Evercare

SPECIAL NEEDS PLANS

Medicaid Managed Care Congress
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UnitedHealth Group

Presentation Overview

- **Background on the Evercare Model**
- **Transition to Special Needs Plans**
- **Discussion of Potential State Relationships with Special Needs Plans**
- **Challenges**

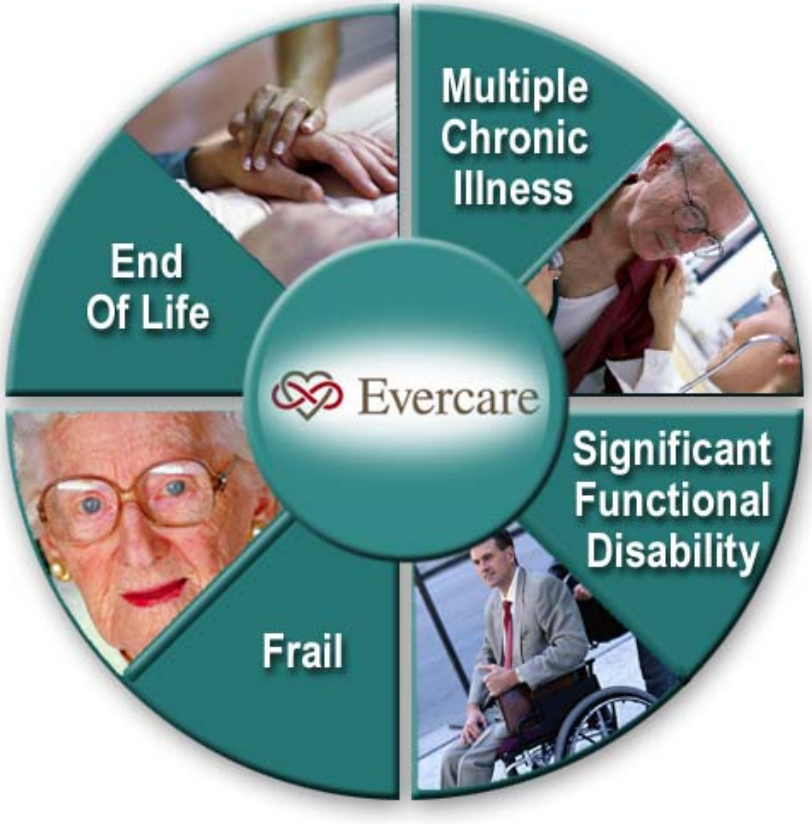
Evercare Organizational Background

Our mission is to optimize the health and well-being of aging, vulnerable and chronically ill individuals

- **Parent organization - UnitedHealth Group**
  - Diversified health and well-being organization
  - Comprised of six business segments, each serving a unique population
- **Part of Ovations, business segment focused on care for individuals over age 50**
  - Provide Medicare supplement to 3.5 million AARP members
  - Medicare Advantage plans serving 330K beneficiaries
  - Evercare serves 70K elderly and physically disabled members
  - Offering Medicare Part D nationwide in 2006
- **Sister organization with AmeriChoice**
  - Serving 1.4 million TANF, SCHIP and ABD beneficiaries

Our Mission

To optimize the health and well being of vulnerable, aging and chronically ill individuals



Medicare Demo Results

- Evercare members reported higher satisfaction with all care items as compared to the control groups at 97% in 2002
- Evercare families reported significantly higher satisfaction on:
  - Seen often enough
  - One person in charge
  - Spends enough time
  - Explanation of health problems
- Evercare members and families were more likely to recommend their nursing home
- 50% reduction in hospitalization with no adverse outcome
- 50% reduction in ER use

Source: "Nursing Home Residence Covered by Medicare Risk Contracts," Journal of American Geriatrics, April 2002 , Vol 50, No. 4

Special Needs Plan (SNP)

New type of Medicare Advantage coordinated care plan focused on individuals with special needs created by Section 231 of the MMA.

- **Institutionalized Beneficiaries:**
  - Those who reside or are expected to reside continuously for 90 days or longer in Skilled Nursing Facility/Nursing Facility (SNF/NF);
  - Those individuals living in the community but requiring a level of care equivalent to that of individuals in SNF/NF.
- **Dually Eligible Beneficiaries:**
  - Beneficiaries must have Medicaid coverage at the time of enrollment;
  - SNP's may enroll full and/or partial duals (Medicare Savings Program)
- **Beneficiaries with Chronic Conditions**
  - To provide as much flexibility as the law allows and because this is a new "untested" type of MA Plan, CMS did not set forth in regulation a detailed definition of severe and disabling chronic conditions;
  - CMS will evaluate proposals on a case-by-case basis;
  - CMS will consider appropriateness of target population; clinical programs and special expertise; other unique features of the SNP serving the proposed target population.

SNPs –What is Special?

- **SNPs are a *Medicare* Product**
  - **No requirement to coordinate with Medicaid**
  - **States may not have SNPs in their radar**

- **Different Marketing and Enrollment rules than Medicare Advantage**
  - **Able to target enrollment**
  - **Able to accept new enrollees all year**

- **Same payment and care coordination rules as MA-PDs**

SNPs provide great potential to improve care for duals and people with chronic health conditions.

Transition and Implementation Issues

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- **Some Special Needs Plans transitioned from a Medicare Demonstration or from a state designed Medicaid/Medicare integrated initiative.**

- **Other plans responded to the incentives in the law and regulations and formed plans to serve duals, the institutionalized or persons with chronic illness**

Expect different implementation issues to arise in each type.

2007 Filings due before much experience with SNPs.

States have had other priorities in 2006

Care Coordination

- **The Special Needs Plan legislation was a way to make certain Medicare demonstration projects "permanent".**

- **All of these projects had a formal approach to care coordination or care management to improve the quality of care while achieving appropriate cost savings.**

- **The SNP legislation does not require any "special" care management approach for the target groups- institutionalized, duals, or persons with chronic and disabling conditions.**

  All Medicare Advantage plans must have a Chronic Care Improvement Plan

  Current Quality Measurement Metrics Focus on Acute Measures

Care Coordination

Development of care coordination requires significant investment in assessment, stratification of risk, predictive modeling, developing the plan of care and the hiring, training and ongoing support of the care managers.

Will new entrants to the SNP market make the upfront investment?

What changes do current programs have to make to scale-up for new enrollees?

Will enrollment be sufficient to support the care management infrastructure?

Will beneficiaries and their representatives differentiate among plans on the basis of the care coordination model?

Will risk adjustment be adequate for plans with all high need enrollees? Current methods do not recognize frailty or dementia as cost drivers.

Will states use SNPs as a basis for care coordination for duals?

Cost sharing and the duals

State Medicaid programs vary in coverage of services and payments for those services.

- **Plan design and bids have to make assumptions about the cost sharing available from Medicaid.**
- **Providers may or may not be able to claim Medicaid cost sharing. *No automatic "cross-over" claim?***
- **States may have existing ABD managed care contracts for Medicaid services with other plans.**

State Cost Sharing Requirements

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- **Premiums**
  - States must pay Part B Premiums for the various categories of duals
  - States may pay for the premium charged by a Medicare Advantage plan (MA-PD and SNP)
    - Designated in state plan
    - Option permitted for premiums to be paid for regular or supplemental Medicare benefits deemed as cost effective to the State.
  - States may contract with MA-PDs/SNPs for Medicare cost sharing and for some or all Medicaid services

- **Medicare Co-pays and Deductibles**
  - States must pay Medicare co-pays and deductibles
  - States can limit these payments to the Medicaid rate
  - Many states have set these rates at 80% of Medicare FFS

State Incentives to Pay Medicare Cost Sharing through Capitation

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- **Pay Correctly. Assure that their cost sharing is limited under the plan model to that provided in FFS; the actuarial equivalent models used by MA plans could result in more cost sharing on certain services on a claim –by- claim cost sharing basis.**
- **Reduce Paperwork. Eliminates the claim-by claim payment of deductibles and co-insurance. Reduces burden on providers and beneficiaries.**
- **Access data. The contract can permit data sharing on drug and health care utilization for full and partial duals**

State Incentives to "Wrap" Medicaid Services into SNP contracts

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- Add Part D excluded drugs ; eliminates two pharmacy management system for same person
- Provide the opportunity for better care management for all services
- Assure access to a broader provider network
- Encourage development of certain types of MA-PD and SNP benefit and cost sharing structures
- Use SNP as a means to begin broader reform
- Leverage additional services for beneficiary
  - *Many states have very limited or no dental, vision etc.*

No State Relationship with Special Needs Plans

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- State pays all Medicare Cost Sharing on Fee For Service basis
  - Part B premiums ($88.50 per person per month)
  - Medicare co-insurance
  - Medicare deductibles
- State is a secondary payer to SNP plan
  - Balance billing by providers

Considerations

- No coordination of services between state and plans
- Providers bear burden of billing plan and state for Medicare-covered services
- State has unpredictable costs

Potential Models for SNP and State Medicaid Coordination

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- **Default**
  - **Medicaid State Plan services are provided by state; state pays Medicare co-pays up to state plan level as a secondary payer to SNP enrollment; no formal relationship with SNP.**
  - **Or, state pays premium based plans on an individual by individual basis as “cost effective" insurance**
- **Capitated wrap-around contract with state for Medicare cost sharing only**
- **Plan level integrated model**
  - **Health plan pursues contracts with Medicaid for additional services such as OTC drugs, HCBS, nursing home**
  - **Plan has to follow separate Medicaid and Medicare requirements for appeals, marketing, performance measurement, etc**
- **Three party integrated model: a three way contract between the State, CMS and the health plan.**
  - **Prior to SNP option, used by MN,MA, WI as early innovators to design comprehensive programs**

Potential Models for SNP and State Medicaid Coordination (cont)

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- **State as Active Purchaser**
  - **State crafts a Medicaid contract with a SNP with active leveraging of the Medicare benefit and contract requirements**
  - **Special Needs Plan benefits because marketing, performance measurement, reporting, enrollment and other rules are consistent with the Medicare requirements.**
  - **State and SNP benefit from sufficient enrollment to support care coordination infrastructure**
  - **Beneficiary benefits from care coordination; seamless benefit structure, enrollment in Medicare plan**
  - **State can use to rebalance the long term care system**

Example: New York's Medicaid Advantage (acute services)

SNPs and Medicaid Long Term Care

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- SNPs can manage care to prevent premature NH entry
  - SNPs can enroll the partial duals
- Institutionalized beneficiaries are overwhelmingly dual eligibles
  - The states are the primary purchaser of long term care; a formal relationship is desirable.
  - States are concerned with the management of care within the nursing home;
    - Overall quality
    - Medication management
    - Use of other services, especially transportation, ER, therapy, avoidable hospitalizations
    - Assurance that short term stays remain short-stay

SNPs can be a catalyst for the growth of integrated long term care initiatives that strengthen and rebalance the long term care system.

Challenges to SNP Growth

- **Payment appropriate to the cost of serving populations with high needs**
  - **Risk adjustment is improved: does not account for frailty or intensity of certain chronic conditions**
  - **CMS has not updated the Medicaid State Plan on Cost Sharing for the Duals**
- **Methodologies for determining Part D low income subsidies will reduce non-drug supplemental benefits.**
- **Difficult to market to duals without a state partnership**
  - **One by one sales**
  - **Care coordination; not price, is the value for duals**
  - **Duals enrolled in a PDP plan may be reluctant to change**

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