DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrep	10-28-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-185	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Mr. Keck, Deps Cleared 11/1/11, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

UnitedHealthcare Community Plan
100 Executive Center Drive,
Ste. A-13
Columbia, SC 29210

October 26, 2011

Mr. Anthony Keck
Agency Director, SCDHHS
P.O. Box 8206
Columbia, South Carolina 29202-8206

Dear Tony:

UnitedHealthcare Community Plan is excited about the plans South Carolina has to integrate care for dual eligible individuals. As you know, the needs of this population are complex and a program designed to integrate the Medicare and Medicaid benefits will both improve quality as well as decrease costs.

Nationally, we serve nearly 2 million dual eligibles in Part D, Medicare Advantage, Special Needs Plans (SNPs), and Medicaid plans. Of this, more than 160,000 are in SNPs in 34 states. In addition, we serve more than 125,000 complex individuals – including dual eligibles – in Medicaid long-term care programs. We have experience integrating Medicare and Medicaid benefits through plan level integration in many markets and since the inception of Massachusetts' Senior Care Options Plan (SCO) have been a participating plan to comprehensively integrate benefits through program design. This national experience has provided us a unique perspective on how to develop programs that will optimally meet the needs of these complex beneficiaries.

As South Carolina works with CMS, health plans, advocates, and others to develop an integrated approach to dual eligible South Carolinians, we would like to offer a few recommendations for consideration. In addition to these recommendations, we would offer the expertise of our Complex Care Products Team should additional questions arise or clarification on these recommendations is needed.

We believe there are a few fundamental elements to creating a model that will most effectively meet the goals of the State. First, the rates must be developed in such a way as to ensure programmatic success. This is especially true as the State works with CMS in developing the Medicare funding. UnitedHealthcare believes that the Medicare funding should be based on dual eligible fee-for-service experience rather than aggregate Medicare experience. We know from serving a broad array of Medicare beneficiaries, that Medicare costs differ significantly for a beneficiary only eligible for Medicare as compared to those who are dually eligible. Establishing the Medicare funding on aggregate Medicare experience will underfund the costs of those to be served in South Carolina's integrated program.

In addition to ensuring dual eligible fee-for-service experience is the basis for establishing the Medicare funding, we would recommend the State advocate for individual risk adjustment similar to the process established for PACE programs while not requiring the membership meet the nursing home level of care as established within PACE. This will allow individually risk adjusted Medicare funding that would adjust for the population served – both those who have met the nursing home level of care and those duals who have not.

These Medicare focused funding priorities should be matched with the establishment of a Medicaid capitation that is appropriately supportive of the goals of an integrated model. The Medicaid rates should be actuarially sound and based upon fee-for-service experience. Our experience has indicated that a blended rate – one that blends community and nursing home rates based on fee-for-service experience – is most effective at aligning incentives to encourage repatriation of nursing home residents while avoiding placements as often as possible. In addition, should the State intend to include a savings assumption based on things such as re-balancing nursing home utilization, this assumption should be reasonable and based on experience in other states with a long-standing history of successfully and progressively increasing use of community-based services.

Secondly, we recommend that enrollment in the integrated program should be as broad as possible. Limiting the program to certain diagnoses or subpopulations will limit the impact to the State and require duplicative administrative burdens. Furthermore, we recommend enrollment into the program be mandatory and at a minimum individuals should be automatically enrolled with minimal, time limited options to opt out to allow for plan stabilization. Voluntary programs, such as SCO have had very limited enrollment even many years after enrollment, thereby further jeopardizing the ability to broadly impact the sustainability of the Medicaid program.

Thirdly, benefit design should be inclusive of all Medicare, Medicaid, and waiver services. Implementation of a program such as this is an opportunity to explore additional waiver-type benefits for inclusion. We believe a broad array of community-based benefits can be beneficial to maintaining independence and avoiding or prolonging use of costly services such as nursing home, emergency rooms, or hospitals. In conjunction with a broad benefit design, it is important to minimize barriers to using home and community based services. Barriers such as waiting lists or slots to access 1915 (c) services can actually result in an obstacle to community placement for individuals who can be safely cared for in the community.

In addition, eligibility levels can impact access to benefits and should be carefully considered by the State in developing an integrated approach. For instance, we recommend having placement in a nursing home require a higher eligibility threshold than accessing community services. This allows for minimal barriers to accessing services in the community while

placing an additional eligibility burden on those in need of nursing home services. In addition, the State may consider a home and community based services "light" benefit set for individuals who have not met the nursing home level of care threshold but could benefit from a limited benefit set – such as homemaker, shopping, home-delivered meals, etc. – in order to avoid further functional decline or increased risk of exacerbations of chronic conditions.

Finally, quality measurement should be a foundational element of program design for dual eligibles. We encourage the State to negotiate with CMS standards that are applicable to the population to be served in the integrated program and avoid the application of either Medicaid metrics that are not demonstrative of quality for duals or application of the Medicare STAR rating criteria. A dual-specific quality monitoring program should be based upon indicators that are meaningful to individual beneficiaries as well as demonstrate program and health plan effectiveness. We recommend the State consider creating a quality model that is based on seven domains. These are: participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and system performance.

Supplemental to these fundamental program design recommendations, we have additional programmatic suggestions for consideration by the State based on our experience in supporting dual eligibles through our various products. We are attaching an overview of these program elements for consideration.

Thank you for the opportunity to provide feedback as the State moves to creating an integrated program. We believe there are significant opportunities to positively impact the quality and costs associated with these beneficiaries and there is an unprecedented opportunity to create an effective program with the support of CMS.

Should you have any questions or if we can provide more insight based on our experience, please feel free to contact me at (803)726-1732.

Sincerely,

Dan Gallagher
Plan President
UnitedHealthcare Community Plan

Cc: Sam Waldrep, Deputy Director
Enclosure

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Designing Programs for Complex Populations
Essential Elements

Element	Description
Population	o Broad inclusion of populations key to most impactful program. o Individuals should be included in program that are not yet eligible for long-term care – aged, blind, and disabled (ABD)individuals – to ensure ability to identify individuals who are at risk and provide services to avoid future decline
Enrollment	o Mandatory enrollment is fundamental to program success and ability to provide systemic program improvement o Auto assignment should ensure equal enrollment and mix among plans o Consideration of weighted assignment to high quality plans following at least 12 months of program experience
Eligibility	o Eligibility requirements must be established to minimize barriers to waiver participation o Ideal program includes equal or tiered eligibility making nursing home placement equal to or more difficult than waiver placement o Waiver waiting lists ideally should not be used to limit ability to repatriate or seek community placement
Lock-In	o Sufficient lock-in -- optimally 12 months – is necessary to achieve quality improvement
Program Responsiveness	o Health plans should have the ability to assess ABD members for nursing home level of care and/or waiver eligibility o Sufficient incentives should exist to encourage repatriation and nursing home avoidance o Contractual requirements should support appropriate utilization and care plan development
Benefit Design	o Comprehensive benefits ideal to ensure holistic and cost effective alignment of services
Consumer Direction	o MCO maintains responsibility to assess individual appropriateness and develop care plan for member to administer o State maintains relationship with Fiscal Intermediary (FI) for payroll, background checks, training, etc.
Assessments	o MCO determines appropriate timing for assessments driven by individual needs and program participation

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Element	Description
Care Tools	o MCO should be allowed to utilize proprietary care plan tools following approval from State
Cost Effectiveness	o Program should include individual cost effectiveness versus program cost effectiveness to support appropriate alignment of cost effective services/benefits
Staffing Ratios	o MCOs should be allowed to determine appropriate staffing ratios based upon individual members' needs
Redetermination	o MCO should facilitate redetermination to ensure continuity of care
Quality	o Quality metrics should be established based upon the populations served by the program and supportive of specific program goals such as nursing home avoidance
Rate Methodology	o Rates should be established based upon a blended rate methodology o Rates should include reasonable savings assumptions and nursing home displacement rates o Separate rate cells for non-nursing home level of care ABDs o Separate rate cells for nursing home level or care dual eligibles and non-nursing home level of care dual eligibles o Special populations – such as special needs kids, developmentally disabled – rates should be established based upon cost + methodology
Incentives	o Rates should be financially sound with reasonable savings assumptions o Rates should be based upon balanced up and down side risk o Quality incentives should be based on appropriate quality metrics for population and should be additive to performance
Risk Adjustments	o Implemented after 3 years of program experience

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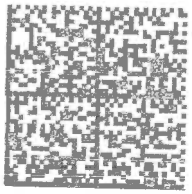
100 Executive Center Drive, Ste. A-13, Columbia, SC 29210

FIRST CLASS



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Department of Health & Human Services
OFFICE OF THE DIRECTOR

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Log # 185

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki Haley • Governor

November 1, 2011

Mr. Dan Gallagher
Plan President
UnitedHealthcare Community Plan
100 Executive Center Drive, Suite A-13
Columbia, South Carolina 29210

Dear Mr. Gallagher:

This letter is in response to your recent correspondence concerning integrating care for dual eligible individuals. As noted in your letter, the health care needs of the dual eligible population are complex and the creation of a program that integrates Medicare and Medicaid has the potential to improve quality and decrease costs. In considering the impact of a new integrated care model, elements such as rate development, enrollment, and benefits are fundamental to the design process and future success of this program.

As a member of the Integrated Care Workgroup (ICW), we value your participation and recommendations to this important health care initiative. We look forward to your continued interest and collaboration throughout the design and development process, as it is important that the collective voice of the ICW be heard on issues impacting the care and services for our dual eligible beneficiaries.

Sincerely,

Sam Waldrep
Deputy Director

Office of Long Term Care and Behavioral Health
P. O. Box 8206 • Columbia, South Carolina • 29202-8206
(803) 898-2502 • Fax (803) 255-8209

Brenda James - Log 000185

From: Teeshla Curtis
To: Brenda James
Date: 11/01/2011 1:56 PM
Subject: Log 000185
CC: Nathaniel Patterson
Attachments: Ref Log 000185 Response.PDF

Brenda,

Attached is the response for Log 185.

Teeshla