

# Aetna Medicaid

*Special Needs  
Plans....*

*What Works; What  
Doesn't*



# Topics

- Aetna Medicaid Overview
- Special Needs Plan (SNP) Overview
- Mercy Care experience as Medicare Advantage Dual SNP and ALTCS Medicaid MCO
- Focus on Long-Term Care Model

# Overview Aetna Medicaid

- We manage services for more than 1 million members in 12 states:
  - Arizona, California, Connecticut, Delaware, Florida, Indiana, Maine, Maryland, Missouri, New Hampshire, Pennsylvania, Texas
  - \$3.5 billion in health care expenses annually
  - Over a decade of Medicaid managed care experience with Risk and ASO contracts with states and provider owned health plans
  - Experience with TANF, CHIP, ABD, LTC programs
  - Schaller Anderson purchase in 2007

# What is a SNP?

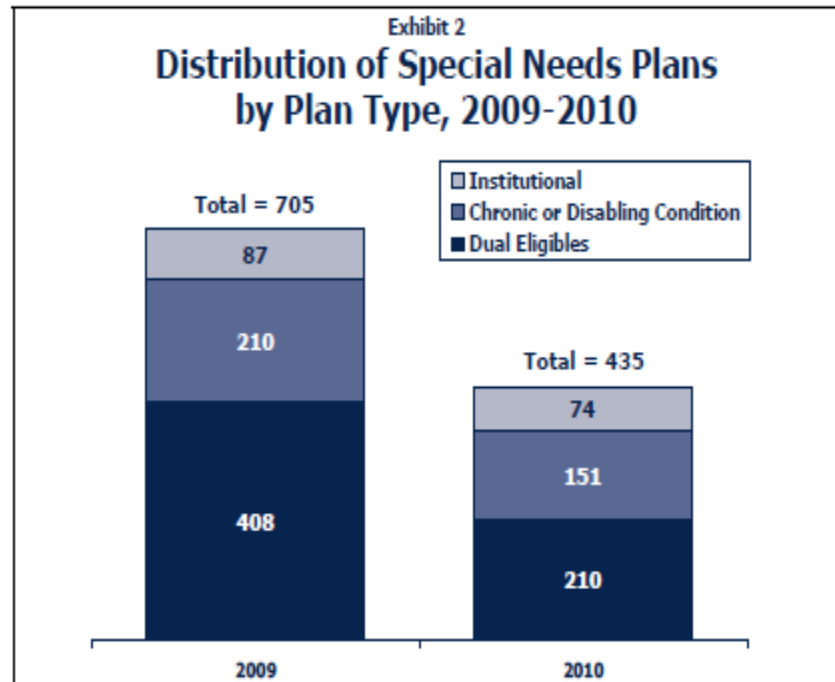
- Medicare SNPs are a type of Medicare Advantage Plan
- Enrollment is limited to three categories of Medicare beneficiaries
  - Institutional SNP
  - Chronic Condition SNP
  - Dual eligible SNP (today's focus)
- All SNPs must offer Part D prescription drug benefit and, unlike mainstream Medicare Advantage, members may enroll or dis-enroll on a month-to-month basis

# SNP History and Authority

- Health Care Reform extends SNPs through 2013
  - Extension of SNPs beyond 2013 requires legislation
  - Dual SNPs require coordinating state Medicaid contract
    - Any new Dual SNPs or geographic expansions through 2012
    - All Dual SNPs require state coordinating contracts for 2013
- History
  - SNPs first authorized by Medicare Modernization Act of 2003 through 2007
  - Congress first extended SNPs through 2010 with a one-year moratorium in 2008
  - Extensive SNP regulatory requirements exist

# Number of SNPs decrease in 2010

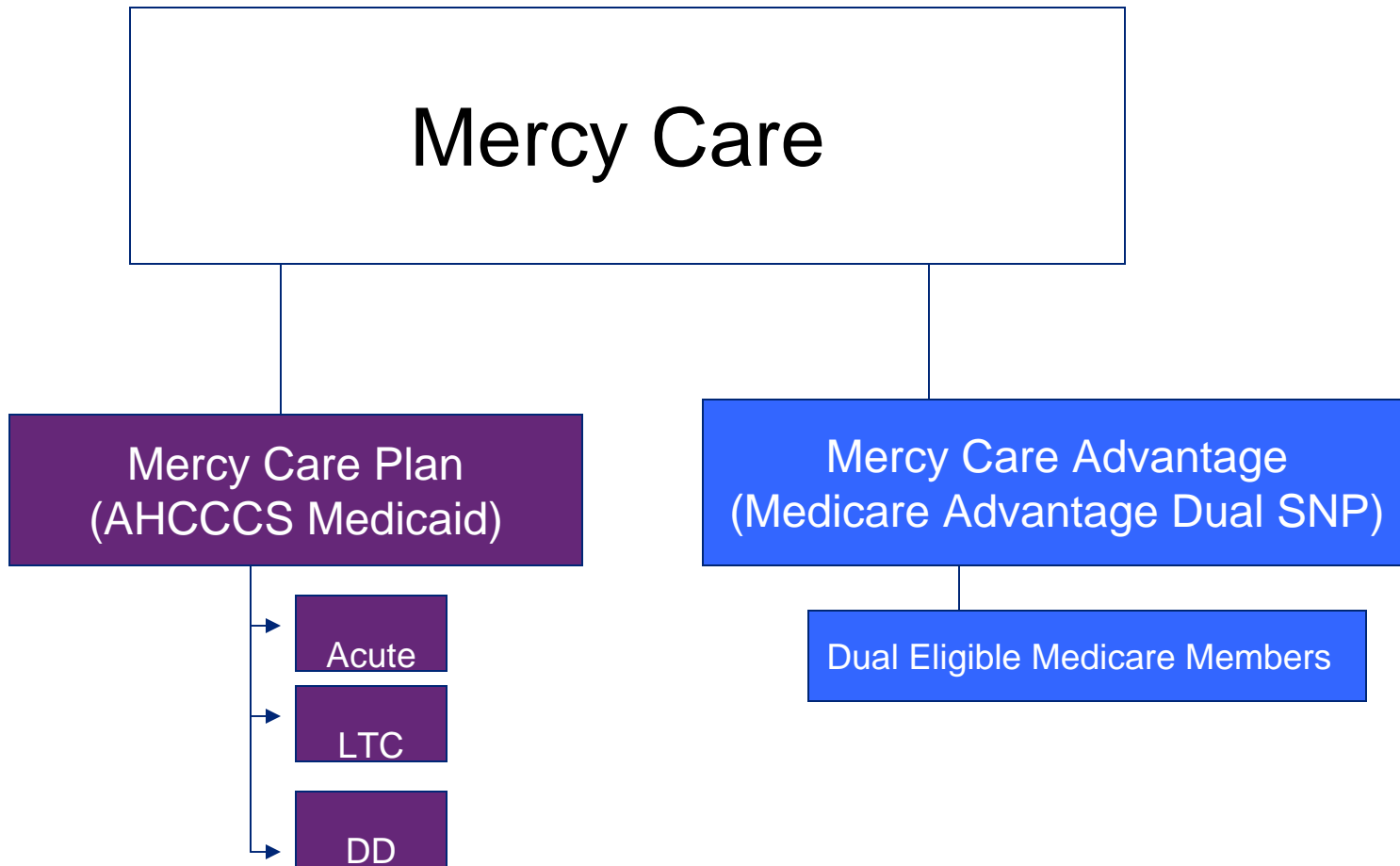
- All SNP types had decrease in number of plans for 2010
- Factors behind decrease
  - Requirement that dual SNPs must obtain state contracts (not all states willing) in addition to CMS contract (new or expanding service areas)
  - Model of care, benefit design, and administrative requirements
  - Profitability of plans
  - Low enrollments in many plans
  - Questions about longevity of SNP authorization



**NOTE:** Excludes Special Needs Plans (SNPs), demonstrations, Health Care Prepayment Plans (HCPPs), Program of All Inclusive Care for the Elderly (PACE) plans, and employer-sponsored (i.e., group) plans, and other plans for selected populations (e.g. Mennonites).

**SOURCE:** MPR analysis of CMS's Landscape Files for 2009 and 2010 for the Kaiser Family Foundation.

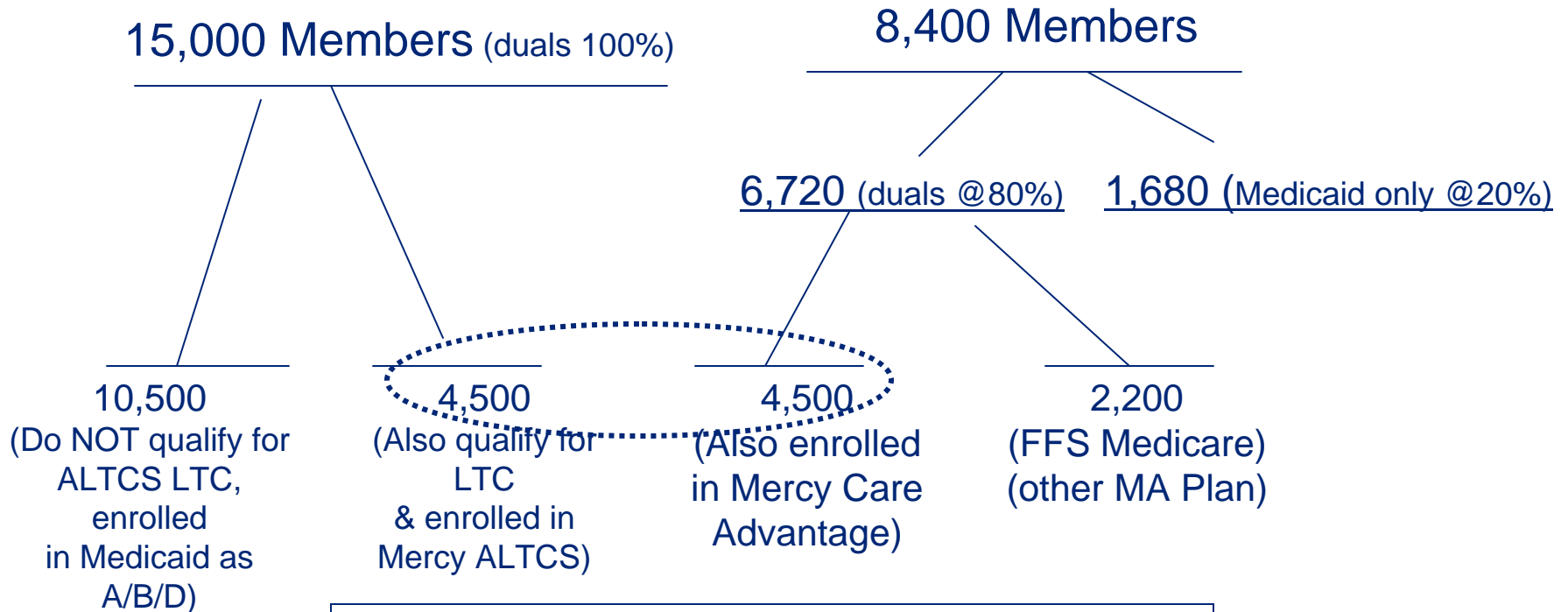
# Mercy Care Scope of Business



# Mercy Care Membership

## Mercy Care Advantage (Medicare Dual SNP)

## Mercy Care ALTCS (Medicaid Long-Term Care)



*Note: 4,500 dual eligible members enrolled in both Mercy Medicare SNP and ALTCS Medicaid LTC*



# Mercy Care's Long-Term Care Financial Experience



- Acuity of membership receiving LTC is not always reflected in the federal Medicare Advantage Dual SNP capitation rate
  - Coding from providers
  - Rapid decline not always reflected in rates
- As the percentage of duals being managed in HCBS rather than an institutional setting increases, there is a corresponding increase in primarily covered Medicare medical costs

## Future

- Health Care Reform will allow PACE frailty adjustment for Medicare Advantage plans that meet certain LTC criteria (2012 earliest)

# Advantages

- From the members' perspective:
  - Mercy Care's dual SNP offers its members these advantages:
    - Integration of benefits (one set of member mailings, customized member materials that include Medicare and Medicaid benefits, single case manager)
    - "Value-added" services complimentary to Medicaid benefits
    - Specialized provider network and care plans developed by interdisciplinary team
- From Medicare Advantage plan perspective
  - Dual SNPs offer an entre into state Medicaid contracting
- From a Medicaid plan perspective
  - Dual SNPs offer a way to contract for both the Medicare and Medicaid covered benefits for dual members

# Disadvantages

- For health plans
  - Two separate contracts each with unique regulatory, enrollment, claims and reporting requirements with the associated administrative expense
  - Potential for adverse selection that poses significant risk that can be unaccounted for risk adjusted rates
  - Significant new federal quality standards that can be challenging especially among smaller plans with limited resources (care plans, NCQA, IDT)
- For most states
  - Lack of availability of SNPs statewide (especially in rural areas)
  - Inability to share in savings generated from the Medicare-covered benefits
- For all parties
  - Uncertainty of federal funding for Medicare Advantage plans in the aftermath of Health Reform
  - Uncertainty of authorization of SNPs beyond 2013

# Focus on Long-Term Care

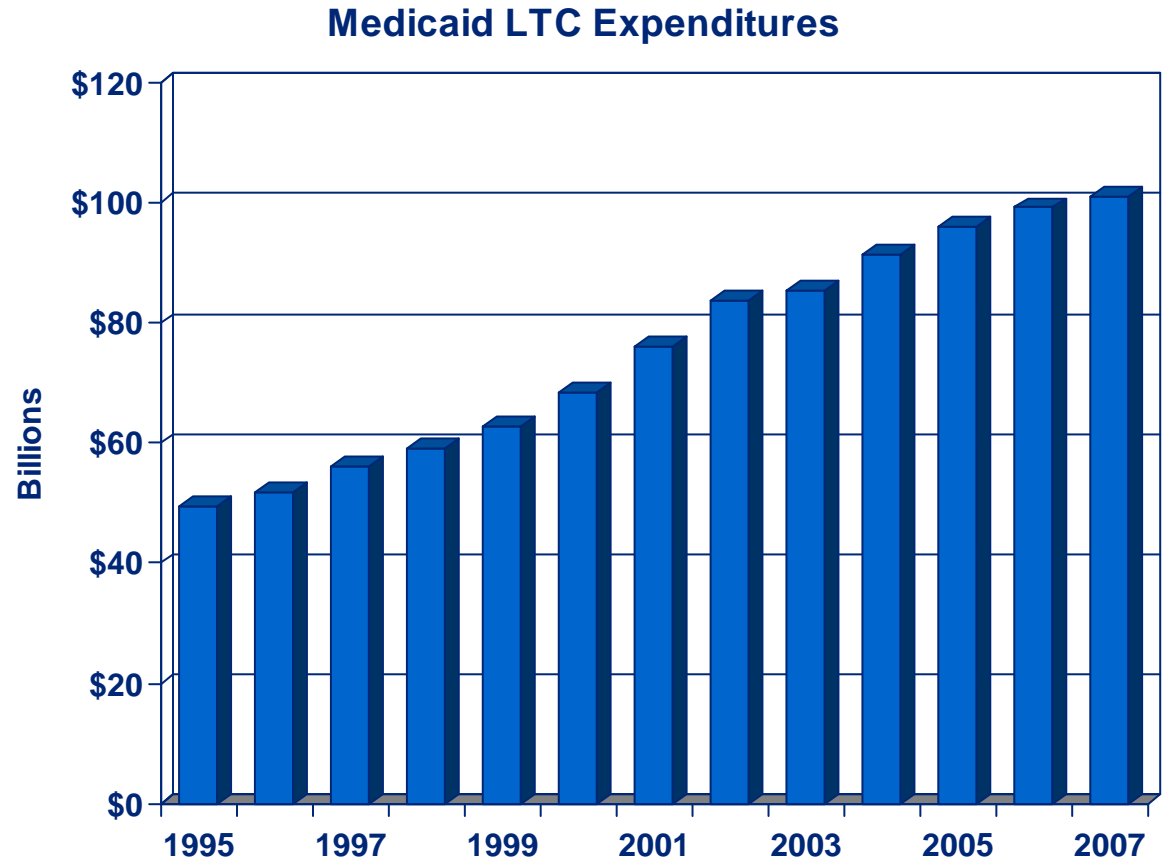


If rebalancing long-term care from an institutional to home and community-based services is the primary focus for states, then let's focus on the long-term care component.

Remember 75% of all the cost for the dual members goes to LTC services such as nursing facilities.

# Medicaid LTC Expense Increasing

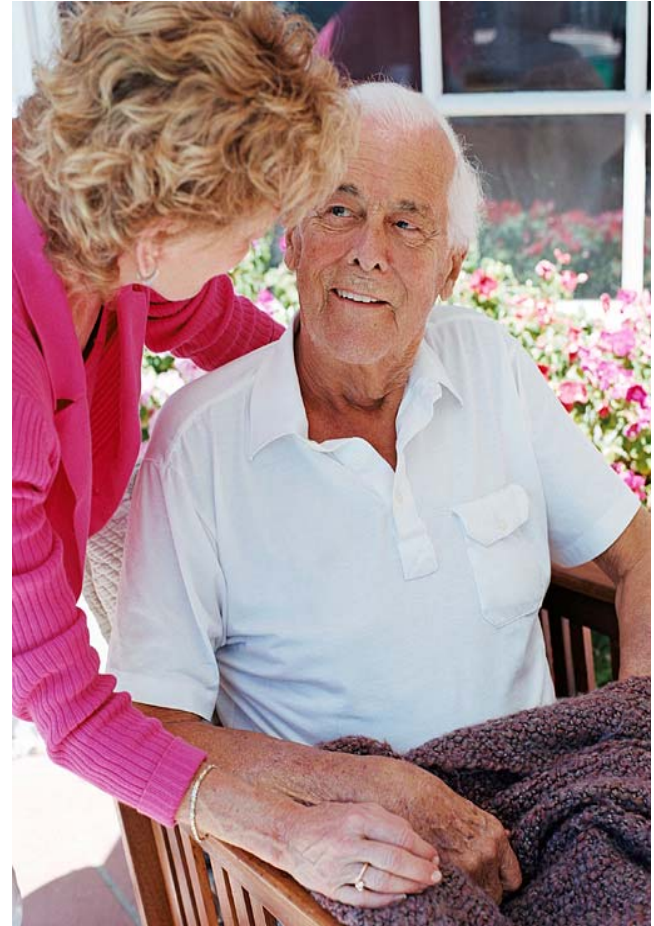
- LTC spending has more than doubled from \$49.4 billion in 1995 to \$101.2 billion in 2007.
- By 2026, the first wave of baby boomers will turn 80 years old



Source: CMS data, Division of Financial Operation. B. Burnwell compiled.

# Aetna Medicaid Long-Term Care Model Components

- Member-centered approach that enables members to tailor services according to their individual needs and preferences
- Care coordination enables members to reside in the least restrictive setting possible, while supporting maximum independence
- Risk-based, fully or partially capitated financial structure that provides incentives for the most cost-effective placement of individuals



# Aetna Medicaid Long-Term Care Model

## Member-Centered Approach



- Home & Community-Based Care (HCBS) services:
- Consumer-directed care
  - Full array of home & community-based support

- Assisted-living centers
- Adult-day care
- Congregate care homes/adult foster care
- Individual homes

- Support services
- Home modifications
  - Assistive equipment
  - Durable medical equipment (DME)

- Institutional care (NF)
- Custodial
  - Specialty Care

- Acute services for non-duals
- Cost sharing for duals

\* Covered medical cost for all non-duals and state cost-sharing responsibility for duals.

# Win for Medicaid recipients

- An AARP study shows 87% of people age 50 and older, or those who are physically disabled, want to receive services in their own homes.





# Win for States

- Eliminate costly institutional care bias
  - Assist states with “rebalancing” strategies while utilizing a model that supports the Americans with Disabilities Act and the Olmstead decision
- Transfer financial risk from state to managed care plan
- Provide states with a more predictable budget process than fee-for service (FFS) unmanaged models



# Win for States (cont.)

## Based on Aetna Medicaid's experience, managed LTC models can:

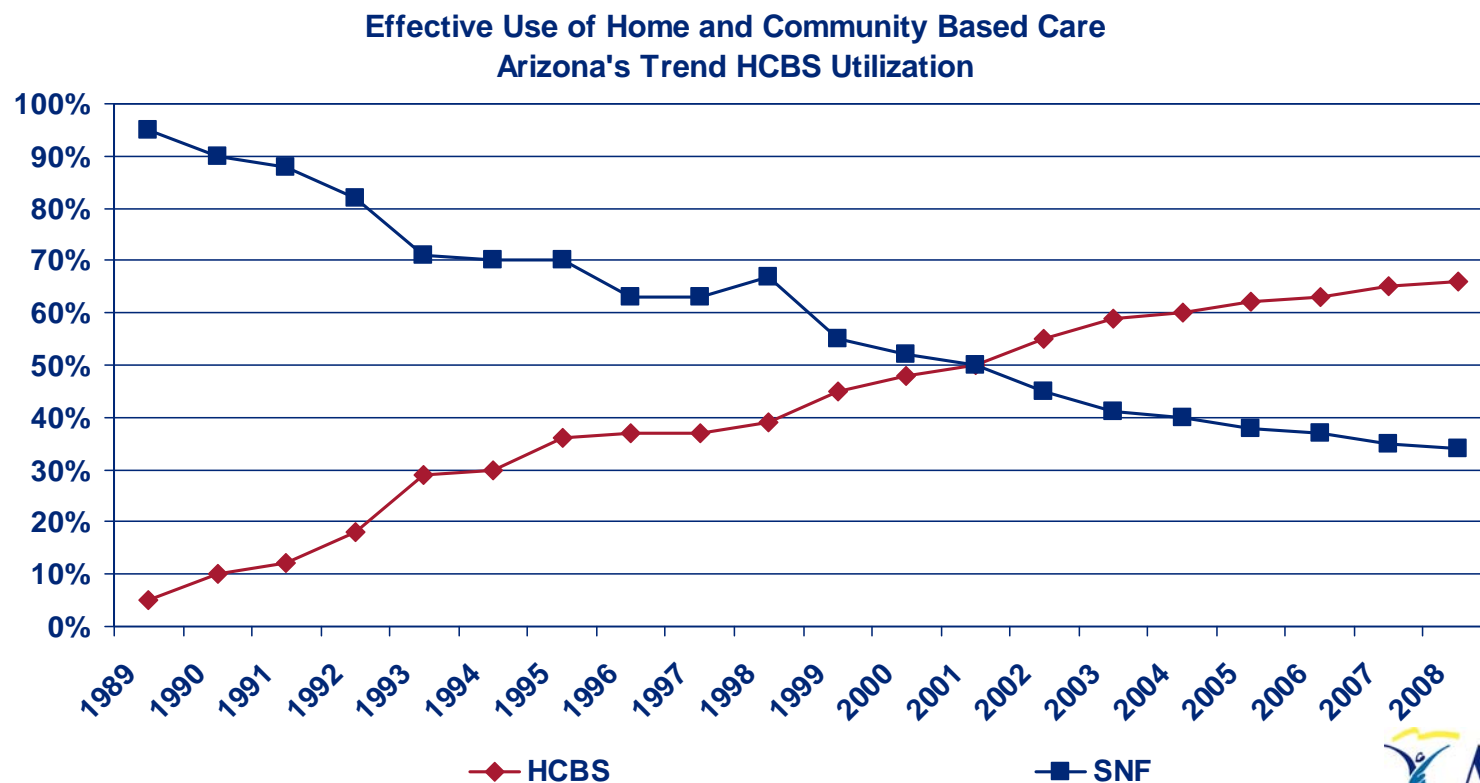
- Yield an initial savings ranging from 5% to 13% compared to equivalent fee-for-service (FFS) programs

### ALTCS Medicaid MCO capitation rates

- \$4,947 pmpm NH
- \$1,700 pmpm HCBS
- \$3,247 pmpm state relative savings or \$38,964 pmpy

# Arizona's Success: Rebalancing Institutional and HCBS Services

- As the largest membership ALTCS Medicaid MCO, Mercy Care has been a proud partner with the state since 1989



# Questions...

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