home	100.0	(63)	<b>97.5</b>	(78)
Boarding home	0.0	(0)	<b>2.5</b>	(2)

TABLE VL2 (continued)

	Questionnaire Respondents		All Other ElderCare Clients	
Unable to Perform Following Activity without Help:				
Do housework	100.0	(66)	98.8	(80)
Do laundry	100.0	(65)	98.7	(78)
Shop	100.0	(64)	97.5	(79)
Prepare own meals	98.4	(63)	96.2	(76)
Get to places beyond walking distance	96.9	(62)	96.2	(76)
Walk outside	95.3	(61)	93.7	(74)
Use stairs	93.8	(61)	93.3	(70)
Bathe	80.0	(52)	57.2	(68)
Dress/undress	67.2	(43)	72.7	(56)
Handle money	65.2	(43)	63.6	(49)
Take medicine	58.1	(36)	62.8	(49)
Take care of personal appearance	52.3	(34)	61.3	(46)
Use telephone	48.4	(31)	55.7	(44)
Eat	34.9	(22)	40.8	(31)
Sometimes or Usually Unable to Get to Bathroom in Time	29.8	(14)	44.8	(26)
Vision (with Glasses) Is Poor or Blind	39.6	(19)	39.7	(27)
Hearing (with Aid) Is Poor or Deaf	22.0	(13)	28.8	(23)
Speech Poor or Nonexistent	11.9	(7)	19.8	(16)
Walks poorly or Is Bedbound	49.2	(29)	39.5	(30)
Uses the Following Medical Devices:				
Wheel chair	33.3	(22)	40.5	(34)
Walker	31.8	(21)	32.1	(27)
Cane	24.2	(16)	28.6	(24)
Oxygen	13.6	(9)	7.1	(6)
Lift	9.1	(6)	2.4	(2)
Catheter	4.5	(3)	5.0	(5)
Colostomy equipment	1.5	(1)	1.2	(1)
Artificial limb	0.0	(0)	1.2	(1)
Other	18.2	(12)	23.8	(20)
Number of Hospital Stays in Last Year				
0	41.0	(16)	30.8	(16)
1	35.9	(14)	42.3	(22)
2 or 3	23.1	(9)	23.1	(12)
4 or more	0.0	(0)	3.8	(2)

TABLE VI.2 (continued)

	Questionnaire Respondents		All Other ElderCare Clients	
Number of Nursing Home Stays in Last Year				
0	95.0	(38)	89.1	(49)
1	5.0	(12)	7.3	(4)
2 or more	0.0	(0)	3.6	(2)
Number of Visits to the Doctor in the Last Year				
0	5.6	(2)	3.9	(2)
1 to 6	27.8	(10)	33.3	(17)
7 to 12	50.0	(18)	41.2	(21)
13 or more	16.7	(6)	21.6	(11)
Intellectual Functioning				
Sometimes or often appears <b>confused</b>	34.0	(18)	54.1	(40)
Sometimes or <b>almost</b> never is willing to do things when asked	17.0	(9)	27.5	(19)
Age given is more than 5 years off	18.4	(9)	25.4	(17)
Sometimes or almost never reacts to own name	10.7	(6)	10.8	(8)
Health Insurance				
Medicaid only	13.6	(9)	9.5	(8)
Medicaid and Medicare B	36.4	(24)	47.6	(40)
Medicaid and Medicare A and B	50.0	(33)	42.9	(36)
Some private insurance	6.2	(4)	4.8	(4)
support <b>Services</b>				
Is receiving help from <b>family</b> and <b>friends</b> only	48.5	(32)	48.8	(41)
Is receiving help from agency <b>only</b>	21.2	(14)	16.7	(14)
Is receiving help <b>from</b> family, friends, and agency	13.6	(9)	13.1	(11)
Is receiving help <b>from</b> neither	16.7	(11)	21.4	(18)
Has a Problem with Transportation	87.9	(58)	85.7	(72)
Sample <b>Size</b> <sup>a</sup>	66		84	

SOURCE Age, sex, and Medicare coverage come from the ElderCare MIS. Other data for this table come from the Mt. Sinai ElderCare Plan Screening Questionnaire.

NOTE: The characteristics of questionnaire respondents were compared with all other ElderCare clients using simple comparison of means (t-tests) and chi-square tests.

TABLE VL2 (continued)

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The total number of survey respondents who also had screening questionnaires was **66**; the total number of analysis sample members who completed screening questionnaires, but not satisfaction questionnaires, was 84. However, item **nonresponse** led to **smaller** sample sizes for **specific** table entries. See Appendix Table **A.2** for the degree of item **nonresponse** for each table entry.

\*Respondent/other client differences statistically **significant** at the 95 percent level of **confidence using** a two-tailed test.

except one: the level of mental confusion (34 percent of **survey** respondents, compared with **54** percent of other clients, were **described** by case managers as sometimes or often confused during the enrollment assessment). This difference in mental impairment is not surprising, since case managers **did** not attempt to interview the most confused clients. Although only 43 percent of the 156 clients included in the evaluation were represented in the survey, those represented and those excluded could be viewed as essentially similar along demographic **characteristics**, level of disability (other than mental confusion), social resources, and other characteristics.

## B. FACTORS THAT AFFECTED ENROLLMENT DECISIONS

The effectiveness of marketing strategies and incentives for and barriers to enrollment were two **key evaluation issues addressed in the client survey**. Table VL3 summarizes responses to survey questions designed to address these **issues**.<sup>3</sup> Clients were likely to have learned about **ElderCare** from a number of sources. **Most** respondents had learned about **ElderCare** through another organization: 41 percent had been referred to **ElderCare** by health professionals (such as hospital discharge planners), and 39 percent by some other program.<sup>7</sup> Among the other program referral sources were Mt. Sinai's Medicaid Prepaid Health Plan, from which some of the earlier **ElderCare** clients had come, and TEACH, one of the other two Medicaid home- and **community-based** waiver programs in the county, **from** which a substantial number of clients were referred in March 1989 and again in July 1989. Referrals among **ElderCare**, Channeling, and **TEACH** appear

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<sup>3</sup>Although 67 clients completed surveys, some clients failed to respond to particular questions. Table A.6 contains information on the degree of item **nonresponse** for each entry in Table VL3. Table A.7 contains item **nonresponse information** for each **entry** in Table VL4. **The** level of item nonresponse for these two tables (**excluding** those who did not respond to questions due to the logical flow of the **instrument**) **was** generally under **5 percent**.

<sup>7</sup>During the pretest, case managers found that reading the list of **possible** plan referral sources to clients was **terribly** time-consuming, because the naming of potential sources prompted many clients to talk at length about each. Case managers also said that for the most part **they** knew how each client had heard about the plan. **Consequently**, to ease the burden of interview administration on **the** case managers, the case manager was permitted to **fill** in the referral **source(s) used by clients if she knew it; otherwise, the case manager read the client the full list of** potential sources.

TABLE VI3

FACI'ORS AFFECI'ING ENROILMENT DECISIONS  
(Absolute Sample Size in Parentheses)

	Percentage with Response	
Source of Knowledge about <b>Eldercare</b> <sup>a</sup>		
Friend or relative ( <b>ElderCare</b> member)	7.6	(5)
Friend or relative (nonmember)	13.6	(9)
Doctor	4.7	(3)
Nurse, social worker, or someone else at a hospital	41.3	(26)
Another program or agency	38.5	(25)
Media:		
Newspaper	3.1	(2)
Magazine	1.5	(1)
Radio	3.1	(2)
Television	<b>21.5</b>	(14)
Discussion with Others		
Friends encouraged	61.2	(41)
Friends discouraged	1.5	(1)
Friends had no opinion	7.5	(5)
Did not discuss with friends	29.9	(20)
Doctor or other medical <b>person</b> encouraged	27.3	(18)
Doctor or other medical person discouraged	1.5	(1)
Doctor or other medical person had no opinion	4.5	(3)
Did not discuss with doctor	66.7	(44)
Decision to Join Elder-Care		
Client decided alone	<b>30.8</b>	(20)
Client decided with family	<b>41.5</b>	(27)
Client did not participate in the decision	<b>27.7</b>	(18)
Benefits as Enrollment Incentives		
The following were important in deciding to join <b>ElderCare</b> <sup>a</sup>		
Payment for prescription drugs	84.6	(55)
Help with housekeeping or personal care	90.8	(59)
Assistance from a case manager	<b>72.3</b>	(47)
Provision of adult day care	57.8	(37)
Provision of caregiver respite	61.5	(40)
Escort to medical appointments	73.9	(48)
Concerns Prior to Enrolling		
None	54.4	(31)
Dubious about HMO <b>status/different</b> color Medicaid <b>card</b>	<b>8.8</b>	(5)
Changing physicians/getting referred to <b>specialists</b>	<b>10.5</b>	(6)
General concern about quality of care/other concerns	<b>26.3</b>	(15)

TABLE VI.3 (continued)

	Percentage with Response	
Potential Barriers to Enrollment and Later Satisfaction		
Plan description provided by Elder-Care <b>staff</b> :		
Easy to understand	86.4	(57)
<b>Difficult</b> to understand	1.5	(1)
Undecided or do not recall description	12.1	(8)
Clarification to plan description		
No clarification needed	84.0	(42)
Some <b>clarification needed</b> <sup>b</sup>	16.0	(8)
Aware of Need to Receive Covered Services <b>from</b> Providers <b>Affiliated</b> with <b>ElderCare</b> ?		
Yes	77.6	(52)
No	22.4	(15)
Difficulty in Obtaining or Completing Application Materials?		
Yes	4.6	(3)
No	95.4	(63)
<b>Sample Size</b> <sup>c</sup>	67	

SOURCE: Data for this table come from the client satisfaction questionnaire.

<sup>a</sup>**Because** multiple responses were permitted, percentages for this grouping may sum to more than 100 percent.

<sup>b</sup>**Seven** respondents gave **specific examples** of issues that they felt required **clarification**. These issues included the precise nature of the benefits covered and the need to change to plan physicians.

<sup>c</sup>**The** total number of survey respondents was 67. However, item **nonresponse** led to smaller sample sizes for specific table entries. See Appendix Table A6 for the degree of item **nonresponse** for each table entry.

to have been a routine occurrence when program operators believed that an applicant was ineligible for their program or might better be served by one of the other programs.

In addition to making itself known to formal service providers in the community, **ElderCare** used a variety of media to attract new clients. By far the most effective seems to have been its television coverage: 21 percent-or 14 respondents-reported **that** they had heard about Elder-Care on television, compared with 3 percent or fewer who reported that they had heard about it on the radio or read about it in newspapers or magazines. The reported effectiveness of the television spots on a local Spanish-language station by survey respondents was consistent with the perceptions of plan staff as reported during the case study interviews. Word-of-mouth recommendations by family and friends were cited by just over **20** percent of respondents as one of their sources of knowledge about **ElderCare**, while referrals **from** physicians were noted relatively less often as sources of knowledge about **ElderCare**, cited only by 5 percent of the sample. As is evident from Table VI.3, some respondents learned about **ElderCare from** several **sources**.

Although only approximately a **fifth** of the respondents reported that they had initially heard about **ElderCare from** a **friend** or relative, most respondents (70 percent) **discussed** the decision to enroll in **ElderCare** with a friend prior to joining, and **nearly** 90 percent of those friends encouraged them to join the plan. In contrast, only 33 percent of the respondents discussed the decision to enroll with their physicians or other medical professionals. **However**, of those who did discuss the decision with a medical professional, most were encouraged to join. Joining **ElderCare** was ultimately either a joint decision between the client and his or her family (for 42 percent of the respondents) or was a decision made solely by the client (for 31 percent of the respondents). Twenty-eight percent of the respondents indicated that the client was excluded **from** this decision making process, which is consistent with the fact that roughly a third of the clients included among survey respondents were **described** at enrollment as sometimes or often confused.

The survey then asked which of the expanded benefits covered by the plan were particularly important in the decision to enroll in **ElderCare**. The expanded benefits named in the marketing literature were prescription drugs unrestricted by the regular Medicaid cap, home care, case management, adult day care, caregiver respite, and escort service. Each of these services was rated as important by at least half of the respondents. Home care was the most popular enrollment incentive, rated **as** important by **91** percent of the sample; unlimited prescription drugs were deemed important by **85** percent, and case management and **escort** to medical appointments were each deemed important by just under threequarters of all respondents. The availability of adult day care and caregiver respite were cited as important relatively less often.

The survey attempted to identify **perceived** barriers to enrollment in the outreach and intake processes, as well as reservations that **existed** in the minds of clients prior to enrolling. Just over half of the respondents reported that they had no concerns prior to enrolling, possibly because respondents in general had prior direct experience with Mt. Sinai Medical Center or were generally familiar with **Mt. Sinai's** reputation. **In** addition, as with **all** interview responses **discussed** here, respondents include only those clients who succeeded in enrolling in the program and had not subsequently disenrolled, while omitting those who had found enrollment barriers **insurmountable** (and those who were dissatisfied with the plan and **disenrolled** prior to June **1989**). That is, those with serious concerns prior to enrolling may never have completed the **enrollment** process.

A quarter of the respondents had general concerns about the quality of care that they might receive. A tenth-6 respondents-had concerns about having to change physicians or their ability to receive referrals from **ElderCare staff** to **specialists** outside the **plan**. Similarly, only 9 percent were worried about joining a prepaid health plan (**PPHP**) per se, or about the requirement that they replace their white Medicaid card with a blue Medicaid PPHP card. The last **finding** stands in contrast to the initial perceptions of plan staff that the change in card color was a serious concern of clients and potential clients, due both to their distrust of **HMOs** in south **Florida** and

to reported difficulties with providers (particularly pharmacists) who did not understand **ElderCare** reimbursement policy. To address their concerns, plan staff made an effort to inform community providers of their reimbursement policy, and thus the issue of card color declined in importance over time. The result of these efforts by **ElderCare** staff may be reflected in the relative **lack** of concern about the card color by survey **respondents**.<sup>5</sup>

Respondents found that the introductory description of the plan by the case managers was **easy** to understand. Only 2 percent-1 respondent-reported **difficulty** in understanding the explanation; another 12 percent did not remember the description or had no opinion of it. Seven respondents (16 percent) said that certain aspects of the plan could have been made clearer in this description, including a more detailed description of the **specific** services provided and the requirement about the change in physicians. Indeed, approximately a quarter of respondents **reported** that they were unaware of the requirement that covered services **could** be received only **from** providers **affiliated** with **ElderCare**. Finally, **virtually** all respondents (95 percent) reported no **difficulty** in either obtaining or completing application materials.

### C. SATISFACTION **WITH PLAN SERVICE**!3

The satisfaction of clients and their informal caregivers with plan services ultimately **affects** their willingness to stay with the plan, and thus directly **affects** the viability of the plan. **Interviews with** plan staff indicated their beliefs that clients and caregivers **were** very satisfied with **ElderCare**, and that **ElderCare** was meeting its goal of delaying institutional placement. The client survey allowed us to question clients and caregivers **directly** about these issues. For the most part, the **results** of the **survey** agreed with the perceptions of staff

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<sup>5</sup>A concern of potential applicants to the national **S/HMO** Demonstration and one cited by its **evaluators** as an impediment to meeting initial enrollment goals was the demonstration status of the plans, a piece of information which plans were **required** to **include** in their marketing literature. No such requirement was in **effect** for **ElderCare**.

Table VL4 summarizes responses to a series of questions about the satisfaction of **clients** with medical care, services delivered in the home, and transportation services provided by ElderCare. As noted in Chapter III, ElderCare began to offer off-site physicians the opportunity to serve ElderCare clients in response to the number of clients who were **disenrolling** to return to their former primary care physicians. Elder-Care **also** added a Spanish-speaking physician to its on-site staff. At the time the survey was administered, approximately a quarter of the respondents reported seeing off-site primary care physicians. Access to physician **services** appeared to be good: respondents were able to schedule appointments for nonemergency care in just under 3 **days**,<sup>6</sup> over 90 percent stated that the appointment times they were given were convenient, and the average time spent in the waiting room when at an appointment was reported to be approximately 20 minutes. Satisfaction with the **quality** of care received was also **high**: approximately 90 percent rated the professional competence and the communication skills of their physicians as good or excellent. Of the approximately **two-thirds** of the respondent sample who had a referral to a specialist, roughly 85 percent assessed the ability of their primary care physicians to make referrals as good or **excellent**.<sup>7</sup> None of the respondents rated the quality of physician care as poor. Of the 59 respondents who reported that they had a primary care physician or regular practice setting where they went for health care prior to enrolling in **ElderCare**, three-quarters felt that their care in Elder-Care was better than it had been, and another fifth rated their care as about the same.

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<sup>6</sup>When those with regularly prescheduled appointments were designated as **scheduling** appointments with no delay, the average number of days required to scheduled a nonemergency appointment was 2.

<sup>7</sup>Although the wording of this question did not allow us to assess **precisely** the **willingness** of physicians to make referrals, the fact that the majority of respondents indicated **that they** were satisfied with the ability of their physicians to make referrals was encouraging, since the financial incentives for **ElderCare**, and **PPHPs** in general, run counter to making referrals outside of the plan.

TABLE VL4

**FACTORS AFFECTING ENROLLMENT DECISIONS**  
(Absolute Sample Size in Parentheses)

	Percentage with Response	
<b>Physician Services</b>		
Location of Primary Care Physician		
Mt. Sinai	76.1	(51)
Elsewhere	23.9	(16)
<b>Timeliness</b> of Appointments		
Number of days wait for appointment'	27	
Percentage responding that appointment times <b>were</b> convenient	<b>92.3</b>	<b>(60)</b>
Number of minutes wait for appointment in waiting <b>room<sup>a</sup></b>	21.1	
Rating of Physician's Professional Competence		
Excellent	<b>59.1</b>	<b>(39)</b>
<b>Good</b>	33.3	<b>(22)</b>
Fair	7.6	<b>(5)</b>
Poor	0.0	<b>(0)</b>
Rating of Physician's Ability To Communicate		
Excellent	63.6	<b>(42)</b>
<b>Good</b>	28.8	<b>(19)</b>
Fair	7.6	<b>(5)</b>
Poor	0.0	<b>(0)</b>
Rating of Ability to Get Referrals To <b>Specialists</b>		
Excellent	47.8	<b>(32)</b>
<b>Good</b>	16.4	<b>(11)</b>
Fair	7.5	<b>(5)</b>
Poor	0.0	<b>(0)</b>
Never had a referral	<b>28.4</b>	<b>(19)</b>
Of Those with a Primary Care Physician Prior to <b>Enrollment</b> , Comparison of Care <b>from ElderCare</b> with Prior Care		
<b>ElderCare</b> better	75.0	<b>(42)</b>
<b>ElderCare</b> about the same	19.6	<b>(11)</b>
<b>ElderCare</b> worse	5.4	<b>(3)</b>
<b>Inpatient Hospital Services</b>		
Percentage Using <b>Services</b> as Plan Client	<b>44.8</b>	<b>(30)</b>
Location of Stay (for those with a stay)		
Mt. Sinai only	73.3	<b>(22)</b>
Other facility	26.7	<b>(8)</b>

TABLE VL4 (continued)

	Percentage with Response	
<b>Inpatient Hospital Services</b> (continued)		
Rating of <b>Overall</b> Quality of Inpatient Stay (for Those with a Stay)		
Excellent	31.0	(9)
<b>Good</b>	<b>65.5</b>	<b>(19)</b>
Fair	3.5	(1)
Poor	0.0	(0)
<b>Home-Based Services</b>		
Percentage Using Home Care	94.0	(63)
Rating of the Reliability of Home Care Workers (for Those Using Home Care)		
Excellent	45.9	(28)
<b>Good</b>	45.9	<b>(28)</b>
Fair	6.6	(4)
Poor	1.6	(1)
Rating of <b>Overall</b> Quality of Home Care (for <b>Those</b> Using Home Care)		
Excellent	<b>48.4</b>	<b>(30)</b>
<b>Good</b>	<b>48.4</b>	<b>(30)</b>
Fair	1.6	(1)
Poor	1.6	(1)
Ability of <b>ElderCare</b> to Change Home Care, if Requested (for <b>Those</b> Using Home Care)		
<b>Easy</b>	<b>100.0</b>	<b>(63)</b>
<b>Difficult</b>	0.0	(0)
Transportation		
Percentage Using Transportation	91.0	(61)
Rating of Reliability of <b>Transportation</b> (for <b>Those</b> Using Transportation)		
Excellent	<b>32.8</b>	<b>(20)</b>
<b>Good</b>	57.4	<b>(35)</b>
Fair	8.2	(5)
Poor	1.6	(1)
Ability of <b>ElderCare</b> to Change Transportation, if Requested (for Those Using Transportation)		
<b>Easy</b>	100.0	<b>(61)</b>
<b>Difficult</b>	<b>0.0</b>	<b>(0)</b>
Change to <b>Prepaid Health Plan Medicaid Card</b>		
Percentage Reporting Some <b>Difficulty</b> with New <b>Card</b> <sup>b</sup>	13.4	(9)

TABLE VL4 (continued)

	Percentage with Response	
<b>Most Valuable Service Provided by ElderCare<sup>c</sup></b>		
<b>All Services/Coordination</b> and General <b>Responsiveness</b> of Case Managers and the Plan	55.4	(36)
Personal Care and Housekeeping	33.9	(22)
Doctors	9.2	(6)
Transportation	<b>9.2</b>	<b>(6)</b>
Prescription Drugs/Supplies	<b>9.2</b>	<b>(6)</b>
Other <b>Specific</b> Services	3.1	(2)
Delay of <b>Institutionalization</b>		
Percentage Who Thought <b>ElderCare Can Keep People</b> out of Nursing Homes	86.6	(58)
Percentage Who 'Thought <b>ElderCare Kept Respondents</b> Out of Nursing Home	<b>98.3</b>	<b>(56)</b>
<b>Sample Size<sup>d</sup></b>	67	

**SOURCE:** Data for this table come from the client satisfaction questionnaire.

<sup>a</sup>The average days wait was calculated excluding 16 respondents with **prescheduled appointments**; the maximum number of days wait for an appointment was 7. The maximum time reportedly spent waiting in the waiting room to see the doctor was **100** minutes. However, 95 percent of the sample reported waiting 30 minutes or **less**.

<sup>b</sup>**Nine** respondents reported **difficulties** using the plan Medicaid card, including **difficulty** in purchasing medicine and problems with physician payments.

<sup>c</sup>**Multiple** responses were coded when more than one **specific** aspect of the plan was referred to **as** most valuable. Thus, responses to this question sum to more than 100 percent

<sup>d</sup>**The** total number of survey respondents was 67. **However, item nonresponse** led to smaller sample sizes for specific table entries. See Appendix Table **A.7** for the degree of item **nonresponse** for each question.

Only **5** percent-3 respondents-perceived that their care **from ElderCare** was not as good as it had **been.**<sup>8</sup>

**Forty-five** percent of the respondent sample reported having had an inpatient stay since joining the plan. Approximately **three-quarters** of those with a stay (or stays) had that stay exclusively at Mt. Sinai Medical Center. Over 95 percent of **those** with a stay at any location assessed the quality of their hospital care as good or excellent. ‘This assessment did not differ between those who received all of their inpatient care at Mt. Sinai and those who did not.

Almost all of the respondents (94 percent) reported receiving some home care, such as personal care, housekeeping, or escort services, while in **ElderCare. ElderCare staff** cited home care as a particularly important source of care for plan **clients**, a point that was corroborated by the utilization data presented in the previous chapters. Home care is a **difficult** service to monitor because it is delivered outside the direct purview of plan **staff**. However, case managers frequently discussed home care receipt with clients and informal caregivers either at the case manager’s or the client’s initiative. In some parts of the United States, the quality of home care (that is, the reliability and skill level of home care workers) is inadequate. The case study reported that the quality of home care is not an issue in South Florida because an adequate supply of trained, bilingual home care workers exists, although a shortage of nurses in the area was noted. Respondents who received home care seemed quite **satisfied** with **those** services: over 90 percent rated both the reliability and the quality of the care as good or excellent. (However, unlike physician and hospital services, one person rated their home care as poor.) All reported that it was easy to contact **ElderCare** and make changes to their home care arrangements if necessary.

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<sup>8</sup>**Responses** about the quality of and **access** to physician **services were disaggregated according** to whether the respondent saw an **on-site** or off-site **physician**. In general, relative to their on-site counterparts, the 16 respondents who saw off-site physicians **were** somewhat **more** likely to rate the quality of their care as excellent versus good. **However**, off-site clients also reported slightly, though not **significantly**, longer wait times for appointments (2.2 days versus 2.0 days) and slightly longer delays in the waiting room (24 minutes compared with 20 minutes).

Over 90 percent of the sample of respondents used transportation services. Staff noted that transportation was a particularly difficult service to arrange and monitor, due both to the large size of Dade County and to the poorly developed private taxi system in the area. Transportation providers included a number of regular taxi services and medical transport companies, as well as Mt. Sinai Medical Center. However, 90 percent of those who used transportation assessed the reliability of transportation services as good or excellent, and only one person assessed them as poor. Again, all users said that it was easy to make changes to their transportation arrangements through ElderCare if they needed to do so.

As noted in Section VLB, staff were concerned that the card-color change requirement gave clients both a disincentive to enroll and later an incentive to disenroll if they encountered any difficulties in using the blue card. Only 9 respondents (or 13 percent) reported any difficulty in using their cards. (By necessity, this figure excludes clients, if any, who disenrolled prior to the survey because of difficulties they experienced in using the card.)

Finally, clients were asked to name the one service provided by ElderCare that they liked best and to judge whether ElderCare had been successful at keeping them out of nursing homes. Respondents were asked to name "one thing you liked best about the ElderCare program," with responses recorded in an open-ended fashion. However, many respondents listed a number of services that they felt were valuable, and the enthusiasm of their responses reflected their high overall satisfaction with the plan. Well over half of the sample of respondents said that they "loved" all the services, particularly the help offered by the case managers and the responsiveness of the case managers to their problems. Approximately a third said that the most valued service provided was home care. Smaller proportions (around 10 percent, or 6 respondents) cited physician care, transportation, or prescription drugs and supplies as their most valued service. The distribution of these responses differed somewhat from the distribution of responses to the question that asked clients to name the services that prompted them to enroll in ElderCare. As

noted in Section VLB, the most popular enrollment **incentives** were home care and the coverage of all prescription drugs, whereas case management services were noted relatively less frequently as incentives. This difference **in** responses confirms observations made by case managers that, prior to enrolling, clients did not realize how much **they** would appreciate the **service** coordination and personal concern for their problems that would be provided by case managers, but that later **they** came to appreciate these **services** enormously as actual clients.

The client and caregiver respondents to this survey overwhelmingly felt that participation in **ElderCare** could keep elderly individuals out of nursing homes (**87** percent of the respondents). An even larger proportion (98 percent) felt that **ElderCare** had kept them (or their elderly family members) out of a nursing home. Again, these responses **necessarily exclude** a small number of clients who could not be interviewed because **they** were in nursing homes. Furthermore, on a number of occasions, staff who were interviewed for the case study referred to the commitment of informal caregivers for **ElderCare** clients to keeping their family elderly members at home. **This** commitment was corroborated by the fact **that**, even though **ElderCare** clients were quite **frail** at enrollment, fewer than 10 percent reported having been in a nursing home prior to enrollment. Thus, even at the risk of tremendous **financial**, physical, and emotional hardship, most clients would probably not have been placed in nursing homes in the **absence** of **ElderCare**. However, the almost universal perception that this program was responsible for preventing or delaying institutionalization speaks to the enormous **satisfaction** and **confidence** that clients and caregivers derived from their participation.

#### D. SUMMARY

Marketing strategies initially adopted by **ElderCare** were intentionally quite conservative, but were made more **aggressive** as the plan became better established, by targeting the large **Spanish-**speaking population of Miami Beach, particularly through television coverage. However, although the television coverage appeared to be more effective than other media efforts, referrals to the

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plan by other organizations (**particularly** hospital discharge planning departments) dominated the reported referral sources. The low referral rate **from** physicians and the **relative infrequency with** which respondents consulted with their physicians prior to enrolling are noteworthy in light of the often traditional assumption that primary care physicians are the entry point for the elderly into the larger health care system

The survey **identified** no major barriers to enrollment in the intake and application procedures: application materials were reported to have been **accessible**, and respondents generally understood the parameters of the plan, with the exception that about a quarter of the clients did not grasp the requirement that they might receive covered services only from providers affiliated with **ElderCare**. Approximately half of the respondent sample had no concerns about changing health care systems prior to joining the plan. Concerns noted by the other half of the sample included a general anxiety about entering into a new health care system, while fewer expressed concerns **about** having to change physicians or Medicaid cards. (As noted earlier, individuals who found insurmountable barriers in the application process or had overriding concerns about enrolling in the plan, and thus did not **enroll** in the plan, were **necessarily** excluded from the survey.) The most important enrollment incentives were reported to be the availability of home care and the unlimited coverage of prescription drugs.

Clients stated that plan services were readily accessible, and they were highly satisfied with them. Clients saw plan physicians either on site at **the** Mt. Sinai clinic or, for some, in their own communities. The average wait for a nonemergency appointment was two days, and scheduled appointment times were **generally** described as convenient. Over **90** percent rated their care from the plan physicians as good or excellent, and reported that the care was the same as or better than the care they received prior to enrolling in Elder-Care. Over **90** percent of the respondents used home care or transportation services. Of the home care and transportation users, over **90** percent

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**rated** the quality of those services as good or excellent. All reported that it was easy to make changes to their home care or transportation arrangements through **ElderCare**.

Openended responses to a question about the plan services valued most highly by clients reflected a high degree of overall satisfaction with all services. In particular, case management emerged as a highly valued service, and one to which clients did not attach much value prior to enrollment. **Virtually** all respondents believed that their participation in **ElderCare** had kept them out of nursing homes.

As noted in earlier chapters, **ElderCare** was able to identify specific problems that were adversely affecting enrollment and **service** delivery, due to the compact structure of the organization, the ongoing and **frequent** communication among **staff** members, and a commitment by staff to make the program succeed that compelled them to adopt innovative approaches to resolving problems as they arose. This commitment and the **flexibility** of the program at **identifying** and resolving problems were clearly the factors that generated the high level of satisfaction expressed by clients and caregivers in the evaluation **survey**.

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## VII. CONCLUSIONS

Elder-Care, the single plan implemented under the Frail **Elderly** Project of the Florida Alternative Health Plan, was one of a number of programs in the last 15 years to address the need for long-term care services by an increasingly large proportion of **frail elderly** citizens. **ElderCare** built upon earlier experiments, such as the National Long Term Care Demonstration (Channeling) and its **predecessors**, which used case management to coordinate and arrange for services in fragmentary community-based service systems and to support rather than supplant the efforts of informal caregivers to provide effective and cost-efficient alternatives to institutional care. **ElderCare** moved beyond the Channeling model by integrating the management of both acute and long-term care under a prepaid, **capitated** system in which a **single** provider assumed financial responsibility for the plan, and thus joined such programs as the national S/HMO Demonstration and On Lok in investigating alternative methods for delivering **health** care to the **elderly**.

The purpose of the evaluation of **ElderCare** has been as **follows**: (1) to document its organization and operation, including its planning and implementation **difficulties** and how they were overcome, as **well** as the characteristics of the **clients** who **enrolled** in the plan; (2) to assess the satisfaction of clients, their informal **caregivers**, and providers with **plan** arrangements, and to identify barriers to their satisfaction, and to assess the satisfaction of the state with **recordkeeping** by the plan; and (3) to estimate the cost of the plan relative to the **capitation** payments it **received**, the cost of nursing-home care, and the cost of delivering services in the Medicaid fee-for-service sector.

### A **ELDERCARE: ORGANIZATION, OPERATIONS, AND THE CHARACTERISTICS OF CLIENTS**

**ElderCare** was established as a nonprofit **subentity of Mt. Sinai Medical Center**, **an** institution which is **strongly** committed to serving the elderly and interested in expanding its market share in

**the** increasingly competitive health care environment of Dade County, Florida. **ElderCare** operated autonomously on a day-to-day basis within the Medical Center, but received substantial financial support **from** the Medical Center in the form of administrative assistance, physical space and equipment, and the provision of some direct **services** at no charge to the plan or at very favorable rates of reimbursement. **ElderCare** had a relatively small **staff**, which facilitated **frequent** communication among **staff members** and kept the plan **from** becoming overly bureaucratic, which in turn allowed problems both at the plan and client level to be **identified** and resolved expediently.

The initial marketing strategy adopted by the plan was quite **conservative, in the belief that sufficient** demand existed for the **services** of the plan without more **aggressive** outreach, and due to the concerns of plan and state **staff** that the **capitation** payments might not be **sufficient** to cover costs, suggesting that it might be prudent to guard against the early **overextension** of the plan. However, early enrollment was slower than **expected** and disenrollment rates higher than **expected**, particularly because many clients disenrolled to return to their community physicians. After a year of operations, a new marketing director was **hired**, and the marketing strategy was made more aggressive; the marketing director increased contact with organizations and individuals in the community who might **serve as sources of referral** to the plan and developed television spots aimed **directly** at potential clients. In addition, the plan began to allow clients to retain their **community** physicians if the physicians would agree to the prior authorization procedures of the plan, and it **added a Spanish-speaking physician to its on-site staff. As a result, disenrollments to return to** community physicians declined noticeably. The **flexible** approach to **problem-solving** taken by **the** plan also permitted it to add **services** to those **originally** covered by the plan, sometimes on a case-by-case basis, as the need for them was **identified**.

**ElderCare** had no **difficulty** in enlisting the **services** of **external** providers for **services** at acceptable rates. Plan staff believed that it was the reputation of **Mt. Sinai Medical Center** that induced many providers to participate and accept reimbursement at or below the Medicaid **fee-for-**

service rates, even though the plan itself did not **serve** a large number of clients. Because the Dade County health care service environment was relatively rich, **ElderCare** was able to terminate **contracts with providers who were not delivering the quality of service required by the plan, which** was particularly a problem with transportation **providers**. Nor did **ElderCare experience difficulty** in establishing recordkeeping systems to meet the monitoring needs of the plan and the State, as had some of the other Medicaid Competition Demonstration providers. The institutional support and knowledge of the Medical Center facilitated this process, and the nonbureaucratic nature of the plan and its small size **imposed** relatively modest demands on the plan's **recordkeeping systems**. However, **plan staff stated** that the demonstration status **of the project kept** them from **investing** the time and money to improve the **recordkeeping** systems that would have been required by a larger caseload.

Over the period of observation for the evaluation (September 1987 through June **1989**), **ElderCare served** 156 clients, 16 of whom died, 21 of whom **disenrolled** to return to community physicians, and 9 of whom were disenrolled due **primarily** to the fact that they lost their Medicaid **eligibility**. The clients were predominantly Hispanic, more than **half were older** than 50, most had **difficulties** with mobility, and many **required assistance** with **dressing**, bathing, or eating. **ElderCare** clients appeared to have been at least as **frail** as Channeling demonstration participants and On Lok clients, **two** groups acknowledged as frail and in need of formal assistance not readily available to communitydwelling elderly. However, most Elder-Care clients had either some informal or formal support system in place prior to enrolling in the demonstration, and fewer than 10 percent reported having been in a nursing home in the year prior to enrollment, perhaps reflecting a commitment by many clients and their informal **caregivers** to keep clients in the community, as was **also noted by plan staff during case study interviews**. **Indeed, programs such as ElderCare are likely** to attract clients and caregivers who have strong preferences for maintaining clients in the community and who will make an effort to seek out support **services**, as evidenced by the fact that

over a **fifth** of the clients who enrolled in **ElderCare** were **already** receiving **Medicaid-covered** home- and community-based care before they enrolled in the plan

**B. ELDERCARE: THE SATISFACTION OF CLIENTS, INFORMAL CAREGIVERS, PROVIDERS, AND THE STATE**

The 67 clients and informal caregivers who responded to a questionnaire administered by plan case managers appeared to be satisfied with their plan participation and believed that participation had delayed the institutional placement of the clients. Home care and access to **prescription** drugs beyond the fee-for-service Medicaid cap were the primary enrollment incentives cited by respondents. However, case management emerged as **one** of the most valued services provided by the plan once clients were enrolled. Most respondents felt that the quality of care **from** the plan was good, that services were accessible, and that the plan **was** responsive to the needs of clients to change **service** arrangements. **ElderCare staff believed** that the plan had fostered **familial** relationships between clients, **caregivers**, and staff, thus facilitating **frequent** communications (primarily by telephone) and the ability of staff to respond to the needs of clients.

Since none of the providers with whom **ElderCare** contracted voluntarily terminated a contract **with** the plan, it can be concluded that providers were generally satisfied with their arrangements with the plan. A case study interview with **ElderCare's** primary provider of home care services supported this conclusion. Home care workers and plan case managers communicated often, and each respected the judgments of the other. Thus, home care workers were able to play a valuable role in monitoring **the** condition of clients.

Finally, the State liaison for the project and plan **staff communicated freely**, which facilitated identifying and resolving problems on both sides. **The length of time required by the State to formally verify enrollment in the plan (four to six weeks) was considered by plan staff to be a** problem for clients whose conditions required immediate service. **Consequently**, the **plan** began to serve some clients at its own **financial** risk before the State completed formal **enrollment**. **The**

State liaison also intervened manually in the **enrollment** process to **prevent** delaying **enrollment** when problems emerged with **specific** clients. However, the plan and the State **liaison** noted that serving clients prior to formal enrollment and manual intervention in state enrollment **procedures** **might** not be **feasible** with a plan that contained more clients.

### C. THE COSTS OF ELDERCARE

A complex **methodology** **was** adopted by the state to calculate the capitation payments received by **ElderCare**. Because the **methodology** **was** based on **service-specific** reimbursement levels in the Medicaid fee-for-service sector in **fiscal 1986**, **adjustments were required to** account for changes in Medicaid reimbursement rates, and the capitation payments were entirely recalculated in late **1988** based on **fiscal 1987** and **1988** data in order to account for a major increase in Medicaid reimbursement rates and to capture the use of home- and community-based services more accurately for the target population. At the end of the evaluation period, the plan was entitled to **receive** between approximately \$900 and \$1,500 per month per client, **depending** on the client's level of Medicare coverage.

A number of steps were taken to keep the **costs** of **operating** the plan within the capitation payments. They included adopting the Medicaid limit of 45 days of inpatient care per year and a limit on the coverage of nursing home care to 6 months. **The** medical **director** **received** a capitation payment for each client to cover the costs of physician and other medical services and had to authorize such services prior to their use, making the medical director responsible for access to and the cost of such care. Case managers authorized the receipt of home- and **community-based** services, **and**, although they were **given** neither client nor **caseload-specific** spending **caps**, they adopted what was described during case study **interviews** as a "**cost-conscious**" approach to **ordering services**. **In addition, the** plan shopped around for **providers** who would serve clients at **reimbursement** levels consistent with the plan's budget.

Although project developers and plan staff had voiced concern about *the adequacy* of the capitation payments to **cover the costs of operating the plan** from its very **inception**, a comparison of revenues and expenses for the plan between September **1987** and June **1989** showed that the plan just about broke even, ending the period with a very small **surplus** (2 percent of *revenues*). However, **Mt. Sinai Medical Center** provided a substantial subsidy to the plan. Thus, while we may conclude that the capitation payment was adequate to **cover the budget line item costs of operating ElderCare**, these costs are **likely to substantially** underestimate the true cost of operating the **plan**.

**ElderCare's** costs were **also** compared with costs for other **types** of care. At **\$1,000** per client per month, **ElderCare** costs were substantially lower than the average of approximately \$2,400 per month that Medicaid reimbursed for beneficiaries in nursing homes in **1988**. **ElderCare** costs also appeared to have been **well** below the **cost** of care delivered under the national S/HMO demonstration expanded care program, **although** it was not **possible to identify** the causes for the **ElderCare/S/HMO** difference. **Finally**, reimbursements for and the levels of use of **ElderCare** services were compared with **Medicaid-red reimbursement and service use** for a sample of Medicaid beneficiaries in the fee-for-service sector who, like **ElderCare** clients, had been **assessed** by the CARES nursing-home preadmission **screening** program as **requiring** a nursing-home level of care, but who were recommended for diversion to **home-** and community-based care (**referred to as the CARES diversion group**). Although this comparison was severely limited by a lack of comparable data for the two groups **that described their** level of disability, **health** status, mortality, level of informal support, and dates of Medicaid **eligibility**, one conclusion **emerged**: despite *the fact* that **ElderCare** was reimbursing most providers at or below the Medicaid **fee-for-service** rate and was operating within the limitations of the capitation payments, **ElderCare** spent more on its clients than Medicaid spent on the CARES **diversion group**. **This conclusion** was derived in *large* measure from the fact that the rate at which **ElderCare** clients used **home-** and community-based **services** supplied by the plan was higher than the rate at which the CARES group used such

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**services** funded by Medicaid. However, because CARES group members could have **received** these **services** from a variety of programs not funded by Medicaid (and thus not measured in this evaluation), their receipt is likely to represent an expense to other state and local programs.

**ElderCare** clients also appeared to have used inpatient, physician, transportation, and home health services to a greater extent than did the CARES diversion group, but their rate of outpatient service use declined **from** what **it** had been prior to enrolling in the plan and was somewhat lower relative to the CARES group, and **ElderCare** clients had significantly lower rates of nursing-home use than the CARES group. Although **nursing-home-use** rates were not particularly high for either group (only 3 percent of **ElderCare** clients had a nursing-home stay following enrollment in the plan, compared with 12 percent of the CARES group), of those with nursing home stays **ElderCare** clients had shorter stays and longer delays until their **first** stay. However, due to the shortcomings of the data, it is not **possible** to attribute these differences entirely to participation in **ElderCare**.

#### D. ELDERCARE: THEPOTENTIAL FOR REPLICABILITY

**ElderCare** clearly met the objectives of the Frail Elderly Project. It was able to contract on a prepaid basis for the full complement of health and support services while remaining within the budget constraints of the capitation payments (which were set well below Medicaid reimbursement levels for beneficiaries residing in nursing homes), but not without a substantial subsidy **from** its institutional host, Mt. Sinai Medical Center. **ElderCare attracted**, retained, and appeared to satisfy a frail caseload with numerous physical and mental impairments by **changing** its marketing approach when initial efforts appeared to be too **conservative**, by maintaining open lines of **communication** throughout the organization to facilitate identifying problems, and by adopting innovative solutions to those problems. Clients, informal caregivers, **providers**, and the State all seemed satisfied with the performance of the plan. Even if objective data suggest that few **ElderCare** clients would **actually** have been in nursing homes in the absence of the plan, clients and caregivers who

**responded** to the evaluation questionnaire unanimously **believed** that the plan was **responsible for** preventing or delaying **institutionalization, reflecting** the enormous satisfaction and confidence that clients and caregivers derived from their participation.

However, we may ultimately judge **ElderCare** by assessing whether it **should** or could be replicated by other providers in other parts of the state of Florida or elsewhere. The results of the evaluation suggest that the replication of the **ElderCare** model would have to be justified on the basis of its ability to improve access to health care and on the high level of satisfaction that clients and caregivers experienced with participation, rather than its cost relative to Medicaid expenditures in the fee-for-service sector for a group of beneficiaries who were **nursing-home-eligible** but recommended for community diversion. As occurred in the **Channeling demonstration**, a frail elderly population with multiple service needs was **identified**, but the rate of nursing-home use for those outside the demonstration was not very high, and thus the cost savings due to delayed institutional placement were not **realized**. Moreover, the longer that home- and community-based Medicaid waiver programs are available and the better known they become, the more likely they may be to attract beneficiaries and caregivers who have a commitment to **community** care but have a compelling need for formal **services** to supplement their caregiving efforts.

The growth of the **frail** elderly **population**, along with the evolution of a pool of caregivers who have children to care for in addition to **frail** elderly parents (the so-called “sandwich” generation), suggests that improving access **to** health care and supporting informal caregiving efforts may be sufficient grounds for replicating a **successful program**. In **any** attempt to replicate the **ElderCare** model, it would be important to **preserve** two of the plan’s most important characteristics: open lines of communication among staff members and between **staff** and clients, and a flexible approach to problem solving. However, it is **difficult** to say whether these features **can be preserved in a program that may be much larger than ElderCare**. **In addition, the plan**

benefitted in a number of ways from having a large institutional host that was well-known and well-respected in community, particularly in terms of enlisting external service providers.

ElderCare's experience also suggests that an important change **might be** made in a replicated program: an increase in the capitation payments to offset the degree to which Mt. Sinai Medical Center subsidized **ElderCare** in the event that other institutional hosts would not be willing to provide a similar level of subsidization. Clearly, if other hosts were not willing to undertake the level of investment that Mt. Sinai made and if replicated programs could not drastically reduce the level of service provided to clients or otherwise cut costs dramatically (which seems unlikely), the capitation payments would have to be increased substantially to cover the costs of operation.

The flexible, innovative, open-minded approach taken by the **ElderCare** staff to identifying and resolving problems was the plan's hallmark and a major source of its **success**, because it implicitly acknowledged that, although we speak of finding alternative ways to care for the frail elderly as a group, this group comprises human beings whose individuality must be preserved and respected by any system designed to respond to their diverse needs.

#### E. ELDERCARE AS AN ONGOING PROGRAM

Because the Florida Department of Health and Rehabilitative **Services (DHRS)** and Mt. Sinai Medical Center felt that **ElderCare** met the service needs of its frail elderly target population at a reasonable cost, when the cooperative agreement between DHRS and HCFA expired on December 31, 1989, **ElderCare** was combined with Mt. Sinai's Medicaid prepaid health plan. The combined organization is known as the Mount Sinai Health Maintenance Organization, Inc. (Mt. Sinai HMO). As part of the Mt. Sinai HMO, **ElderCare** combines elements of the demonstration plan with elements of a traditional acute-care HMO. The new health plan is required to provide only the medical and institutional services of the demonstration plan; home- and community-based services are not covered under terms of the contract. However, the plan provides home- and community-based services as a way of managing the risk of institutional services. The concept of

managing the **financial** risk of nursing-home care by providing home and community-based **services** is **similar** to the concept of managing the risk of inpatient care by providing appropriate preventive care and better access to physicians and other practitioners.

As a demonstration, **ElderCare** operated under four waivers of **federal** Medicaid requirements: the state's 2176 Waiver, and waivers of comparability, **statewideness**, and **enrollment** composition. The 2176 Waiver, which was statewide rather than **plan-specific**, allowed the state to receive federal cost-sharing funds for home- and community-based services. The waiver of comparability permitted **ElderCare** to enroll clients based on their health status rather than requiring the plan to make its services available to **all** Medicaid beneficiaries. The waiver of **statewideness** allowed the plan to be implemented by a **single** provider at a **single** site. And the waiver of **enrollment** composition allowed **ElderCare** to serve **only** Medicaid beneficiaries, **rather** than requiring that it enroll a specified percentage of **"commercial" clients**.

As part of the Mt. Sinai **HMO**, the 2176 Waiver is not needed because the contract between **DHRS** and **Mt. Sinai HMO** does not call specifically for the provision of home- and **community-**based services. Such services are provided at the initiation of Mt. Sinai HMO in order to manage financial risk. The waiver of comparability is unnecessary because **Mt. Sinai HMO** is open to all **SSI-eligible** Medicaid beneficiaries. However, Mt. Sinai HMO receives a higher **capitation** payment for members assessed by the **CARES** program as requiring a nursing-home level of care. The waiver of **statewideness** is **unnecessary** because DHRS does not wish to restrict the model to a single location, and is now **trying** to interest other providers **in** implementing the model in other parts of the state. **Finally**, a separate waiver of **enrollment** composition is **unnecessary** because **Mt. Sinai HMO** was already operating under such a waiver prior to the **restructuring**. This waiver is due to expire in a year, at **which** time the HMO must have commercial members.

At **the** end of 1989, 114 clients were **enrolled in ElderCare**. In early **December**, the clients were informed of the change in the **plan's** organizational **structure** both in writing and by their case

managers. Clients were given the choice of returning to Medicaid fee-for-service coverage or remaining with **ElderCare** as part of the **Mt. Sinai** HMO with both the same service package and the same plan **staff**. All but 2 clients chose to remain with the plan. However, the uncertainty that surrounded the plan as details of the continued model **were** negotiated among Mt. Sinai, **DHRS**, and HCFA disrupted the regular marketing and enrollment **activities** of the plan. Thus, very few new clients were enrolled during the later months of 1989 and the **first** months of 1990. Nevertheless, as of June 1990, Mt. Sinai HMO was serving 128 clients **assessed** by CARES as requiring a nursing-home level of care. For its part, DHRS is planning to implement the model at other locations in the state, having taken the opportunity afforded by the **ElderCare** demonstration to determine the most workable and efficient parameters for delivering services under the model and for placing the model in the larger Medicaid system\_



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**APPENDIXA**  
**SUPPLEMENTAL TABLES**

TABLE A.1

**ITEM NONRESPONSE FOR ENTRIES IN TABLE IV.2:  
CHARACTERISTICS OF ELDERCARE CLIENTS AT ENROLLMENT**

	Number Missing	Percentage Missing
Age	0	0.0
<b>Mean age (years)</b>		
Age distribution		
<b>65-75</b>		
<b>76-80</b>		
<b>81-85</b>		
86 and older		
Sex	<b>0</b>	<b>0.0</b>
Female		
Male		
<b>Race/Ethnicity</b>	<b>12</b>	<b>8.0</b>
White		
Black		
Cuban		
Haitian		
Other Hispanic		
Other		
Marital status	<b>7</b>	4.7
<b>Married</b>		
Widowed		
Divorced		
Other		
Living Arrangement	7	4.7
Lives alone		
<b>Lives with spouse</b>		
Lives with others		
Current <b>Residence</b>	<b>7</b>	4.7
Private home		
<b>Boarding house</b>		
Unable To <b>Perform</b> Following Activity <b>without</b> Help:		
Do housework	<b>3</b>	2.0
Do laundry	<b>6</b>	4.0
Shop	<b>5</b>	3.3
<b>Prepare own meals</b>	<b>7</b>	4.7
Get to places beyond walking distance	<b>7</b>	4.7
<b>Walk</b> outside	<b>7</b>	4.7



TABLE A.1 (continued)

	Number Missing	Percentage Missing
Intellectual Functioning		
Sometime5 or often appears confused	23	15.3
Sometimes or almost never willing to do things when asked	28	18.7
<b>Age given is more than 5 years off</b>	34	22.7
Sometimes or almost never reacts to own name	<b>20</b>	13.3
Health Insurance		
Medicaid only	0	0.0
Medicaid and <b>Medicare B</b>		
Medicaid and Medicare A and B		
Some other private insurance	1	0.7
support <b>Services</b>		
Is receiving help <b>from</b> family and <b>friends</b> only	0	0.0
Is receiving help from agency only		
Is receiving help from family, friends, and agency		
Is receiving help from neither <b>family, friends,</b> nor <b>agency</b>		
Has a problem with transportation		
Sample Size'	<b>150</b>	

NOTE: Item **nonresponse** for this table is due to an absence of **information** from the screening questionnaire.

TABLE A.2

COMPARISON OF ELDERCARE **CLIENTS** AND CARES DIVERSION GROUP  
 MEDICAID DATA DURING THE PREPROGRAM PERIOD, CARES  
 SAMPLE **RESTRICTED** TO THOSE WITH CLAIMS DURING  
**PRE- OR IN-PROGRAM PERIOD**  
 (Percentage with Characteristics **Unless** Otherwise Noted;  
 Absolute Sample Size in Parentheses)

	ElderCare	CARES
Age at Enrollment/Community Diversion <b>Date<sup>a</sup></b>		
<b>Mean Age (years)</b>	80.4	<b>82.8</b>
<b>65-75</b>	<b>23.1</b> (36)	175 (119)
<b>76-80</b>	24.4 (38)	<b>19.6</b> (133)
<b>81-85</b>	26.9 (42)	<b>25.9</b> (176)
<b>86 and older</b>	<b>25.6</b> (40)	37.1 (252)
Sex		
Male	263 (41)	<b>25.7</b> (175)
Female	73.7 ( <b>115</b> )	743 ( <b>505</b> )
<b>Any Medicaid</b> Claims in Preprogram <b>Period</b>	942 (147)	89.1 (605)
Average Monthly Reimbursement for Medicaid-Covered <b>Services (\$)</b>		
Total for all <b>services</b>	<b>406</b>	350
Inpatient	<b>228</b>	219
Nursing home	<b>9</b>	16
Outpatient/emergency room/ ambulatory surgery	16	<b>8</b>
Physician and other practitioner	4	4
Home- and community-based <b>services</b>	<b>50</b>	<b>5</b>
Transportation	<b>17</b>	8
All other <b>types</b> of <b>service<sup>b</sup></b>	<b>83</b>	<b>90</b>

TABLE A2 (continued)

	ElderCare		CARES
<b>Any Use of Medicaid-Covered Services During the Year</b>			
Inpatient	39.7 (62)	*	52.6 (358)
Nursing home	<b>4.5 (7)</b>		3.7 (25)
Outpatient/emergency room/ambulatory surgery	46.8 (73)	•	34.1 (232)
Physician and other practitioner	423 (66)	•	<b>58.5 (398)</b>
Home- and community-based services	21.8 (34)	*	5.9 (40)
Transportation	372 (58)		37.4 (254)
<b>Average Monthly Utilization of Medicaid-Covered Institutional Services</b>			
Number of inpatient days	<b>.55</b>		<b>.73</b>
Number of nursing home days	<b>.16</b>		30
Sample Size	156		680

SOURCE: Data for this table **come from** the **Florida MMIS** Adjudicated Claims **File**.

The age distributions for the **ElderCare** and CARES samples were **significantly different** at the 95 percent level of **confidence** based on a **chi-square test**.

“Other” includes home health, **pharmacy**, HMO, laboratory, and X-ray services, durable medical supplies, hospice services, and claims with no “category or service” code entered on the file.

- **ElderCare/CARES difference is statistically significant** at the 95 percent level of **confidence** in a two-tailed test.

TABLE A.3

**AVERAGE MONTHLY REIMBURSEMENT FOR ELDERCARE CLIENTS AND THE CARES DIVERSION SAMPLE BY TYPE OF SERVICE DURING THE IN-PROGRAM PERIOD: CARES SAMPLE RESTRICTED TO THOSE WITH CLAIMS DURING THE PRE- OR IN-PROGRAM PERIOD**  
(Dollars per Client per Month)

	ElderCare		CARES
Reimbursement for All Services	<b>640</b>	*	371
Inpatient Services	<b>280</b>	*	108
Nursing-Home <b>Services</b>	10	*	100
Outpatient <b>Services<sup>a</sup></b>	3	*	7
Physicians and Other <b>Practitioners<sup>b</sup></b>	8		4
Home- and Community-Based <b>Services<sup>c</sup></b>	229	*	57
Transportation	31	*	8
Home Health <b>Services<sup>d</sup></b>	9		10
<b>Pharmacy<sup>e</sup></b>	48	*	<b>65</b>
<b>er<sup>f</sup></b>	24	*	12
Average Number of Months in Observation Period	73	*	121
<b>Sample Size</b>	156		680

NOTE: For the **ElderCare** sample, data for this **table** come **from ElderCare** program records of reimbursements to providers and Medicaid Management Information System (MMIS) pharmacy records. For the CARES sample, data come **from the MMIS**. Ninety-&e percent of the 156 **ElderCare** sample members had at **least** one claim to **ElderCare during** the in-program period. Ninety-four percent of the 680 CARES sample members had at least one paid Medicaid claim during the in-program **period. Those** with no paid claims during the period had their reimbursements set to zero.

Individual reimbursement values are **formed by dividing** the total reimbursement **for** a sample member over his or her period of **observation** by the total number of months in his/her period of **observation**. For **ElderCare clients**, the period of observation begins with the month of enrollment in **ElderCare** and ends with the month of termination (or June **1989** for **those** who have not terminated). For the CARES **population**, the period of observation begins with the date of recommendation for diversion to **community-based services** and ends in June 1989.

**ElderCare** outpatient **services** include those delivered **in** an outpatient facility or **emergency** room. CARES outpatient services include those delivered in an outpatient facility, an ambulatory surgery facility, or a community mental health clinic.

**For ElderCare**, reimbursement for physician visits includes the amount deducted from the medical director's **capitation** payment plus reimbursements made by the plan for Medicare deductible and coinsurance claims. The **dollar value** of the deduction from the medical director's capitation payment was not available on an individual-level basis prior to the establishment of the plan's MIS (July 1988). Thus, physician reimbursements for **ElderCare** are somewhat understated.

**For ElderCare**, "home- and community-based services" include in-home respite, personal care, home management, adult day health care, and inpatient respite. For CARES, "home- and **community-based services**" include Medicaid 2176 waiver services, such as chore, homemaker, **personal** care, respite, case management, adult day health care, **health** support, and counseling.

**Home health services** include skilled care **delivered** at home by a nurse, therapist, or medical social worker.

**Pharmacy** reimbursement for **ElderCare** includes payment for **pharmacy services** reimbursed **directly** by **ElderCare** plus payment for pharmacy services reimbursed by Medicaid and billed later to **ElderCare**.

**For ElderCare**, "other" includes laboratory and X-ray and supply and equipment claims. **For CARES**, "other" includes laboratory and X-ray, supply and equipment, HMO and hospice claims, and claims with no category of **service** coded on the **claim**. The **ElderCare/CARES** difference in "other" **service** reimbursement was dominated by a difference for supplies and equipment.

● **ElderCare/CARES difference is statistically significant** at the **95** percent level of **confidence** in a two-tailed test.

TABLE A4

SERVICE USE BY ELDERCARE **CLIENTS** AND THE CARES DIVERSION  
**SAMPLE** BY TYPE OF SERVICE DURING THE IN-PROGRAM PERIOD,  
**CARES SAMPLE RESTRICTED TO THOSE WITH CLAIMS DURING**  
 PRE- OR IN-PROGRAM PERIOD  
 (Absolute Sample **Size** in Parentheses)

	<b>ElderCare</b>		<b>CARES</b>
Percent with Claims during Period	<b>94.9</b> (148)		93.7 (637)
Inpatient Services			
Percent with any stay during the period	39.1 (61)	•	30.7 (209)
Number of days per month	1.19	•	036
Number of admissions per month	0.12	•	0.03
Nursing-Home Services			
Percent with any admission during the period	<b>3.2</b> (5)	•	<b>14.3</b> (97)
Number of days per month	0.15	•	1.70
Number of admissions per month	0.01	•	0.06
Outpatient <b>Services<sup>a</sup></b>			
Percent with any use	17.9 (28)	•	<b>30.4</b> (206)
Number of days/visits per month	0.06	•	<b>0.21</b>
Physicians and Other <b>Practitioners<sup>b</sup></b>			
Percent with any use	64.1 (100)	•	31.0 (211)
Number of visits per month	0.67	•	0.11
Home and Community-Based <b>Services<sup>c</sup></b>			
Percent with any use	<b>84.0</b> (131)	•	213 (145)
Number of hours per month	<b>26.80</b>	•	4.79
Transportation			
<b>Percent</b> with any use	<b>71.8</b> (112)	•	34.4 (234)
Number of one-way trips per month	<b>1.72</b>		339
Home Health <b>Services<sup>d</sup></b>			
Percent with any use	<b>23.7</b> (37)	•	<b>3.7</b> (25)
Number of visits per month	<b>0.25</b>	•	0.07

TABLE A4 (continued)

	ElderCare		CARES
<b>Pharmacy<sup>c</sup></b>			
Percent with <b>any</b> use	84.0 (131)	•	99.7 (617)
Number of prescriptions per month	219	•	327
Average Number of Months in Observation Period	73	•	121
<b>Sample Size</b>	<b>156</b>		<b>680</b>

NOTE For the **ElderCare** sample, data for this table come **from ElderCare** program records of reimbursements to providers and the Medicaid Management Information System (**MMIS**) pharmacy records. For the **CARES** sample, data come **from the MMIS**. **Ninety-five** percent of the 156 **ElderCare** sample members had at least one Medicaid claim during the **in-program** period. **Ninety-four** percent of the **680 CARES sample members** had at least one paid Medicaid claim during the **in-program** period. Those with no paid claims had their **service use set to zero**.

Variables for individual units of **service** are formed by dividing the total units of service for a sample member over his or her period of **observation** by the total number of months in **his/her** period of observation. A binary indicator of any service use by type of **services** was also created. For **ElderCare** clients, the period of observation begins with the month of enrollment in **ElderCare** and ends with the **month** of termination (or June 1989 for those who have not terminated). For the CARES population, the period of observation begins with the date of recommendation for diversion to community-based services and ends in June 1989.

<sup>a</sup>**ElderCare** outpatient services include those **delivered** in an outpatient facility or emergency room **and use visits as unit of service**. CARES outpatient services include those **delivered** in an outpatient facility, an ambulatory surgery facility, or a community mental health clinic. **MMIS** outpatient claims include both days and visits as unit of service.

<sup>b</sup>For **ElderCare**, the use of physician services includes visits **covered** under the medical director's capitation payment, as well as visits to outside providers for which the plan **received** claims for Medicare coinsurance and deductible payments. Unlike reimbursement, use data on individual-level visits covered under the medical director's capitation payment were available prior to July 1988.

<sup>c</sup>**ElderCare "home-** and community-based **services"** include in-home respite, personal care, home management, and adult day health care. Inpatient respite use is excluded **from** this table because the unit of **service (days)** was inconsistent with hours used for the other **services**. **ElderCare** adult day **health** care claims used both days and hours as the unit of **service**, but hours predominated. CARES services include Medicaid 2176waiver services, such as chore, homemaker, personal care, respite, case management, adult day health care, health support, and **counseling**.

<sup>d</sup>**Home health services include** skilled care **delivered** at home by a nurse, therapist, or medical social worker.

TABLE A.4 (continued)

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\*Pharmacy use for **ElderCare comes from** claims for pharmacy **services** reimbursed **directly** by **ElderCare** plus claims for pharmacy **services** reimbursed by Medicaid and later billed to **ElderCare**.

\***ElderCare/CARES difference is statistically significant** at the 95 percent level of **confidence** in a **two-tailed test**.

TABLE A.5

## ITEM NONRESPONSE FOR ENTRIES IN TABLE VI.2: COMPARISON OF QUESTIONNAIRE RESPONDENTS WITH ALL OTHER ELDERCARE CLIENTS

	Respondents		Other Clients	
	Number Missing	Percentage Missing	Number Missing	Percentage Missing
Age	0	0.0	0	0.0
Mean age (years)				
Age distribution				
65-75				
76-80				
81-85				
86 and older				
Sex	0	0.0	0	0.0
Male				
Female				
Race/Ethnicity	2	3.9	10	11.9
White				
Black				
Cuban				
Haitian				
Other Hispanic				
Other				
Marital Status	2	3.0		6.0
Married				
Widowed				
Divorced				
Other				
Living Arrangement	3	4.5		4.8
Lives alone				
Lives with spouse				
Lives with others				
Current Residence	3	4.5		4.8
Private home				
Boarding house				
Unable to Perform Following Activity without Help:				
Do housework	1	0.0	3	3.6
Do laundry	2	1.5	5	6.0
Shop		3.0	3	3.6
Prepare own meals	2	3.0	5	6.9
Get to places beyond walking distance		3.0	5	6.0
Walk outside	2	3.0	5	6.0
Use stairs	1	1.5	9	10.7
Bathe	1	1.5	6	7.1
Dress/undress		3.0		8.3
Handle money	0	0.0	7	8.3
Take medicine	4	6.1	6	7.1
Take care of personal appearance	1	1.5	9	10.7
Use telephone	2	3.0	5	6.0
Eat	3	4.5	8	9.5
Sometimes or Usually Unable To Get to Bathroom in Time	19	28.8	26	31.0

TABLE A.5 (continued)

	Respondents		Other Clients	
	Number Missing	Percentage Missing	Number Missing	Percentage Missing
Vision (with Glasses) Is Poor or Blind	18	27.3	16	19.0
Hearing (with Aid) Is Poor or Deaf	7	10.6	4	4.8
Speech Poor or Nonexistent	7	10.6	3	3.6
Walks Poorly or Is Bedbound	7	10.6	8	9.5
Uses or Needs the Following Medical Devices:	0	0.0	0	0.0
Wheel chair				
Walker				
Cane				
Oxygen				
Lift				
Catheter				
Colostomy equipment				
Artificial limb				
Other				
Number of Hospital Stays in Last Year	27	40.9	32	38.1
0				
1				
2 or 3				
4 or more				
Number of Nursing Home Stays in Last Year	26	29.4	29	34.5
0				
1				
2 or more				
Number of Visits to the Doctor in the Last Year	30	45.5	33	39.3
0				
1 to 6				
7 to 12				
13 or more				
Intellectual Functioning				
Sometimes or often appears confused	13	19.7	10	11.9
Sometimes or almost never willing to do things when asked	13	19.7	15	17.9
Age given more than 5 years off	17	25.8	17	20.2
Sometimes or almost never reacts to own name	10	15.2	10	11.9
Health Insurance	0	0.0	0	0.0
Medicaid only				
Medicaid and Medicare B				
Medicaid and Medicare A and B				
Some other private insurance	1	1.5	0	0.0

TABLE A.5 (continued)

	Respondents		Other Clients	
	Number Missing	Percentage Missing	Number Missing	Percentage Missing
Support Services	0	0.0	0	0.0
Is receiving help from family and friends only				
Is receiving help from agency only				
Is receiving help from family, friends, and agency				
Is receiving help from neither				
Has a problem with transportation				
Sample Size	66		84	

NOTE: Item nonresponse is due to the absence of information from the screening questionnaire.

TABLE A.6

ITEM NON-RESPONSE FOR **ENTRIES** IN TABLE VL3:  
FACTORS **AFFECTING** ENROLLMENT **DECISIONS**

	<b>Number Missing</b>	<b>Percentage Missing</b>
<b>Source of Knowledge of ElderCare</b>		
Friend or relative ( <b>ElderCare</b> member)	1	<b>1.5</b>
<b>Friend</b> or relative (nonmember)	1	1.5
Doctor	3	<b>4.5</b>
Nurse, <b>social</b> worker, or someone else at a hospital	4	<b>6.0</b>
Another program or agency	2	3.0
<b>Media:</b>		
Newspaper	<b>2</b>	3.0
Magazine	<b>2</b>	3.0
Radio	<b>2</b>	3.0
Television	<b>2</b>	3.0
<b>Discussion with Others</b>		
friends <b>encouraged</b>	0	a0
Friends discouraged	0	a0
<b>Friends had no opinion</b>	0	<b>0.0</b>
<b>Did not discuss with friends</b>	0	0.0
Doctor or other <b>medical</b> person <b>encouraged</b>	1	1.5
Doctor or other medical person discouraged	1	1.5
Doctor or other medical person had no opinion	1	1.5
Did not discuss with <b>doctor</b>	1	<b>1.5</b>
<b>Decision To Join ElderCare</b>		
Client decided alone	2	3.0
Client decided with <b>family</b>		
Client did not participate in the decision		
<b>Benefits as Enrollment Incentives</b>		
<b>The following were important in deciding to join ElderCare:</b>		
Payment for <b>prescription</b> drugs	<b>2</b>	3.0
<b>Help</b> with housekeeping or personal care	<b>2</b>	3.0
<b>Assistance from a case manager</b>	<b>2</b>	<b>3.0</b>
<b>Provision of adult day care</b>	<b>3</b>	4.5
<b>Provision of caregiver respite</b>	<b>2</b>	<b>3.0</b>
<b>Escort</b> to medical appointments	<b>2</b>	3.0

TABLE A6 (continued)

	<b>Number Missing</b>	<b>Percentage Missing</b>
<b>Concerns Prior to Enrolling</b>	10	14.5
None		
Dubious about HMO status/different color Medicaid card		
Changing physicians/getting referred to specialists		
General concern about quality of care/other concerns		
<b>Potential Barriers to Enrollment and Later Satisfaction</b>		
Plan description provided by ElderCare staff:	1	1.5
<b>Easy to understand</b>		
<b>Difficult</b> to understand		
Undecided or do not recall description		
<b>Clarification</b> to plan description:	17	25.4
No <b>clarification</b> needed		
Some <b>clarification</b> needed		
Aware of Need To Receive Covered Services from Providers <b>Affiliated</b> with <b>ElderCare?</b>	0	0.0
<b>Yes</b>		
No		
<b>Difficulty</b> in Obtaining or Completing Application <b>Materials?</b>	1	1.5
<b>Yes</b>		
No		
Sample Size	67	

NOTE Reasons for item **nonresponse include** the **nonapplicability** of questions based on responses to previous questions, as well as the **nonexistence** or illegibility of **expected** responses.

TABLE A.7

ITEM NON-RESPONSE FOR ENTRIES IN TABLE VI.4:  
SATISFACTION WITH PLAN SERVICES

	Number Missing	Percentage Missing
<b>Physician Services</b>		
Location of primary care physician	0	0.0
Mt. Sinai		
<b>Elsewhere</b>		
<b>Timeliness</b> of appointments	<b>20</b>	<b>29.9</b>
Number of days wait for appointment		
Percentage responding that appointment times are convenient	3	3.0
Number of minutes wait for appointment in waiting room	1	1.5
Rating of physician's professional competence	1	1.5
<b>Excellent</b>		
<b>Good</b>		
Fair		
Poor		
Rating of physician's ability to communicate	1	1.5
Excellent		
<b>Good</b>		
Fair		
Poor		
<b>Rating</b> of ability to get referrals to <b>specialists</b>	<b>0</b>	<b>0.0</b>
<b>Excellent</b>		
<b>Good</b>		
Fair		
Poor		
<b>Never had a referral</b>		
Of those with a primary care physician prior to <b>enrollment</b> , comparison of prior care with care from		
<b>ElderCare</b>	11	16.4
<b>ElderCare</b> better		
<b>ElderCare</b> about the same		
<b>ElderCare</b> worse		

TABLE A.7 (continued)

	Number <b>Missing</b>	Percentage <b>Missing</b>
<b>Inpatient Hospital Services</b>		
Percentage <b>using</b> services as plan client	0	0.0
Location of stay	37	55.2
<b>Mt. Sinai</b> only		
Other facility		
Rating of overall quality of inpatient stay	38	56.7
Excellent		
<b>Good</b>		
Fair		
Poor		
<b>Home-Based Services</b>		
Percentage using home care	0	<b>0.0</b>
<b>Rating</b> of the reliability of home care workers	6	<b>9.0</b>
Excellent		
<b>Good</b>		
Fair		
Poor		
<b>Rating</b> of overall quality of home care	<b>5</b>	7.5
Excellent		
<b>Good</b>		
Fair		
Poor		
<b>Ability of ElderCare</b> to change home care, if requested	4	<b>6.0</b>
<b>Easy</b>		
<b>Difficult</b>		
<b>Transportation</b>		
Percentage <b>using</b> transportation	<b>0</b>	<b>0.0</b>
<b>Rating</b> of reliability of transportation	6	<b>9.0</b>
Excellent		
<b>Good</b>		
Fair		
Poor		

TABLE A.7 (continued)

	Number Missing	Percentage Missing
<b>Transportation (continued)</b>		
Ability of <b>ElderCare</b> to change transportation, if requested	6	9.0
<b>Easy</b>		
<b>Difficult</b>		
<b>Change To Prepaid Health Plan Medicaid Card</b>		
Percentage reporting some <b>difficulty</b> with <b>new card</b>	0	0.0
Most <b>Valuable Service Provided</b> By <b>ElderCare</b>	2	3.0
<b>All services/coordination</b> and general responsiveness of case managers and the <b>plan</b>		
Personal care and housekeeping		
Doctors		
Transportation		
<b>Prescription</b> drugs/supplies		
Other <b>specific</b> services		
<b>Delay Of Institutionalization</b>		
Percentage who thought <b>ElderCare</b> can keep <b>people</b> out of nursing homes	0	0.0
Percentage who thought <b>ElderCare</b> kept <b>respondent</b> out of nursing home	10	14.9
Sample <b>size</b>	67	

**NOTE:** Reasons for item **nonresponse** include the **nonapplicability** of questions based on responses to previous **questions**, as well as the **nonexistence** or **illegibility** of **expected responses**.

APPENDIX B  
ELDERCARE **CLIENT** OPINION SURVEY

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## ElderCare Client Opinion Survey

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INTRODUCING THE SURVEY TO CLIENTS:

READ VERBATIM, THEN ADDRESS QUESTIONS AND CONCERNS AS NECESSARY.

ENGLISH:

**ElderCare** is doing a study to find out how the **ElderCare** program might improve services to its members. We thought a good way to find out would be to **ask** people who are now in the program for their opinions. I would like to ask you some questions about how you found out about the **ElderCare** program, why you joined, and how you **feel** about the program now. I will also ask how you think the program might be changed to serve others better.

There are no right or wrong answers to the questions. We only want to know your opinions. If there is something about **ElderCare** that you do not like, this is a good time to tell me about it. I will not take anything you say personally. Your **answers** will not affect the *care you get* from **ElderCare**.

SPANISH:

**ElderCare** esta haciendo un estudio para determinar como podria mejorar los servicios a sus miembros. Pensamos que la mejor manera de hacerlo seria obteniendo las opiniones de los miembros actuales. Le quiero hacer algunas preguntas sobre como ud. descubrio el programa, porque se hizo miembro y que piensa del programa ahora. Tambien le voy a pedir su opinion sobre como el programa podria ser modificado para servir mejor a los miembros.

No hay respuestas ciertas o equivocadas para estas preguntas. Solo queremos saber sus opiniones. Si hay algo que no le gusta sobre el programa este es el momento de decirnoslo saber. Sus respuestas no afectaran el cuidado que ud. recibe de **ElderCare**.

---

INTERVIEWING CONVENTION@,

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1. All introductions, **questions**, and answer categories **in lower** case type are to be read aloud to the respondent.
2. Words and phrases in upper case type are instructions to interviewers or answer categories that should not be read aloud to respondents.
3. Read all questions exactly as worded.
4. Unless instructed otherwise, circle only one answer category for each question.
5. Words in bold face type require substitution if the interview **is** being conducted with a proxy instead of with the **ElderCare** client. \*Before you joined the **ElderCare** program?" would be read 'Before your **mother** joined the **ElderCare** program?'
6. If a word is capitalized and underlined, for example, CLIENT, substitute the appropriate name or title. For example, "**when** you enrolled CLIENT" would be read '**when** you enrolled your mother' or '**when** you enrolled Mrs. Jones.'
7. Words in parentheses are wording choices. Read them as appropriate. For example,
  - o In question 1.1, read "**joined**" if you are speaking with a client and 'enrolled CLIENT' if you are speaking with a proxy.
  - o In question 1.2, read the word **also** if the **respondent** has heard about Eldercare from a friend *or* relative in **question** 1.1. If the answer to question 1.1 is "**no**", it is not necessary to read the word "**also**."
  - o In question **1.2e**, read 'Before you joined. **..**' only if the respondent needs to be reminded that the time frame is prior to enrollment.
8. Interviewers may **record** any factual item such as 2.23-2.24 (hospital stays) without asking if the answer is known. All subjective items must be asked.



	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
c. from another program or organization in <i>your community</i> ?.....01 otro <b>programa</b> o <b>organizacion</b> dentro de <b>la comunidad</b> ?		00	-1
d. Before you (joined/enrolled <u>CLIENT</u> in) <b>ElderCare</b> , did you read about <b>ElderCare</b> in the newspaper?.....01		00	-1
Antes de ( <b>asociarse/enrolar</b> el <u>CLIENTE</u> ) en <b>ElderCare</b> , <b>llego</b> a encontrar <b>informacion</b> sobre el program en <b>algun periodico</b> ?			
e. in a magazine? ..... 01 en <b>alguna</b> revista?	01	00	-1
f. did you (also) hear about <b>ElderCare</b> on the radio?.....01 en <b>un</b> program de radio?	01	00	-1
g. on television?..... 01 <b>un</b> program de television?	01	00	-1

1.3 Before you (joined/enrolled <u>CLIENT</u> in) <b>ElderCare</b> , did you have a regular doctor or place where you went if you were sick or needed advice about <b>your</b> health?	YES.....01 NO . . . . .(ASK Q1.4 NEXT)....00 DON'T KNOW.... (ASK Q1.4 NEXT)....-1
Ante8 de ( <b>asociarse/enrolar</b> el <u>CLIENT</u> &) en <b>ElderCare</b> , frequentava ud. <b>Algun</b> medico u otro <b>lugar</b> cuando se sentia <b>enfermo</b> o queria <b>counsejo</b> sobre la <b>salud</b> ?	

<p>1.3a How does <b>ElderCare</b> compare to your previous source of health care? Is it better, worse, or about the same?</p> <p>Como ud. compararia el program de <b>ElderCare</b> al tipo de servicio que recibia anteriormente: es <b>mejor</b>, peor o caei <b>igual</b>?</p>	<p>BETTER..... 01</p> <p>WORSE..... 02</p> <p>ABOUT THE <b>SAME</b>..(ASK 41.4 NEXT)..03</p>
<p>1.3b Why do you say that?</p> <p>Porque dice <b>eso</b>?</p>	<p><b>RECORD ANSWER HERE.</b></p> <hr/> <hr/>
<p>1.4 When you (joined/enrolled <b>CLIENT</b> in) <b>ElderCare</b>, <b>you were</b> given a new kind of Medicaid card. The new card is blue and had Prepaid Health Plan written on it (<b>SHOW EXAMPLE</b>). <b>Is</b> having a different Medicaid card a problem for <b>you</b>?</p> <p>Quando ud. (se ● socio/enrolo el <b>CLIENTE</b>) en <b>ElderCare</b>, recibio <b>una</b> tarjeta de Medicaid diferente. La tarjeta <b>nueva</b> es ● <b>zul y</b> en ella ertava escrito Prepaid Health Plan (<b>MUESTRE EJEMPLO</b>). Esta tarjeta diferente le <b>causa a ud. algun</b> problem?</p>	<p>YES.....01</p> <p>NO.....(ASK 41.6 NEXT)....00</p> <p>DON'T <b>KNOW</b>.... (ASK 41.6 NEXT).....-1</p>

<p>1.5 In <b>what way is it</b> a problem for you?</p> <p>De <b>que manera</b> le <b>causa</b> problem?</p>	<p>MEDICINE PURCHASES.....01</p> <p>PHYSICIAN FEES.....02</p> <p>OTHER (SPECIFY)</p> <hr/> <hr/>
<p>1.6 When you were thinking about (joining/enrolling <b>CLIENT</b> in) Eldercare, just before <b>ENROLLMENT DATE</b>, did you discuss Eldercare with a friend or family member?</p> <p>A / considerar (hacerse miembro/enrolar • l <b>CLIENTE</b>) en Eldercare, antes de la <b>DATA DE ENROLAMIENTO</b>, discutio ud. el program con algun pariente 0 amigo?</p>	<p><b>YES</b>.....01</p> <p>NO.....(ASK Q1.10 NEXT)....00</p> <p>DON'T <b>KNOW</b>... (ASK Q1.10 NEXT)....-1</p>
<p>1.7 Did (this/these) friend(r) or family member(s) encourage you, discourage you, or did (he/she/they) have no opinion on whether you should join?</p> <p>Tal(es) amigo(s) 0 pariente(8) le recomendaron a en contra de hacerse miembro, 0 no le ofrecieron opinion?</p>	<p><b>ENCOURAGED</b>.....01</p> <p><b>DISCOURAGED</b>.....02</p> <p>NO OPMON... (ASK Q1.10 NEXT)....03</p>
<p>1.8 What did (he/she/they) say that (encouraged/discouraged) you?</p> <p>Que fue lo que le dijeron para (animarlo/ desestimularlo) cuando • hacerse miembro?</p>	<p><b>RECORD ANSWER HERE.</b></p> <hr/> <hr/>
<p><b>THERE IS NO Q1.9 IN THIS VERSION</b></p>	

<p>1.10    <b>When you were</b> thinking about joining <b>ElderCare, just</b> before <b>ENROLLMENT DATE</b>, did you <b>discuss</b> (joining/enrolling <b>CLIENT</b>) with a doctor or other medical person?</p> <p><b>Al considerar (hacerse miembro/enrolar el CLIENTE) en ElderCare, antes de la DATA DE ENROLAMIENTO, discutio ud. la cuestion con un medico o otra persona de la area medica?</b></p>	<p>YES..... 01</p> <p>NO.....(ASK Q1.14 NEXT)....00</p> <p>DON'T KNOW. ..(ASK Q1.14 NEXT)....-1</p>
<p>1.11    Did <b>this</b> (doctor/person) encourage <b>you</b>, discourage <b>you</b>, or did <b>(he/she)</b> have no opinion on whether <b>you</b> should join?</p> <p>Tal (<b>medico/persona</b>) la <b>aconsejo</b> a favor 0 en contra del <b>enrolamiento</b> o no dio opinion?</p>	<p><b>ENCOURAGED</b>.....0 1</p> <p><b>DISCOURAGED</b>.....0 2</p> <p>NO OPINION.....(<b>AS K Q1.14</b>).....0 3</p>
<p>1.12    What did (he/she) say <b>that</b> (encouraged/discouraged) <b>you?</b></p> <p>Que fue lo que <b>le</b> dijeron para (<b>animarlo/ desestimularlo</b>) <b>encuanto</b> a <b>hacerse miembro?</b></p>	<p><b>RECORD ANSWER HERE.</b></p> <hr/> <hr/>
<p><b>THERE IS NO Q1.13 IN THIS</b> VERSION.</p>	

1.14 In the end, who made the decision to have **you** join **ElderCare**? Did **you** make the decision yourself, did **you** and a family member decide together, or did someone make the decision for you?

**Finalmente, quien** tomo la decision robre **su membresia** en **ElderCare**. Fue **una** desicion **suya**, de ud **y su familia**, o de **alguna** otra persona?

CLIENT DECIDED **ALONE**.....01  
JOINT DECISION.....02  
CLIENT DID NOT PARTICIPATE  
IN DECISION.....03

1.15 Still thinking of the time just before you joined **ElderCare**, what were some of your concerns about the **ElderCare** program? If there was anything **that almost** made you not (join/enroll **CLIENT** in) **ElderCare**, please tell me that too.

Antes de hacerse **miembro**, **cuales** fueron **sus propias** preocupacionee en **cuanto al programa**? **Cuenteme tambien** si hubo algun **aspecto** que **casi** lo llevo a **desistir**?

WRITE CONCERNS HERE.

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1.16 Before you joined **ElderCare**, were you aware that **ElderCare** provided any of the following services if needed, in addition to services regularly covered by Medicaid...

Antes de hacerse **miembro**, sabia ud. que **ElderCare**, en **adicion** a los servicios normalmente ofrecidos por Medicaid, provcia los **siguientes** servicios de acuerdo con su necesidad...

IF YES, **ASK:** Was this important or not important in deciding to join **ElderCare?**

**SI POSITIVO, PREGUNTE:** Tuvo eso **importacia** o no en su decision de hacerse **miembro**.

AWARENESS

IMPORTANCE

DON'T

NOT

KNOW **NO YES** IMPORTANT IMPORTANT

a. All prescribed *drugs* required for your medical needs.

Todas la **medicinas por receta** que **sean designadas** por su medico.

-1 00 01 -ASK-> 01 02

b. Help with housekeeping, meal preparation, family budgeting, and home accident prevention.

**Ayuda con los quehaceres de la casa**, con el presupuesto familiar, **preparacion de comidas y prevencion** de accidentas en el hogar.

-1 00 01 -ASK-> 01 02

c. In-home assistance with bathing, dressing, walking, eating, and supervision of medications.

**Asistencia para banarse, vestirse, caminar, comer y supervision de medicinas en el hogar.**

-1 00 01 -ASK-> 01 02

d. A **case manager** to help you coordinate care **needs and** arrange for needed services.

**Gerente de casos para**  
 ● **yudarle a coordinar sus necesidades con los servicios disponibles.**

-1 00 01 -ASK-> 01 02

		AWARENESS			IMPORTANCE	
		DON'T KNOW	NO	YES	IMPORTANT	NOT IMPORTANT
e.	Adult day health care. Cuidado diurno de adultos.	-1	00	01	-ASK-> 01	02
f.	Respite care so caregivers can take a break.  <b>Alivio para la persona que lo cuida.</b>	-1	00	01	<del>-ASK-&gt;</del> 01	02
g.	Escort service to accompany you to and from health care visits.  Servicio de acompañante para sus citas medicas.	-1	00	01	<del>-ASK-&gt;</del> 01	02
1.17	Before you (joined/enrolled <u>CLIENT</u> in) <b>ElderCare</b> , were you aware that any medical treatment or health care service paid for by <b>ElderCare</b> must be provided by a participating <b>ElderCare</b> doctor or by Mount Sinai <b>ElderCare</b> Plan?  <b>Sabia ud. antes de (asociarse/enrolar el CLIENTE) en ElderCare, que cualquier tratamiento medico u otro servicio cubierto por ElderCare deve ser prwisto atraver de un medico participanta del ElderCare o atraver del Plan.</b>	YES.....	NO.....	DONT KNOW.....	01	00 -1

<p>1.18 Before you (joined/enrolled <u>CLIENT</u> in) <b>ElderCare</b>, a member of the <b>ElderCare</b> staff visited your home to explain the program to you and your family. Was this explanation easy to understand or difficult to understand?</p> <p>Antes de (asociarse/enrolar el <u>CLIENTE</u>) en <b>ElderCare</b>, un empleado de <b>ElderCare</b> fue a su casa y la explico el program a ud. y su familia. La explicacion fue facil o dificil para entender?</p>	<p>EASY..... 01</p> <p>DIFFICULT.....0 2</p> <p>CANNOT <b>DECIDE</b>.....03</p> <p>NO RECALL OF <b>EXPLANATION</b>.....04</p>
<p>1.19 Was there any aspect of the <b>ElderCare</b> program that should have been made clearer to you before enrollment?</p> <p>Huvo algun aspecto del Program que la deberian haber aclarado antes de su enrolamiento?</p>	<p>YES..... 01</p> <p>NO..... (ASK 41.21 NEXT)....00</p> <p>DON'T KNOW...(ASK 41.21 NEXT)....-1</p>
<p>1.20 What is that?</p> <p>Cual fue?</p>	<p>RECORD ANSWER HERE.</p> <hr/> <hr/>

<p>1.21 Did you have <b>any</b> difficulties getting information about <b>ElderCare</b> or applying to the <b>ElderCare</b> program?</p> <p>Tuvo ud. <b>alguna</b> dfficultad <b>para</b> obtener <b>informacion</b> o aplicar <b>para</b> el program?</p>	<p><b>YES</b>.....01</p> <p><b>NO</b>.....(<b>ASK Q2.1</b> NEXT)....00</p> <p><b>DON'T KNOW</b>.... (<b>ASK 42.1</b> <b>NEXT</b>).....-1</p>
<p>1.22 What difficulties did you encounter?</p> <p>Cualee fueron <b>las</b> dificultades que eacontro?</p>	<p><b>RECORD ANSWER HERE.</b></p> <hr/> <hr/> <hr/>

**SECTION 2--OPINIONS ABOUT ELDERCARE SERVICES AND MEMBERSHIP**

<p>2.1 My next <b>questions</b> concern the services and care that you get now as a <b>member</b> of the <b>ElderCare</b> program. What is the one thing that you like best about the <b>ElderCare</b> program?</p> <p><b>La proximas preguntas seran sobre los servicios y el cuidado que ud. recibe como miembro del programa ElderCare. Que es lo que que mas le gueta del program ElderCare?</b></p>	<p>RECORD <b>ANSWER</b> HERE.</p> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>2.2 And what one <b>thing</b> about <b>ElderCare</b> would you change if you could?</p> <p>Que <b>cosa</b> cambiaria <b>si</b> fuera porible?</p>	<p>RECORD <b>ANSWER</b> HERE.</p> <hr/> <hr/> <hr/>
<p>2.3 How would you rate Mount Sinai Medical Center <b>as a place of</b> care ? Do you think it is excellent, good, fair, or poor?</p> <p>Que <b>opina</b> ud. robe <b>los</b> cuidador ofrecidor por al hospital <b>Mount Sinai</b>? Son excelenter, <b>buenos</b>, regularer, o deffcfente?</p>	<p><b>EXCELLENT</b>.....0 1</p> <p>GOOD..... 02</p> <p><i>PAIR</i>.....03</p> <p>POOR..... 04</p> <p><b>HAVEN'T RECEIVED CARE A?</b>  <b>MT. SINAI/DON'T KNOW</b>.....05</p>
<p>2.4 When you <b>see YOUR ELDERCARE PRIMARY CARE PHYSICIAN</b> for a routine <b>visit</b>, do <b>you</b> go to Ht. <b>Sinai</b> or romewhere else?</p> <p>Cuando <b>ud. ve A SU MEDICO PRINCIPAL</b> para un chrqueo de rutina, va 81 <b>Mount Sinai</b> 0 a otro lugar?</p>	<p><b>MT. SINAI</b>.....0 1</p> <p><b>SOMEWHERE ELSE</b>.....0 2</p>

<p>2.5 When you go to your doctor for care, how do <b>you usually</b> get there?</p> <p>Quando <b>va a su</b> medico que medio de trasporte <b>usa</b>?</p>	<p>DRIVEN BY RELATIVE OR <b>FRIEND</b>.....01</p> <p>TAXI..... 02</p> <p>PUBLIC BUS.....03</p> <p><b>SPECIAL TRANSPORTATION</b> (PROVIDED BY MOUNT SINAI OR OTHER <b>SPECIAL NEEDS PROGRAM</b>).....04</p>
<p>2.6 About how long does it usually take for <b>you to</b> get there?</p> <p>Quando <b>tiempo normalmente</b> se tarda <b>para</b> llegar a la <b>consulta</b>?</p>	<p>     _ _ _  MINUTES</p>
<p>2.7 Not counting <b>emergencies</b>, how many days do <b>you</b> have to wait between the <b>time that you</b> want an appointment with your <b>ElderCare</b> doctor and the day of your appointment?</p> <p>No contando <b>emergencias</b>, cuantos dias usted tiene que <b>esperar</b> entre el tiempo que usted quiere una cita con su medico de <b>ElderCare</b> y el dia de su cita?</p>	<p>SAME MY = 00</p> <p>NEXT DAY = 01</p> <p>      - : -   DAYS</p>
<p>2.6 How convenient are the appointment <b>times</b> you are given? Are they <b>convenient</b> or inconvenient?</p> <p>Las citas de medico que recibe, son en <b>horario</b> conveniente o no?</p>	<p><b>CONVENIENT</b>.....0 1</p> <p><b>INCONVENIENT</b>.....0 2</p> <p><b>CANNOT DECIDE</b>.....0 3</p>
<p>2.9 How long past your appointment time do <b>you</b> have to wait in the waiting <b>room</b> before <b>you see</b> the doctor?</p> <p>Que <b>tiempo</b> a llegado ud. a <b>esperar para</b> ver a su medico, despues de la hora ● rignada?</p>	<p>     _ _ _  MINUTES</p>

<p>2.10 Does this seem like too long to wait or about right?</p> <p>Le parece <b>bien</b> la espera, o <b>creo</b> que espera demasiado?</p>	<p>TOO LONG..... 01</p> <p><b>ABOUT RIGHT</b>.....0 2</p> <p>CANNOT DECIDE.....0 3</p>
<p>2.11 How would you rate your <b>ElderCare</b> doctor's professional competence, that is, (his/her) ability to treat your medical <b>problems</b>? Would you say excellent, good, fair, or poor?</p> <p>Como definiria usted a los <b>doctores de ElderCare</b> profesionales y competentes, eso es si (el o ella) tiene la habilidad de tratar sus <b>problemas medicos</b>? Diria usted <b>excelente</b>, bueno, ● decuado, deficiente.</p>	<p>EXCELLENT.....0 1</p> <p>GOOD..... 02</p> <p>FAIR..... 03</p> <p>POOR..... 04</p>
<p>2.12 And, how about (his/her) bedside <b>manner</b>, that is how easy (he/she) is to talk to and how (he/she) <b>explains</b> things to you? Would you rate it as excellent, good, fair, or poor?</p> <p>Y, que tal <b>el comportamiento de cabecera de</b> (al o ella) con que facilidad (el o ella) la habla o la <b>explica</b> las cosas a usted? Lo <b>considera usted como excelente</b>, bueno, ● decuado, deficiente.</p>	<p><b>EXCELLENT</b>.....0 1</p> <p>GOOD..... 02</p> <p>FAIR..... 03</p> <p>POOR..... 04</p>
<p>2.13 How would you rate your <b>ElderCare</b> doctor's ability to refer you to <b>specialists</b> when necessary?</p> <p>Como clasificaria ud. la ● <b>habilidad que tienen los medicos del ElderCare para hacrle referencia a un</b> ● <b>especialista</b> cuando lo <b>necesita</b>?</p>	<p><b>EXCELLENT</b>.....0 1</p> <p>GOOD..... 02</p> <p>FAIR..... 03</p> <p><b>POOR</b>..... 04</p> <p><b>NEVER HAD REFERRAL</b>..... -1</p>

<p>2.14 CASE MANAGER INSTRUCTION:  <b>DOES/HAS</b> RESPONDENT RECEIVE HOME CARE SERVICES?</p> <p>INSTRUCCIONES AL <b>GERENTE DE CASO</b>: ESTE CLIENTE RECIBE O HA RECIBIDO SERVICIOS EN SU CASA?</p>	<p>YES.....01</p> <p>NO.....(AS K Q2.18 NEXT).....00</p>
<p>2.15 My next questions <i>are</i> about the <b>ElderCare</b> services you get in your home. Overall, how would you rate the home care services you get as a member of the <b>ElderCare</b> program? Would you rate them as excellent, good, fair, or poor?</p> <p>Las siguientes preguntas son acerca del programa <b>ElderCare</b> y los servicios que le provee en su casa. Al todo, como definira ud. los cuidados que recibe en su casa como miembro del program <b>ElderCare</b>, los consideraria ud. <b>excelentes, buenos, ●</b> decuados, o deficiente.</p>	<p><b>EXCELLENT</b>.....01</p> <p>GOOD ..... 02</p> <p>PAIR..... 03</p> <p>POOR ..... 04</p>
<p>2.16 How would you rate the reliability of the home care worker to come on time and complete all the work <b>that (he/she) is</b> ruppored to do? Would you ray she <b>is</b> excellent, good, fair, or poor?</p> <p>Consideraria ud. que los <b>trabajadores</b> de su cudfado eon <b>puntuales y completan todo el trabajo</b> que (el o ella) estan supuesto hacer. Lo consideraria ud. ● <b>xceleate, bueno, adecuado, o deficiente.</b></p>	<p><b>EXCELLENT</b>.....01</p> <p>GOOD ..... 02</p> <p>PAIR..... 03</p> <p>POOR..... 04</p>

<p>2.17 And would you say it is easy or difficult to contact someone at ElderCare if you have a question or want to make a change in your home care routine?</p> <p>Diria ud. que le ha sido facil o dificil ponerse en contacto con una persona del programa ElderCare, cuando ud. a tenido preguntas o a querido hacer cambios en relacion a sus cuidados. Facil, dificil, no sabe.</p>	<p>BASY..... 01</p> <p>DIFFICULT ..... 02</p> <p>DON'T KNOW.....03</p>
<p>2.18 Have you ever used transportation services arranged by ElderCare?</p> <p>Ha usted usado servicios de transportacion para ud?</p>	<p>YES.....01</p> <p>NO.....(A8 K Q2.21 NEXT).....02</p>
<p>2.19 How would you rate the reliability of the transportation arranged by ElderCare? Think about their ability to pick you up and get you to where you are going on time. Would you say transportation arranged by ElderCare is excellent, good, fair, or poor?</p> <p>Como considera ud. los servicios de transportacion arreglados por ElderCare. Pense en la fiabilidad de recojerlo(a) y llevarlo(a) a su destino a tiempo? Diria ud. que las medidas de transportacion que ElderCare le provee son: excelentes, buenas, adecuadas, o deficientes.</p>	<p>EXCELLENT.....01</p> <p>GOOD..... 02</p> <p>FAIR..... 03</p> <p>POOR..... 04</p>

<p>2.20 And would you say it is easy or difficult to contact someone at <b>ElderCare</b> if you have a question or want to make a change in <b>your</b> transportation routine?</p> <p>Diria ud. que le ha sido <b>facil</b> o <b>dificil hacer contacto</b> con <b>alguien</b> en <b>ElderCare</b> cuando ha tenido <b>preguntas</b> o a deseado <b>hacer algun cambio</b> en su rutina de transportacfoa.</p>	<p>EASY. . . . . *.....**..... 01  DIFFICULT .....02  DON'T KNOW.....03</p>
<p>2.21 <b>Have</b> you ever had to nuke a sudden, unexpected change in the services <b>you</b> receive?</p> <p><b>PROBE:</b> Because someone <b>who</b> usually helps <b>you</b> had an emergency or got sick.</p> <p>Ha tenido ud. qua <b>hacer un cambio dramatico</b> en los <b>servicios</b> que <b>recibe</b>? <b>RAZON:</b> porque la <b>persona</b> que <b>usualmente le</b> ● <b>9uda se enfermo.</b></p>	<p><b>YES</b>.....01  NO.....(ASK 42.23 NEXT)....00  DON'T KNOW...(ASK Q2.23 NEXT)....-1</p>
<p>2.22 How would <b>you</b> rate the way <b>ElderCare</b> helped <b>you</b> in this situation? Would <b>you say</b> they were excellent, good, fair, or poor?</p> <p><b>Como</b> considera <b>usted</b> la <b>manera</b> que <b>ElderCare</b> le <b>ayudo</b> en <b>esa situacion</b>? Diria ud. que fue, excelente, <b>buena</b>, ● <b>decuada</b> o <b>deficiente.</b></p>	<p><b>EXCELLENT</b>.....0 1  <b>GOOD</b>..... 02  <b>FAIR</b>.....03  <b>POOR</b>..... 04</p>
<p>2.23 <b>gave you had</b> an <b>overnight</b> hospital <b>stay</b> since <b>you</b> joined <b>ElderCare</b>?</p> <p><b>Ha estado</b> ud. <b>hospitalizado(a)</b> desde que <b>se unio</b> a <b>ElderCare</b>?</p>	<p><b>YES</b>.....01  NO.....(ASK Q2.26 NEXT).....0 2</p>

<p>2.24 (Was this/were any of these) stay(s) at Mt. Sinai Hospital?  Alguna vez en el Mount Sinai?</p>	<p>ONLY AT MT. SINAI.....0 1 ONLY ELSEWHERE.....0 2 AT MT. SINAI AND ELSEWHERE.....0 3</p>
<p>2.25 How would you rate the quality of the care you got as a patient in the hospital? Would you rate the hospital care you got as an ElderCare member as excellent, good, fair, or poor?  Como considera usted la calidad del servicio que le fue ofrecido en el hospital como paciente? Como miembro del ElderCare ud. lo considero, excelente, bueno, • adecuado, o deficiente.</p>	<p>EXCELLENT.....0 1 GOOD..... 02 FAIR..... 03 POOR..... 04</p>
<p>2.26 Since you have been a member of ElderCare, have you ever gone to a non ElderCare doctor even if it meant that you had to pay for the care or service yourself?  Desde que ud. se hizo miembro de ElderCare, ha visto a otro medico no relacionado con ElderCare • u sabiendo que tendria que pagar por el cuidado o servicio ud. mismo?</p>	<p>YES.....01 NO.....(AS K Q2.28 NEXT).....0 2</p>
<p>2.27 Why did you seek care outside of ElderCare?  Porque busco cuidados fuera do ElderCare?</p>	<p>RECORD ANSWER HERE. _____ _____ _____</p>

<p>2.28 Since you have been a member of <b>ElderCare</b>, have you ever gone to any other kind of non <b>ElderCare service</b> provider even if it meant t&amp;t you had to pay for the care or service yourself?</p> <p>Desde qua ud. se hizo <b>miembro</b> de <b>ElderCare</b>, ha ido ud. alguna <b>ves</b> a otro proveedor no <b>relacionado con ElderCare</b>, • un sabiendo qua tendria qua <b>pagar</b>?</p>	<p>YES.....01</p> <p>NO.....(AS K Q2.30 NEXT).....0 2</p>
<p>2.29 Why did you seek care outside of <b>ElderCare</b>?</p> <p>Porque <b>busco usted servicios</b> fuera de <b>ElderCare</b>?</p>	<p>RECORD ANSWER HERE.</p> <hr/> <hr/> <hr/>
<p>2.30 One of the <b>goals of ElderCare</b> is to help people get the care they need in their <b>homes and communities</b> instead of in <b>nursing homes</b>. Do you think <b>ElderCare</b> can help people stay out of <b>nursing homes</b>?</p> <p>Una de las <b>metas</b> de <b>ElderCare</b> es ayudar a la <b>persona</b> a obtener al <b>cuidado</b> que <b>necesita</b>, en su <b>hogar y comunidad</b> en ves de en un <b>anfanato</b>. Crer ud. que <b>ElderCare</b> puede <b>ayudar a mantener las personas fuera</b> do los <b>ancianatos</b>.</p>	<p>YES.....01</p> <p>NO..... 00</p> <p>DON'T <b>KNOW</b>..... -1</p>
<p>2.31 Do you <b>think ElderCare</b> has <b>helped you stay</b> out of a <b>nursing home</b>?</p> <p>Y en lo que se <b>trata</b> de ud. <b>mismo(a)</b>?</p>	<p>RECORD ANSWER HERE.</p> <hr/> <hr/> <hr/>

<p>2.32 For the last question, I would like you to tell me what advice you would give to a friend who was thinking of joining ElderCare?</p> <p>Para la ultima pregunta me gustaria que ud. me dijera que consejo la daria a un amigo(a) qua este pensando asociarse en ElderCare?</p>	<p>RECORD ANSWER HERE.</p> <hr/> <hr/> <hr/>
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THANK RESPONDENT FOR HIS/HER TIME AND COOPERATION.

<p>2.33 CASE MANAGER: WAS THIS INTERVIEW CONDUCTED COMPLETELY WITH THE CLIENT, WITH A PROXY, OR WITH BOTH?</p>	<p>ALL CLIENT.....0 1</p> <p>ALL PROXY.....0 2</p> <p>COMBINATION.....0 3</p>
<p>2.34 CASE MANAGER: DID THIS RESPONDENT HAVE TROUBLE COMMUNICATING?</p>	<p>YES.....01</p> <p>NO.....00</p>
<p>2.35 CASE MANAGER: HOW WAS THIS INTERVIEW CONDUCTED?</p>	<p>PHONE.....01</p> <p>IN PERSON.....0 2</p> <p>COMBINATION.....0 3</p>