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EVALUATION OF THE ERICKSON ADVANTAGE CONTINUING CARE RETIREMENT COMMUNITY DEMONSTRATION
Final Report

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EXECUTIVE SUMMARY

BACKGROUND

As part of their ongoing efforts to provide innovative and effective services that address the current and evolving needs of Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) has sponsored an evaluation of the Erickson Advantage Continuing Care Retirement Community (CCRC) demonstration. In August 2005, CMS approved a demonstration program to set up a Medicare Advantage (MA) plan exclusively within the Erickson CCRCs and managed by Evercare/UnitedHealth Group. Typically, MA plans are bound by the county integrity rule, preventing them from limiting the availability of their plans to geographic areas smaller than a county. The intention of this rule is to prevent MA plans from targeting exclusively low-risk, low-cost, healthier beneficiaries and avoiding beneficiaries who may represent a higher risk and, therefore, a higher cost to the plan. Putting in place an Erickson MA plan available only to residents of the CCRC required a waiver of this rule, and raises the possibility of this kind of risk selection. While CCRC's are more likely to attract an older, more frail subset of Medicare beneficiaries, this theory remains untested. This evaluation examines the effect of the community integrity waiver and help CMS develop the criteria needed to establish MA plans that are limited to residential settings but do not encourage selection bias for low-risk enrollees.

The qualitative and quantitative work described in this report summarizes findings from case studies, focus groups, and secondary data analyses that provide a better understanding of how services are provided within the Erickson CCRC and more specifically, the innovations in the organization and delivery of care by the Erickson Advantage (EA) plan. It presents feedback from the residents of these communities regarding their own experiences and perceptions of the health care provided within the CCRC and the EA plan, and it also characterizes differences in demographics and disease burden both within the Erickson population and between Erickson residents and the surrounding communities. While this report identifies these differences in demographics and disease burden, it did not investigate EA's outcomes or effects on utilization and costs.

CASE STUDY FINDINGS

- Erickson has a strong, resident-centered organizational culture, which is reflected at every level. They actively seek feedback and suggestions from residents and are innovative and improvement-oriented. Erickson develops and pilots new features and services at individual sites before implementing them campus-wide.

- The Erickson Health Medical Group (EHMG) has a strong system of care and continuity of care. Erickson has a substantial investment in on-site subsidized salaried medical care that allows them to implement a very generous style of geriatric practice. The EHMG has implemented a few disease management projects, including a project focused on osteoporosis which is applied to all EHMG patients (not exclusively to EA members), but it does not

systematically employ disease management principles for other chronic diseases such as CHF or diabetes.

- The EA plan seems to support the geriatric-model of medicine practiced at EHMG by aligning incentives and providing the extra staff to support extensive care coordination and follow up. At present, this approach seems to rely on substitution (or care in alternative sites), largely by waiving the rule regarding a three-day hospitalization prior to a nursing home stay (available to all MA plans). It also relies on care coordination, rather than taking a different approach to the nature care provided (such as secondary prevention or organized disease management). That is, it does not demonstrate evidence of proactive primary care or disease management per se.

- The EA benefit provides more options when members need additional services—but it is not clear how often members exercise these options. Much of the Erickson services are covered under the EA plan, giving members greater access without having to pay deductibles for these services as they would under FFS Medicare. Additional work to examine detailed service utilization data from the Erickson EMR system would be necessary to determine the extent to which these services are used by EA members as compared to other Erickson residents.

- Anecdotally, it seems that EA members do benefit from additional services (in particular, the care coordinator and the member services representative), but the effect on clinical outcomes may be marginal as the EHMG model provides a generous set of services even to those residents without EA.

- The EA plan provides a number of benefits for Erickson. In some cases, the close relationship between Erickson and EA may limit the opportunities for other MA plans to compete for Erickson residents' business; however, the case study also demonstrated instances where Erickson staff counseled residents away from EA when another plan was more appropriate for their needs.

    - The EA plan provides an additional service attribute for marketing the Erickson community—there is someone on-site who can help members manage their care across providers.

    - The EA plan may help Erickson recover some of the costs of providing care. As with all MA plans, the EA plan may use profits to finance other services.

    - While the care coordinator is beneficial to EA members, it also benefits Erickson by taking the burden of care coordination off of EHMG.

- The close relationship between Erickson (the CCRC) and the Erickson MA plan, as well as the fact that they are an out-of-network provider for other MA plans may limit the viability of other MA plans as an alternative to EA for Erickson residents who would like to enroll in an MA plan. Many Erickson residents entered with an MA plan and seem content to remain with that plan. In the future, EHMG might induce Erickson residents who are not MA

members to join an EA plan by restricting use of EHMG to EA only. This strategy would depend on the expected volume loss in care and the adverse effects on recruiting new CCRC applicants.

- A comparison of EA's 2008 plan costs and benefits reveals that they are comparable to other plans competing in the same markets, as they would need to if they wish to maintain current enrollment and attract new enrollees.

FOCUS GROUP FINDINGS

- On-Site Medical Care
    - Participants were very satisfied with the quality of care provided by the on-site physicians regardless of their enrollment in Erickson Advantage.
    - The on-site medical clinic was not one of the primary reasons residents chose to move to an Erickson community; rather, the continuum of long-term care services was a more important factor. However, many recognized the convenience of on-site care after they moved to the community and took advantage of it.
    - Participants did not perceive a difference in care provided on-site for EA enrollees compared to non-enrollees.
- Decision to Enroll in Erickson Advantage
    - Cost and convenience were the principal reasons residents cited for choosing EA.
    - Some enrollees also mentioned the care coordinator, member services representative, and waiver of the three-day hospital rule as factors in their enrollment decision.
- Decision Not to Enroll in Erickson Advantage
    - Those not participating in EA most often decided against enrolling because they had retiree coverage that they perceived as better than EA based on cost or covered services.
    - Others did not see a reason to change since they were satisfied with their current plan and preferred sticking with what they knew.
    - Some participants were resistant to switching to a managed care plan because they did not want to be restricted in their choice of physicians or hospitals or because of previous negative experience with a managed care plan.
- Enrollee Experience with Erickson Advantage
    - Overall, EA members were very satisfied with the plan.

- Transportation to medical appointments with off-site specialists and the on-site member services representative were the most frequently mentioned benefits of EA by enrollees.

- Only some enrollees reported using the EA care coordinator's services to schedule transportation to off-site specialists, conduct disease management activities, or coordinate rehabilitation services after a hospitalization or other significant health event.

- Those enrollees who recalled using the care coordinator's services had a positive experience and viewed the care coordinator as an important benefit of Erickson Advantage.

- Observed Differences between Enrollees and Non-Enrollees (see Table 7)

    - Both groups were similar in number of residents who moved from out of state, health behaviors practiced by residents, chronic disease burden, and the use of on-site primary care providers.

    - Enrollees and non-enrollees differed with respect to previous managed care experience, and retiree coverage. EA enrollees appeared to have prior experience with managed care plans, and did not have retiree coverage (or their retiree coverage had been discontinued).

- Miscellaneous

    - Erickson residents appear to be well-informed Medicare consumers.

SECONDARY ANALYSIS FINDINGS

- Erickson residents have higher disease burden than their counterparts in the community, even when the data are age-, race-, and gender-adjusted.

- Compared to the community MA and community FFS control groups, there appears to be an "Erickson Effect" as compared to the community controls, but the EA effect is mixed within Erickson residents:

    - Greater disease burden among the Erickson FFS group as compared to both sets of community controls.

    - Greater disease burden among EA members for certain diseases (kidney, stroke, vascular).

    - Within Erickson, EA members have lower age-, race-, and gender-adjusted HCC scores than their Erickson FFS counterparts.

- No clear evidence of selection bias favoring EA.

POLICY IMPLICATIONS

The case study findings regarding the EA plan suggest that the merits of this plan are tied in large part to the unique system of care at the Erickson communities, specifically the EHMG. The EA plan encompasses a medical model that supports a strong geriatric focus and continuity of care, which offers a significant advantage over other MA plans that do not have a similar focus in their provider network. Much of this benefit is already available to residents without EA status, although it must be subsidized by Erickson. While the merits are attributable more to the Erickson model than to the EA plan itself, to the extent that the EA plan supports this model, it represents a benefit to its members. Although not a specific CMS intention of the waiver, by enabling CCRCs to recoup the cost of the investment they have made in better geriatric care, the waiver may encourage CCRCs to support their clinical operations and provide additional services. It is not clear whether the availability of a waiver and the ability to recover the costs would be sufficient to induce a CCRC to develop a model like Erickson's or whether all CCRCs would choose to invest their resources in the same way.

As this phase of the EA demonstration comes to a close, CMS has four options:

1. Terminate the project with sufficient advance notice to allow enrollees to make alternative arrangements.

2. Provide the county waiver and allow the program to become an MA program.

3. Allow the program to become an MA program but without the county waiver (i.e., they would have to allow all county residents to join).

4. Continue the demonstration status.

Presumably if CMS terminated the demonstration, EA could apply to be a traditional MA program without the county waiver (option #3).

The arguments in favor of granting the waiver are that there are minimal negative effects; granting a special status to CCRCs would mean that their residents would have access to a set of services not available to other residents in the same county. The program could allow more CCRC residents to enroll in such programs. These programs might encourage other CCRCs to develop the same type of on-site geriatric capacity because they would have a business case for creating such services.

It is important to consider that granting such a waiver would mean developing a set of eligibility criteria. In addition to meeting standard MA criteria, should CCRCs be required to show the capacity to deliver on-site geriatric care? This is a higher standard that is imposed on other MA vendors but a special status is being requested.

Continuing the demonstration status would temporize until CMS policies around managed care are solidified. It could also provide an opportunity to see how the program operates in a more mature state. Further evaluation could assess the effects on utilization and quality. Such an evaluation could rely solely on administrative data (there is good reason to expect that United HealthCare Group and Erickson would cooperate in providing such data), or it could combine administrative data analysis with beneficiary surveys to address quality in more depth and test the effects of this care on functioning and quality of life.

1.0 INTRODUCTION

In an effort to further advance the Medicare program in the face of evolving market needs, the Centers for Medicare & Medicaid Services (CMS) conducts a number of innovative demonstration projects. These projects help CMS determine the effect of potential Medicare program changes that may offer new methods of service delivery, types of services, or payment approaches on a variety of stakeholders. As part of this effort, CMS will also sponsor evaluation projects to assess the demonstration outcomes and findings to help inform policy changes. As one of these evaluation efforts, CMS contracted with Pacific Consulting Group (PCG) and its partner, the University of Minnesota, to evaluate the Erickson Advantage Continuing Care Retirement Community (CCRC) Demonstration. CCRCs offer long-term contracts that provide housing and access to specified health services in an environment that allows movement from one level of care to another as residents' needs change. The Erickson CCRC provides on-site medical care on a fee-for-service (FFS) basis, and under this demonstration arrangement, through an Erickson-sponsored Medicare Advantage (MA) plan known as Erickson Advantage (EA).

The EA demonstration represents a program change for CMS as it introduces a Medicare managed care product to the CCRC care model. Typically, Medicare Advantage (MA) plans are bound by the county integrity rule, preventing them from limiting the availability of their plans to geographic areas smaller than a county. The intention of this rule is to prevent MA plans from targeting exclusively low-risk, low-cost, and/or healthier beneficiaries and avoiding beneficiaries who may represent a higher risk and, therefore, a higher cost to the plan. Putting in place an Erickson MA plan that is available only to residents of the CCRC required a waiver of this rule, and it raises the possibility of this kind of risk selection. The CCRC's mission to serve the needs of individuals with chronic conditions should result in a resident population with an above average burden of chronic illness; however, this theory remains untested. This analysis effort aims to identify the effect of the county integrity waiver and determine whether it encourages selection bias for low-risk enrollees. Specifically, we address the following research questions:

- Are there differences in the demographic characteristics of the EA enrollees, Erickson residents not enrolled in EA, and other Medicare beneficiaries residing in the same geographic area?

- Do the residents of the Erickson communities have a significantly above-average burden of chronic illness as compared to Medicare beneficiaries residing in the same county?

How do EA members compare to other Erickson community residents? How do they compare to other MA plan enrollees?

To accomplish this, the researchers conducted case studies and focus groups at three Erickson communities between February and April 2007: Ann's Choice in Bucks County, PA; Brooksby in Essex County, MA; and Charlestown in Baltimore County, MD. The site visit activities included interviews with Erickson executives and staff, as well as focus groups with Erickson residents and EA members. The goal of the executive and staff interviews was to develop a better understanding of how services are provided within the Erickson CCRC and specifically the innovations in the organization and delivery of care by the EA plan. The objective of the focus groups with Erickson residents and EA members was to learn about their experiences with and perceptions of the health care provided within the CCRC and the EA plan. Analyses of secondary data from the CMS enrollment, Hierarchical Condition Codes (HCCs), and MedPAR data files were also conducted for the nine Erickson sites that had established EA plans in 2006. The purpose of these analyses was to characterize differences in demographics and disease burden within the Erickson population and between Erickson residents and the surrounding communities.

2.0 BACKGROUND

CCRCs originated in Pennsylvania as early as the 1960s, when Quaker communities developed these combined housing and health care arrangements to provide a full spectrum of care for seniors in one location. We are not aware of any systematic report that describes the distribution of medical care arrangements among CCRCs. CCRCs do not need to provide medical care themselves. Residents can arrange to have care through their personal physicians, therefore only the skilled nursing facility needs a medical director. There is then a continuum of medical care giving among CCRCs. Erickson would be at one extreme, with a panel of salaried physicians, indeed whose services are subsidized by the corporation. The next step down the continuum would be to have organized relationships with one or more medical groups to offer care to residents; this might include providing clinic space on the campus. Simply providing clinic space without specific arrangements would be a next lower step. Different CCRC models can offer a range of contract types, including extensive FFS and rental agreements. Extensive housing contracts provide residential services—amenities and unlimited specified health-related services with little or no substantial increase in monthly payments. These arrangements usually have higher entrance fees with more predictable future costs. FFS models include housing—residential services and amenities for an established fee, but additional health care services are not included. Access to these services can be guaranteed, but consumers may be required to pay established FFS rates. In this arrangement, while entrance fees can be lower, future costs are more uncertain. At the other end of the spectrum are simple rental agreements where housing is rented on a monthly or annual basis, and the CCRC may provide (but not guarantee access to) FFS health care.

Entrance fees for CCRCs can be substantial—in 2004, entrance fees ranged from $38,000 to $400,000. Whether any portion of this fee is refundable varies by community. As residents must have sufficient assets to move to a community of this type, most do not qualify for Medicaid, so non-Medicare health and personal services are paid out-of-pocket. In addition to entrance fees, monthly fees can vary considerably depending on the size of the housing unit and the other services covered (meals, utilities, housekeeping, personal care, etc.). These monthly fees ranged from $650–$3,500 per month in 2004. In the case of one of the Erickson communities, at the Charlestown location in 2006, entrance deposits ranged from $91,000 for a studio to $494,000 for a two-bedroom apartment—this deposit is marketed as 100% refundable, unless these assets are drawn upon to cover skilled nursing facility or other types of care. Monthly fees at the Charlestown community in 2006 ranged from $1200 per month to $2050 per month, again depending on the size of the unit.

Available published research on CCRCs is limited. Our review of the literature revealed very few articles that examined the relationship between CCRC residence and hospital or nursing home utilization. Sloan and colleagues examined the relationship between supportive services provided in a capitated environment and the use of nursing home and personal care services. The authors found that those CCRCs offering completely pre-paid long-term care coverage reduced nursing home care by 13% and personal care by 5%. They did not find evidence of selection bias among those in the CCRC with long-term care contracts, but were careful to point out that residents with these more expensive contracts were wealthier than

other CCRC residents, suggesting the possible influence of socio-economic status on utilization of these services. Cohen compared residents in six CCRCs to the general elderly population to examine patterns of nursing home use. The authors found greater risk of lifetime entry into nursing home care as well as greater risk of repeat entry into nursing home care, but a shorter length of stay per admission. Other research into non-CCRC community-based models include programs such as the Program for All-Inclusive Care for the Elderly (PACE), the Long-Term Home Health Care Program (Nursing Home Without Walls), and other home- and community-based services (HBCS) programs. While these programs are all community-based, they do not offer the same combination of housing and services available within a CCRC.

3.0 CASE STUDY AND FOCUS GROUP FINDINGS

3.1 SITE SELECTION

Site visit locations for the case studies and focus groups were chosen from locations where EA was offered in January 2006. This was done so there would be sufficient experience with the EA plan to support recruiting for the EA focus groups and so that EA staff would be sufficiently established at each site to comment on their experiences. Sites in Virginia were excluded due to differences in hospital contracting there. It was also discussed at the kickoff meeting that selecting a site with a single provider might be an interesting comparison; however, there were no sites established in January 2006 or earlier in the designated states that had only a single provider. In light of the above criteria, the following three sites were selected:

- Charlestown (Baltimore County, MD)
- Brooksby (Essex County, MA)
- Ann's Choice (Bucks County, PA)

Charlestown and Brooksby were selected because they are both well-established Erickson sites with high enrollment numbers. Ann's Choice was selected for comparison since it has high enrollment but a smaller number of providers based on-site. Key features of the Erickson CCRC sites visited are provided in Table 1; site characteristics specific to EA are shown in Table 2.

Table 1
Summary campus characteristics of selected case study sites

Feature	Charlestown	Brooksby	Ann's Choice
Location	Catonsville, MD	Peabody, MA	Warminster, PA
Date Opened	December 1983	June 2000	August 2003
Number of physicians on staff in March 2007	4	2	2
Number of physicians budgeted for March 2007	5	4	4
Number of geriatricians on staff in March 2007	1	0	1
Number of NPs on staff in March 2007	3	2	1
Number of NPs budgeted for March 2007	3	2	1
Number of current residents in March 2007	2,238	1,825	1,321
Number of residents budgeted for March 2007	2,269	1,792	1,324
Number of neighborhoods	3	3	2
Number of independent living units in March 2007	1,536	1,343	1,029
Number of assisted living apartments in March 2007	132	28	Not Applicable
Number of skilled nursing beds	244	104	Not Applicable

SOURCE: All data provided by Erickson.

Table 2
Summary of Erickson Advantage characteristics of selected case study sites

Feature	Charlestown	Brooksby	Ann's Choice
Number of EA members in March 2007	285	150	213
Percent of residents enrolled in EA in March 2007	12.7%	8.2%	16.1%
MA plan penetration for State in 2006	4.5%	15%	28.5%
Percent of residents enrolled in MA plans in 2006	3%	13%	27%
EA premium in 2007	$126	$126	$126

NOTE: Percent of residents enrolled in Erickson Advantage (EA) was calculated based on EA enrollment and number of current residents.

NOTE: Percent of residents enrolled in Medicare Advantage Plans was calculated using CMS data provided in December 2006.

SOURCE: All data are provided by Erickson, except Medicare Advantage (MA) Plan Penetration for state which came from Kaiser Family Foundation Medicare Health and Prescription Drug Plan Tracker at www.kff.org/medicare/healthplantracker/topicresultspf.jsp?I=8&rt=2&sr=45.

3.2 CASE STUDY METHOLOGY

Guided interviews were conducted with Erickson and EA executives and staff. There was some similarity in the questions asked of both executives and front-line staff, giving the researchers the opportunity to hear responses from multiple organizational perspectives. The interview guides were adapted for the different interviewee types, based on the relevance to the interviewees' roles and responsibilities. These questions were asked at all three sites, with the goal of understanding the organization and delivery of care, as well as identifying key differences across the sites that may reflect differences in the stages of campus development or populations served. The main focus of the interview questions is outlined below. The interview guides are included in Appendix A.

- Campus Overview
- Erickson Advantage
    - Enrollment expectations and experience
    - Marketing efforts

    - Benefits of EA
    - Issues/challenges
- Medical Clinic
    - Clinical model
    - Staffing
    - Information systems
- Care Coordination
    - Role of the care coordinator
    - Assessment and follow up

At the first site visit, a one-day series of meetings was held on the Charlestown campus with Erickson, EA, and UnitedHealth Group executives and was also attended by the CMS Project Officer. The purpose of these meetings was to get an overview of Erickson, the EA Health Plan, and their experiences in the first year of operation, and to develop an understanding of the Erickson clinical model. We also met with John Erickson, the Erickson CEO, to learn about his vision for Erickson and the EA health plan.

At each site visit, the team interviewed the campus executive director, the resident life manager, the EA member services coordinator, and the EA sales and marketing representative. Group discussions were held with the medical center staff, which included the campus medical director, the EA care coordinator, and a nurse practitioner.

3.3 FOCUS GROUP METHODOLOGY

Focus groups were conducted with EA members and with non-EA members concurrent with the site visits. The objective of these focus groups was to learn about their experiences with and perceptions of the health care provided within the CCRC and the EA plan.
Focus groups were conducted at the same locations as the site visits. Two focus groups, one for EA enrollees and one for non-enrollees, were conducted at each site. Using CMS data, we identified all residents living independently at each site depending on their EA enrollment status (917 in total). We then identified spouses/same-household pairs and randomly excluded one person from each pair (90 were excluded). Spouses were excluded to avoid over-representing a single household. Once these exclusions were made, potential participants were randomly selected from this list. Phone numbers were obtained from Erickson, and participants were recruited by phone by Pacific Market Research. Efforts were made to screen out potential participants receiving health benefits through the VA, Tricare, or state or local governments because it was thought they would have retiree benefits and would be unlikely candidates for enrollment in EA; however, several teachers were included in the groups.

Because we wanted to concentrate on residents with chronic diseases, those who did not report having any of the following chronic health conditions were also excluded: heart disease, high blood pressure, diabetes, arthritis, chronic lung disease (e.g., bronchitis, emphysema, asthma), depression, stroke, cirrhosis, kidney disease, cancer (not skin), anemia, and dementia (e.g., Alzheimer's). Only four potential participants were screened out for not having any of the above chronic conditions. For the Erickson Advantage enrollee groups, only those enrollees who had seen a physician while enrolled in the plan were included. Recruiting for a mix of race was

not possible due to sample demographics—i.e. the Erickson communities we visited are predominantly Caucasian. A reasonable mix of gender for the age group was achieved. When comparing participants to the population from which the sample was drawn, we see that beneficiaries aged 85 and over were slightly underrepresented in our focus groups, and females were slightly overrepresented. This is not unexpected for groups with Medicare beneficiaries and does not introduce significant bias (Tables 3 and 4).

Table 3
Enrollee sample demographics by gender

	Number of Participants	Female	Male
Enrollee			
EA focus group participants	24	83%	17%
Sample pool of EA members at the 3 sites visited	408	68%	32%
Non-enrollee			
EA focus group participants	26	81%	19%
Sample pool of EA members at the 3 sites visited	4,206	67%	33%

SOURCE: Sample data in Table 3 were obtained from CMS.

Table 4
Sample demographics by age

	Number of Participants	65-74 Years	75-84 Years	85 years or older
Enrollee				
EA focus group participants	24	8%	71%	21%
Sample pool of EA members at the 3 sites visited	408	13%	47%	40%
Non–enrollee				
Non-enrollee focus group participants	26	12%	62%	27%
Sample pool of non-enrollee members at the 3 sites visited	4,206	11%	52%	36%

SOURCE: Sample data in Table 4 were obtained from CMS.

Ten participants were recruited for each group with the expectation that seven to eight would attend. Over-recruiting with the expectation of a certain percentage of non-attendees is standard practice for focus groups. Because these focus groups were held on-site, the expectation was that this would be less of an issue; however, illnesses and other conflicts could also prevent attendance, so some over-recruiting was necessary. A total of 24 Erickson Advantage enrollees and 26 non-enrollees participated across the three sites (Table 5). At the beginning of each group, participants were handed a consent form to review and sign. One participant did not wish to sign the consent form so was asked to leave the group.

Table 5
Focus group participant demographics

	Charlestown Enrollee	Charlestown Non-Enrollee	Brooksby Village Enrollee	Brooksby Village Non-Enrollee	Ann's Choice Enrollee	Ann's Choice Non-Enrollee	All Sites Enrollee	All Sites Non-Enrollee
Number of Participants	8	7	8	9	8	10	24	26
Age								
64-74 years	1	0	1	1	0	2	2	3
75-84 years	5	5	6	4	6	7	17	16
85 years or older	2	2	1	4	2	1	5	7
Education								
High school or less	3	3	1	3	3	1	7	7
Vocational school or some college	2	2	4	1	2	5	8	8
College degree or more	3	2	3	5	3	4	9	11
Gender								
Male	0	2	2	2	2	1	4	5
Female	8	5	6	7	6	9	20	21

NOTE: Data shown above are based on participants' responses during the screening process.

Group discussions were led by the Principal Investigator and were recorded for note-taking purposes. Focus group participants were asked a series of questions regarding their decision to move to an Erickson community, their perception of Erickson Advantage, and their experience with the on-site medical care. In addition, enrollees were asked about their satisfaction with Erickson Advantage and about their experience with specific benefits. In general, this was a very savvy group. They demonstrated a considerable understanding of insurance and Medicare for a consumer group. They were also health conscious. See Appendix B for the moderator guides for enrollees and non-enrollees developed with input from CMS. The groups were approximately an hour in duration and were conducted on-site at each of the three Erickson communities. An honorarium is also standard practice for focus groups, to compensate attendees for their time. For these groups, participants were paid an honorarium of $40, which they received at the conclusion of the focus group.

Responses from the three sites were compiled with attention to any differences across sites using the audio recordings and notes taken during the groups. Themes were identified based on the questions in the moderator guide and through careful review of the responses. The findings from the three sites are reported herein.

3.4 THE ERICKSON CONTINUING CARE RETIREMENT COMMUNITIES

Erickson communities offer residents the full spectrum of retirement living options from independent living to assisted living and nursing home care (known as Renaissance Gardens) in a single campus setting. These communities are large campuses with multiple interconnected buildings. The campuses offer multiple dining rooms and many on-site amenities, including gyms, banks, salons, shops, classrooms, and an on-site, closed-circuit television station run by residents. Activities are resident-initiated and run with the support of Erickson staff.

Erickson is targeted to middle-income retirees who transition to the CCRC for the lifestyle (no-maintenance living) and the integration of housing and services. Erickson residents pay a refundable deposit, which allows for low-cost entry for those who have an asset (such as a house) that can be sold. This deposit is viewed as a "nest egg" to cover the future costs of long-term care. There is also a monthly "service package" fee that covers rent, most utilities, some transportation to local shopping areas, security, clubhouse resources, and one daily meal at the on-campus restaurants. The size of the entrance deposit and the monthly service charge depends upon the size of the apartment. There is an additional flat fee for a second occupant. When a resident moves from the residential care section to long-term care, the monthly charge increases substantially. Other services—such as medical care, long-term care, home health, and home support—require additional fees charged on a per use basis. These are paid out-of-pocket when they are not covered by an individual's health insurance.

Unique to the Erickson CCRC is the strong geriatric care model available to residents on-site through the Erickson Health Medical Group (EHMG). The EHMG is staffed by geriatricians and internists with a geriatric focus. Medical visits at EHMG are 20–30 minutes in length (about twice the national norm), and are subsidized by revenue generated from the monthly fees, regardless of whether the resident uses an EHMG provider for their care. Pharmacy services, assisted living, home support, home health, outpatient rehabilitation, and an EMS service are also on the campuses. On newer campuses, some of these services are at different stages of implementation, depending on the age of the campus. As part of the CMS demonstration project, Erickson received a county integrity waiver in order to offer its own Medicare Advantage plan to its residents, known as Erickson Advantage (EA).

Focus group participants most often cited safety and relief from the burden of maintaining a home as their reasons for moving to a retirement community, and as such the amenities described above were important factors in their decision to move to an Erickson community. Some mentioned a specific home maintenance activity that they could no longer perform. Participants felt their capacities declining and wanted to make the choice themselves instead of waiting for an event to occur that would force a move. Several participants were widows who were attracted to the security and social resources provided by a community setting. Some participants were prompted by their own or their spouse's declining health, but few mentioned a specific health-

related event that caused them to move. A few indicated that the choice was not their own but that they moved at the urging of their spouse or children.

Proximity to their own home or to family was a major factor in most participants' decision to move into an Erickson community. Many considered other retirement communities in the area when making their decision to move to a retirement community. This seemed to be more prevalent for the Ann's Choice focus groups since there were several choices in the immediate area. Participants said that the size of the community, the friendliness of residents and staff, the convenience of a campus setting, and the refundable deposit were some of the most attractive and distinguishing features of Erickson communities.

Though most focus group participants did not mention the on-site medical facility as important in their decision because they had providers in the area, many found the EHMG very convenient and switched to on-site primary care providers shortly after moving to the community. Both enrollees and non-enrollees saw a mix of on- and off-site specialists. Most participants moved to an Erickson community before Erickson Advantage was available, so it did not factor in to their decision to move to the community.

Participants felt strongly that Erickson provided good value for their investment. They were attracted to the refundable deposit and felt that the deposit distinguished Erickson from other communities. Most felt that they would still be able to pass this deposit on to their children and did not consider that it could be consumed if they could no longer afford services with their current assets.

Many said that they wanted to move only once and that the availability of long-term care on-site was an important factor in their decision. Participants expressed a general sense that "Erickson will take care of me." The availability of on-site long-term care may in part distinguish CCRCs from other retirement communities.

Several participants mentioned that the friendliness of residents and staff were a draw for them. They felt the respect and courtesy they received from the staff was unique to Erickson and made the campus feel like a community. They felt empowered by the highly active community, saying that it was a place to further develop personal interests and make new friends, not just "a place to come to die."

Another feature that appealed to them was the convenience of a campus setting. Residents enjoyed the easy accessibility of all of the amenities on the Erickson campus: pool, gym, chapel, bank, etc. They also appreciated that all of the buildings are connected by walking bridges so that they can get anywhere in the community without having to go outside.

3.5 THE ERICKSON ADVANTAGE MODEL

The Erickson Advantage health plan is a three-year demonstration project (which has since been extended) resulting from a strategic relationship between Erickson and UnitedHealth Group. This demonstration establishes a Medicare Advantage plan offered exclusively within the Erickson CCRC. The plan was first established at the Charlestown location, where residents were enrolled in a local Blue Cross/Blue Shield (BC/BS) product that subsequently left the market. While Erickson had been able to support their clinical operations with the revenue from the BC/BS plan, it realized it would not be able to do so with the plans remaining in the market. In addition, Erickson residents who were dropped from this plan were highly dissatisfied. The EA plan was developed to meet Erickson's needs and to fill a demand among the Erickson residents.

Hallmarks of the EA benefit package include the following:

- Services from an on-site medical group with access to consultants (some on-site).
- Care coordinator services.
- Elimination of the three-day hospital stay prior to admission to a skilled nursing facility (SNF).
- Transportation for approved physician and hospital outpatient visits.
- No deductible for inpatient acute and mental health services.
- Zero co-payment for primary care office visits.
- Zero co-payment for office visits for certain specialists.
- Reduced co-payment for certain outpatient services.
- Short-term custodial and non-hospice respite care.
- Home care.

Erickson and UnitedHealth Group jointly administer the program, with shared responsibilities and shared resources. UnitedHealth Group is responsible for the actuarial, credentialing, insurance licensing, call center, enrollment, and claims activities. Erickson is responsible for the branding, marketing, sales, HIPAA compliance, member services, and clinical model delivery. UnitedHealth Group and Erickson jointly address CMS regulations, quality assurance, benefit design, product development, and in communities where UnitedHealth Group has an established network, network development. The financial risk is split with Erickson responsible for 70% of the risk and UnitedHealth Group responsible for 30%. At the time of the site visits, the EA plan was established and running in 16 locations in eight states, with three states added in January 2007.

EA is comprised of four separate products that target different market segments: two EA Signature, EA Champion, and Guardian. One EA Signature product is MA only, which is attractive to veterans or others who have prescription benefits from another resource; and the other product is an MA plan with prescription drug benefits (MAPD). The EA Champion plan is targeted towards members with chronic illnesses such as diabetes, COPD, CAD, CHF, or dementia; and the Guardian plan is an institutional plan for SNF residents only. Members can transition to these special needs plans at any point during the year, should their individual needs change.

The EA plan has a network focus, which on campus consists of the Erickson Health Medical Group and various on-site specialists. In communities where UnitedHealth Group is established, Erickson builds on that network with their own preferred network. These networks include hospitals and SNFs (typically Evercare facilities or their own Renaissance Gardens facility), laboratory and radiology, ancillary service providers, transportation providers, and alternative health care such as chiropractic, acupuncture, and massage.

EA enrollees who we spoke with during the focus groups made their decision to enroll in the plan primarily based on cost and convenience. Residents at Ann's Choice, which has the highest percentage of residents who were EA members of the three sites we visited, found EA to be much less expensive than other plans in the area. Some said that EA premiums were half the cost of their previous plans' premiums. This was in contrast to premium information we identified on the Medicare PlanFinder, which indicates that EA's current premiums are in fact at the higher end of the range of MA premiums for plans currently available in Bucks County. In this situation, it is important to note that the focus group participants were comparing the cost of EA to the cost of the plan they were previously enrolled in, which may have been a more expensive Medicare Advantage or fee-for-service plan.

Many of the focus group participants enrolled as soon as EA became available in their community. They felt that EA was less expensive compared to other alternatives and, at the same time, provided good coverage with providers located at a convenient, on-site clinic. Several enrollees also mentioned that they had already switched to on-site providers before EA was introduced so changing providers was not an issue for them. All enrollees were impressed that premiums decreased in 2007 and felt they were getting good value for their money. Since the Erickson physicians are not in-network providers for any other MA plans with the exception of the physicians at the Ann's Choice location, those who wanted the convenience of seeing on-site providers and the cost savings of an MA plan switched to EA. While this exclusive arrangement may suggest that a CCRC-based MA plan would be less sensitive to price-competition, it is important to note that in the case of EA, the plan lowered its premium for 2007, suggesting that it was responding to market pressures.

Most often, those focus group participants not involved with EA decided not to enroll because they had retiree coverage that they perceived as better than EA based on cost or covered services. Others did not see a reason to change since they were satisfied with their current plan and preferred sticking with what they knew. Some participants were resistant to switching to a managed care plan because they did not want to be restricted in their choice of physicians or

hospitals, or because of a previous negative experience with a managed care plan. Most of the non-enrollees with retiree coverage did not think that there was anything EA could offer that would make them switch unless their own retiree benefits changed. Other non-enrollees said they would consider EA in the future when it becomes more established or if they have a change in health status that would necessitate more care. A couple of non-enrollees at Ann's Choice expressed reservations about the network hospital, saying that it had a poor reputation. This suggests that some residents factored in the quality of EA's hospital and provider network when making their decision whether or not to enroll.

In the focus groups, both enrollees and non-enrollees saw free transportation to off-site specialists as a very attractive benefit of EA. Other benefits mentioned by enrollees were not as visible to non-enrollees. Some participants in both groups knew about the waiver of the three-day hospital rule for Erickson Advantage members and saw this as a benefit. This was attractive to participants because, when possible, they would prefer to stay on-site and receive care at the on-site SNF instead of going to the hospital first.

EA plans to build their program further by expanding benefits, reducing premiums, expanding the market to other geographic areas where there are existing Erickson campuses, growing their membership, and strengthening their utilization results. In 2007, EA added an adult day care benefit called Intermissions, and reduced the EA premiums from $135 to $126 per month. Co-payments were also reduced or eliminated for podiatry, DME (in the Champion plan), and for specialists. There is no co-payment for visits to the Erickson Medical Group. At the time of the site visits, EA did not provide gap coverage for prescription drugs, although at the time, this was under consideration for 2008. A comparison of the EA Signature MAPD plan to the top five other MAPD plans in each of the nine Erickson communities (in terms of 2006 enrollment) is provided in Appendix C. To generate this comparison table, we identified the top five plans in each of the nine Erickson communities included in the evaluation and used the CMS Health Plan Management System (HPMS) data from 2008 to compare current plan benefits and costs. These data reveal that EA's 2008 plan costs and benefits are comparable to other plans competing in the same markets, as they would need to if they wish to maintain current enrollment and attract new enrollees.

EA expanded to seven new campuses in 2007 and as of September 2008, had 3,501 members. EA continues to monitor their utilization, with a focus on omitting redundant services, admitting residents to Renaissance Gardens where appropriate in place of an acute care hospitalization, utilizing care coordination and home health care, and maximizing the pharmacy benefit by identifying low-cost generics and using a three-tier pricing system.

Most focus group participants who decided to enroll in EA were highly satisfied with their decision. Only a few participants had anything negative to say about the plan. One participant was displeased because of trouble with coverage for urgent care delivered out of state. Another participant said that when she went to the hospital they had a hard time identifying her Erickson insurance since it was listed under the Evercare name.

When asked what they would like to see offered by EA, several participants mentioned dental care. Optometry and nutrition classes were also mentioned as additional benefits they

would like to see. Most participants did not reach the prescription drug coverage gap, so this was not one of the added benefits mentioned.

3.6 ERICKSON HEALTH MEDICAL GROUP

The Erickson Health Medical Group (EHMG) is a group practice of Erickson-employed, salaried physicians. EMHG is run by a geriatrician, and some of the staff physicians are board-certified geriatricians, while others practice with a geriatric focus. The practice also includes mental health providers and physician specialists. As an Erickson community grows and the need for specialty care increases, the EHMG brings on specialists from the area whom the EHMG medical director identifies as having a similar philosophy of geriatric care.

A unique feature of the EHMG is a standard 25-minute visit for all patients. These extended visits support increased communication, explanation, and attention to the needs of a population with a greater expected burden of chronic illness. The clinic recovers only a portion of the full visit cost from FFS payments. The subsidy for the remainder of the visit costs comes from a mandatory add-on to the basic housing charge, regardless of whether or not the resident uses the clinic or is a member of EA. The same standard of care is offered to FFS and EA patients with some notable exceptions: because the three-day prior hospitalization requirement can be waived for EA members, this allows them to be treated on-site (i.e., can be managed in the clinic, at home, or in the nursing home) and avoid hospitalization. This requirement cannot be waived for those residents covered by traditional FFS Medicare. Also, EA members have available to them the services of a nurse care coordinator, who follows up with patients after their visits and arranges any additional care. The on-campus availability of these EHMG services, in addition to the home health care, means that Erickson can manage many of its residents on campus without sending them to the hospital. Thus, Erickson residents with FFS Medicare may often pay more out-of-pocket for care that is not covered by Medicare because it is not associated with a hospital stay. In contrast, this approach suits managed care well because the EA plan can arrange for care that ordinarily would not be covered in a traditional FFS arrangement, with no additional out-of-pocket cost for the member.

Another feature of the EHMG is the use of an electronic medical record (EMR) system to maintain, track, and communicate patient information. This system, called Centricity, appears to be state of the art, and is used for all EHMG patients. The Centricity system has been adapted for EA patients by programming formulary information and the addition of information about costs and interactions. It is not currently used to develop clinical prompts or warnings, nor does it interact directly with the record system in use by the EA care coordinator. These care coordinator notes, discussed in greater detail in Section 3.7, may address a patient's clinical status or aspects of the care organized on his/her behalf. They might also address problems the patient is having accessing care or following a regimen.

Care in the SNF, known as Renaissance Gardens (RG), is primarily overseen by nurse practitioners (NPs), with physicians following their own patients in the SNF. The NPs handle the assisted living care facility as well. At newer locations, such as Ann's Choice, where RG was not yet established at the time of the site visit, the campus establishes transfer agreements with local SNFs. Erickson physicians, NPs, and the EA care coordinator travel to these SNFs to see

Erickson and EA patients, who will then be transferred back to the Erickson campus when the RG opens.

The EHMG cites their commitment to evidence-based practice, although the examples given by the medical director were mainly in his area of interest—osteoporosis. There does not appear to be a systematic approach to using chronic disease management principles, and the other EHMG staff did not seem as oriented to evidence-based practice. This may be an area to track for evaluation using secondary data. From a regulatory perspective, this suggests that if implementing evidence-based medicine is a criterion or justification for waiving the county-integrity rule, that an operational definition and a means of verifying implementation will become necessary.

Each campus is affiliated with a primary hospital where the majority of admissions occur, in addition to one or two other hospitals in the immediate area. EHMG physicians typically perform rounds at these hospitals on a daily basis, and the EA care coordinators are also on-site to conduct hospital utilization review and discharge planning. At the three campuses visited, the establishment of relationships with the area hospitals is usually based on the market share of that hospital in the local area as well as the capacity needed to handle in-patient admissions from Erickson. It is interesting to note examples where Erickson is influenced by the local hospital market and in other examples where Erickson seems to be influencing the hospital. In the former case, Brooksby awaits the opening of a new satellite location for Massachusetts General Hospital, and may consider changing their established relationships—particularly in cases where local hospitals are charging additional fees. In the latter case, the medical director at Ann's Choice has established a geriatric service unit at the primary hospital, where many of the Erickson patients are treated.

The EHMG practice is restricted to Erickson residents. There is a prior history of managed care at the Charlestown EHMG with a local Blue Cross/Blue Shield provider that has since left the market. At the time of the site visit, with the exception of Ann's Choice, the EHMGs participate only in the EA plan. The EHMG practice at the Ann's Choice campus also cared for a limited number of Keystone 65 members who were Erickson residents. This contract arrangement is unique among the Erickson campuses, established early in the development of the Ann's Choice medical clinic. At the time, Keystone 65 had a large market penetration in Bucks County, where Ann's Choice is located, and this arrangement was established as a way to increase the marketability of the community by making the medical clinic—a significant feature of the Erickson community—available to Keystone 65 members. Through aggressive negotiations, Keystone 65 established a capitated reimbursement rate well below cost for the 25-minute visit that is standard practice at the EHMG. This rate was not adequate to cover the costs of the care the EHMG provided, and given the subsequent cost pressures, the EHMG made the decision to no longer accept new patients with the Keystone 65 plan. This finding illustrates the question about whether a geriatric care model like the one practiced at EHMG is sustainable if it must accept capitation from other large, competitive plans in the area (particularly if it is lower than the FFS payments, which it already supplements) without benefiting from the savings of reduced in-patient care. In the focus groups, there were a few participants who became Erickson residents prior to the point the medical clinic stopped accepting new Keystone 65 patients. Some of these participants saw on-site providers and were very satisfied with the care they received.

One participant was a Keystone 65 member who became an Erickson resident after the clinic stopped accepting new Keystone patients. This individual was disappointed that the on-site providers were not included in her provider network.

Focus group participants were highly satisfied with the health care services they received on-site. They had positive experiences with the Erickson physicians and felt that they were well trained in geriatric care. These participants were also very satisfied with the 25-minute length of appointments, remarking that it was unusual to get that amount of attention from a physician. They also felt that it was easy to request an appointment on the same day with a physician and felt weekend and evening coverage were also good.

The electronic medical record system was another benefit mentioned by those receiving on-site care. They liked the security of knowing that even if they saw a different provider, all of their medical information (including prescriptions) would be available. This was particularly important for residents at the Brooksby Village site, who were dissatisfied with physician turnover that had recently occurred. Participants refer to the fact that a group of on-site physicians left the practice simultaneously. They felt that Erickson mishandled the situation and possibly overworked the physicians, but they did concede that the situation had improved. Participants felt Erickson was very responsive to their concerns about physician turnover, although some non-enrollees decided not to enroll in EA specifically because of this issue. They did not feel comfortable committing to on-site physicians in light of the difficulties with physician retention. The only other negative comment heard at the groups regarding the on-site care was from one Ann's Choice resident with Keystone 65 who joined the community after the clinic stopped accepting new Keystone 65 patients. This individual indicated that the clinic turned her away because they did not accept her insurance. She did not return to the clinic after that incident.

3.7 ERICKSON ADVANTAGE CARE COORDINATOR

The EA care coordinator (EACC) is an RN with an office in or near the EHMG clinic. The role of the EACC is to coordinate all care for EA members, including conducting geriatric assessments for all new members. At each of the three campuses visited, there was one care coordinator serving all EA members. The size of an EACC's case load at any one time varies; some of these members are under active care while others are simply being followed. One EACC estimated that she was providing chronic care case management for approximately 10% of the EA membership at her location. This estimate did not include EA members she was following on an episodic basis for finite or short-term issues.

EACC (and the EA member services representatives) use a system known as "Canopy" to maintain electronic documentation of assessments and follow up. The Canopy system is implemented only for EA members. It allows the EACCs to manage their own patients, including monitoring reasons for inpatient admissions and length of stay. EACCs monitor their member census at the case level (categorized as general, post-episode, or chronic), which triggers three levels of care oversight. A care plan is required for those with a chronic status, although the EACC may implement for others based on her judgment. Any interventions identified in the care plan are automatically added to the care coordinator task list. This system is mainly free text, and

does not have automated protocols to trigger assessments or flag items for action. The Canopy system is separate from the Centricity EMR system used by the EHMG.

It is important to note that distinct from the EACC, Erickson communities have acute care coordinators (ACCs) who coordinate hospital stays and transitions home for residents who are not EA members. The ACCs are salaried employees, whose services are not recompensed by any payment program. ACCs do not manage care for residents beyond the inpatient setting. The EACCs serve only EA members, and coordinate services in the acute, long-term care, and outpatient settings. Table 6 demonstrates the distinction between the EACC and the ACC.

Table 6
Roles of the Erickson Advantage Care Coordinator (EACC) and the Acute Care Coordinator (ACC)

Type of assistance provided	EACC Role	ACC Role
Coordinates hospital stays and transitions home.	yes	yes
Provides information and education on a variety of conditions and health-related issues.	yes	no
Conducts geriatric assessments for all new EA members and provides case management services for those with chronic conditions.	yes	no
Uses Canopy system for case management and when necessary coordinates with primary care physician.	yes	no
Prepares resident for upcoming medical procedures.	yes	no

EACCs have documented protocols for managing care for EA members that are distinct from the activities of the acute care coordinator. EACCs identify members as robust, those with finite medical conditions, and those with chronic diagnoses. For each of these case types, the EACC uses an established process for discharge, post-procedure, or post-incident planning, including managing referrals, treatment plans, and monitoring. Some of these steps require consultations with primary care providers and documenting pertinent data in the Canopy system. For members with chronic diseases who are identified as high risk or who request care management services, the EACC develops a plan of care. This plan of care is reviewed and approved by the primary care provider. The EACC monitors the member to determine if they are meeting the goals outlined in the plan of care, reevaluates, and adjusts the level of care. These activities are unique to the EA plan, and for those members who need this level of care, they represent an added benefit to what they would receive as Erickson residents.

EA focus group participants at two of the sites, Charlestown and Brooksby Village, spoke very highly of the nurse care coordinator who helped them with scheduling appointments and

followed up with them after a hospital visit or other medical event. One member described the assistance she received from the care coordinator: when she was diagnosed with diabetes, the care coordinator explained how to monitor her glucose levels and how to change her diet to manage her condition. A couple of other participants mentioned that the care coordinator helped with their transition from Renaissance Gardens (the long-term care facility) back to their apartment and came to visit them as part of the follow-up.

Several EA members we spoke with in the focus groups had not interacted with the EACC, so they did not see this as a benefit. The EA enrollees in the Ann's Choice focus group did not believe that there was anyone besides their physician who coordinated medical care for them. Since Ann's Choice is a newer community, it may be the case that these enrollees have not used the EACC's services as much. Also some aspects of the care coordination process, such as communicating with on- and off-site providers, are invisible to enrollees. As a result, they may not directly observe the care coordinator working on their behalf. In contrast, several EA focus group participants had interacted with the care coordinator at Charlestown, a more established (and on average, a slightly older) community. A few focus group participants had experiences with receiving health care services in their home, and they were all satisfied with the care. One participant mentioned that she received physical therapy in her home as part of her post-illness rehabilitation. She was satisfied with the care and the follow-up.

3.8 ERICKSON ADVANTAGE MEMBER SERVICES

An EA member services representative is on staff at each Erickson campus where the EA plan is in place. The role of these member services representatives is to assist members with problems or questions they may have about their health services, facilitate issue resolution with administrative aspects of the plan, support care coordinators by linking members with services, and assist with EA sales and marketing activities.

These representatives are well known to the members, and serve as the conduit for issue resolution between members and United Healthcare, which administers the plan. Most of their issue resolution activities are around provider claims and billing—helping members to understand their bills and resolve disputed claims. They also resolve issues around enrollment and eligibility for benefits. They work with the care coordinator to arrange services, order supplies, authorize transportation to medical appointments, and educate members in maximizing benefits and using preferred vendors. They also manage and maintain member and provider service data to identify utilization trends.

EA sees the member services representative as a key competitive advantage for their product, since they provide on-site member support and are the "face" of EA on campus. This has proven to be a particularly effective marketing tool as it provides an established, single point of contact for all service-related issues about the plan. Their role in educating members and arranging services with preferred vendors is undoubtedly helpful to EA in terms of managing costs.

For EA focus group participants, the availability of an on-campus member services representative was one of the most important service attributes. EA focus group participants at

all three sites mentioned the member services representative by name and were very appreciative of the assistance she provided with a number of issues, including questions about co-payments and out of network provider billing and claims issues. In participants' eyes, this level of customer service was one of the benefits that stood out the most to them.

Focus Group Participants' Comments on the Member Services Representative:

"I got a dunning letter from the urologist and I didn't know why. I handed it to her [the member services representative]."

~Brooksby Resident

"Six months later I got a bill saying 'you haven't paid something.' She said 'let me handle it.' It took her a while, but she straightened it out. That's the thing that I did not anticipate ever. Someone said [the member services representative] is my own personal 800-number and that has turned out to be true for me because this system is so vast…there are bound to be mistakes made and you're dealing with technical machines and not always human beings."

~Brooksby Resident

"She is terrific! I've had a couple problems, and I just take my papers up if something is wrong on my statement. She is on the phone while I'm there getting it taken care of…She can solve problems faster than anyone I've ever seen, so they really have a good staff working for Erickson."

~Charlestown Resident

3.9 ERICKSON ADVANTAGE MARKETING

EA sales and marketing activities have been ongoing, with some EA-specific events and some EA marketing at other Erickson events. Some of the marketing occurs along with the marketing for the community, so prospective residents hear about EA as part of the overall package of services available on-site. EA marketing also includes direct mail as well as advertising on the campus closed-circuit television station. Erickson staff provides a great deal of advice and information about MA products, informing prospective members about EA as well as reviewing their existing health benefits.

EA sales and marketing representatives indicated that members are usually drawn to the EA plan by the potential cost savings, at which point they are open to hearing about the other benefits of the plan, such as care coordination, member services, and transportation. Positive word of mouth has also contributed to the growth of EA.

EA has been very successful at Ann's Choice. At the time of the site visit (early 2007), they had already met their 2007 enrollment goals. The high penetration has been attributed to the high percentage of residents (70-75%) who have had experience with other managed care plans. Ann's Choice EA focus group participants also identified the plan as providing a good value, and indicated that the plan was considerably less expensive than other managed care plans in the area, some of which have had 40% increases in premiums and co-payments over the past year. As mentioned earlier, this comment was in contrast to premium information provided on the

Medicare PlanFinder, which indicated that Erickson Advantage's current premiums are in fact at the higher end of the range of MA premiums for plans currently available in Bucks County. Again, it is important to note that the focus group participants were comparing the cost of Erickson Advantage to the cost of the plan they were previously enrolled in, which may have been a more expensive Medicare Advantage or Fee-for-Service plan.

At Brooksby and Charlestown, enrollment has been steady, but slightly lower than expected. In both cases, sales representatives attributed this to the high proportion of residents who have retiree or other benefits that are equivalent to EA. The expectation is that as employer-sponsored plans become more expensive, move to a voucher system, or discontinue their benefits, the EA plan will become more popular.

Sales representatives cited the extension of the Erickson service relationship as a benefit of EA—specifically the increased communications, and the availability of the member services representative and the care coordinator. EA members receive the same attention and service from their health plan that they have come to expect from Erickson. The representatives indicated that some of the benefits of EA, such as the care coordinator and the waiver of the three-day hospital stay prior to nursing home admissions, are difficult distinctions to make to prospective enrollees as these are not services they can directly observe, although as noted earlier, some focus group participants did mention this benefit.

Sales and marketing representatives thought certain benefits would add to the overall marketability of EA: preventive dental care, membership to the fitness facility, and eliminating co-payments for specialist visits. Adding a new benefit to cover generic prescriptions in the coverage gap was only mentioned at the Charlestown site. This was not mentioned as an issue at the other sites.

All participants in the Erickson Advantage and non-Erickson Advantage focus groups had been exposed to the EA marketing efforts. Residents referred to specific EA informational events, as well as EA sponsored events such as blood-pressure screenings or other activities where an EA sales representative was in attendance. Many said that they could not avoid the EA marketing, but none felt pressured to join. Several non-enrollees, many of whom had retiree benefits, were told by EA sales personnel that their current coverage was better or cheaper for them than EA. Residents received information on EA from several sources: mailings, meetings, Erickson staff, and the Erickson TV network. Several participants mentioned viewing a TV program with John Erickson discussing the product.

The Erickson brand was an important marketing feature to many of the EA focus group participants since they felt that Erickson would not offer the plan if it was not good. Enrollees were attracted to the cost and convenience of the plan and many did a side-by-side comparison of benefits before making their decision to enroll. While many of the non-enrollees had retiree benefits, which precluded the need for EA, some non-enrollees had a "wait-and-see" attitude and would consider EA once it became more established and they heard feedback from other residents. Other non-enrollees did not consider the EA plan because of negative experiences with other Medicare Advantage plans leaving the market. This was particularly an issue at Charlestown where several residents had been dropped from a Blue Cross/Blue Shield plan in the

area when the plan was discontinued. Ann's Choice focus group participants seemed to have a better experience with managed care plans, making them more receptive to EA.

3.10 OBSERVED DIFFERENCES FROM THE FOCUS GROUPS

In addition to the focus group findings discussed in the sections above, we observed some key similarities and differences that were worthy of note. These observations are summarized in Table 7.

Table 7
Observed differences between Erickson Advantage (EA) enrollee and non-enrollee focus groups

Category	All Participants	EA Enrollee	Non-EA Enrollee
Number of focus group participants	50	24	26
Participants relocating from out of state	There were a couple of participants who moved from out of state (meaning that they lived in a state other than the state where the Erickson community was located, prior to moving to that community) in all of the groups except the Ann's Choice Non-Enrollee Group. Most participants who came from out of state had to change providers and/or insurance coverage. Several switched to the on-site providers and then switched to Erickson Advantage once it became available.	No observed differences.	The Ann's Choice Non-Enrollee Group did not have any participants who moved from out of state. From other qualitative studies we know that beneficiaries prefer not to change providers, so it may be the case that residents who are local are less likely to enroll in Erickson Advantage since they have local providers in the community.
On-site primary care	All residents with an on-site primary care physician were satisfied with the care they received and felt that the Erickson physicians did a lot to coordinate their care.	All used on-site physicians for primary care.	The majority used on-site physicians. The Brooksby Village group had the fewest non-enrollees using on-site care possibly due to physician turnover. (See "Health Care Services" in Section 4.0.)
Specialists	No observed differences.	Although some specialty care is available at the on-site medical clinics (varies by site), the majority of Erickson Advantage enrollees continued to see one or more off-site specialists.	Non-enrollees were more likely to see off-site specialists, though some did go to the specialists who came to the Erickson campus.

Table 7
Observed differences between Erickson Advantage (EA) enrollee and non-enrollee focus groups, continued

Category	All Participants	EA Enrollee	Non-EA Enrollee
Retiree coverage	No observed differences.	Enrollees did not report having retiree benefits. Some said their retiree benefits were discontinued.	Several non-enrollees had government or other retiree coverage. Some of these residents were not interested in Erickson Advantage because their retiree coverage was superior to Erickson Advantage in terms of cost and/or covered services. Others felt that their current coverage was adequate and affordable, and they did not want to risk switching to Erickson Advantage since they would not be able to switch back to their retiree coverage if they wanted to do so.
Previous managed care experience	No observed differences.	EA enrollees seemed to have had prior experience with managed care, as compared to non-enrollees.	Several non-enrollees at Charlestown mentioned having been dropped from a managed care plan because their plan left the market. They mentioned this specifically as one of their reasons for not considering Erickson Advantage.

Table 7
Observed differences between Erickson Advantage (EA) enrollee and non-enrollee focus groups, continued

Category	All Participants	EA Enrollee	Non-EA Enrollee
Chronic disease burden	Based on participants' responses, differences were not observed in chronic disease burden between enrollees and non-enrollees, though, in general, participants tend to underreport chronic health conditions. Medical data were not available to verify responses. Residents at the two more established sites, Charlestown and Brooksby Village, were older and seemed to have a higher disease burden.	No observed differences.	No observed differences.
Health behaviors	Most participants in both groups reported exercising regularly, being non-smokers, and not drinking more than one alcoholic beverage per day.	No observed differences.	No observed differences.

4.0 SECONDARY DATA ANALYSIS

This section summarizes our findings from the analysis of secondary data acquired from CMS to identify demographic characteristics and chronic disease burden for EA members and control groups, as well as the history of hospital utilization among the study groups.

4.1 DATA SOURCES AND SAMPLING

The data sources for this research include Medicare enrollment data from CMS denominator files, MedPAR files, and Hierarchical Condition Categories (HCC) data from 2004–2006. These data sources provided enrollment and demographic characteristics, hospital utilization data for fee-for-service (FFS) enrollees, and indicators for various chronic conditions commonly used in risk adjustment. The sample was drawn from the 2006 denominator file, with records identified using Federal Information Process Standard (FIPS) state and county codes based on the geographic areas where Erickson communities were located. These included the following counties:

Montgomery, MD	Baltimore, MD
Essex, MA	Plymouth, MA
Wayne, MI	Oakland, MI
Lake, IL	DuPage, IL
Morris, NJ	Monmouth, NJ
Bucks, PA	Delaware, PA
Harris, TX	Dallas, TX
Fairfax, VA	

Subsequently, six counties were excluded because the Erickson community in that county did not have an EA plan available in 2006. The remaining cases were categorized into one of five study groups based on address and managed care enrollment. The groups include: EA members who enrolled between October 2005 and December 2006, Erickson residents with FFS Medicare, Erickson residents who were enrolled in another MA plan, and beneficiaries with MA or FFS Medicare who live outside of the Erickson communities but in the same counties. Some final exclusions were made after the groups were identified to exclude dual-eligibles and beneficiaries under the age of 65. Dual-eligibles were excluded from the analysis to facilitate comparability between Erickson and the community control groups. While there are dual-eligibles among Erickson residents, their numbers are low compared to the community at large: all Erickson residents made substantial deposits to move to the Erickson CCRC, and pay significant monthly fees that would preclude them from Medicaid eligibility. For this reason, we excluded dual-eligibles from the analysis. After this selection process, 55,949 cases remained. The distribution of cases by study group is shown in Table 8. It should be noted that the patterns observed for the 1,000 members enrolled in EA in 2006 may not be representative of the 3,500 members enrolled in September 2008. Our analysis is based on initial enrollment, and these patterns may have changed over time.

Table 8
Distribution of cases by study group

Study Group	Number of cases	Percent of cases
Erickson Advantage	1,000	7%
Erickson FFS	11,584	86%
Erickson other MA	955	7%
Erickson Total	13,539	100%
Community Controls MA	6,150	15%
Community Controls FFS	36,260	85%
Community Total	42,410	100%
Study Total	55,949	

4.2 DEMOGRAPHICS OF ERICKSON RESIDENTS, ERICKSON ADVANTAGE MEMBERS, AND SURROUNDING COMMUNITY RESIDENTS

Demographic data were used to identify differences in characteristics between the specified study groups. In reviewing these data, there were two important factors to consider. First, we considered the differences between Erickson CCRC residents and other Medicare beneficiaries living in the same geographic area. By using this approach, we were able to identify how Erickson residents differed from their counterparts living within the same community. The second factor considered was the difference in characteristics among the Erickson CCRC residents themselves, specifically EA members as compared to other Erickson residents. By examining these characteristics, we were better able to understand how, within a population of CCRC residents, those who chose to enroll in a CCRC-based MA plan might be different from those who remained with FFS Medicare or those who were enrolled in another MA plan.

We began by examining the age distributions for each of the study groups. As shown in Table 9, Erickson residents are older than their community counterparts. In addition, the age distribution for EA members is consistent with the other groups within the Erickson community.

Table 9
Age distribution (years of age) by study group

Study group	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90 years or older
Erickson Advantage	3%	9%	17%	29%	28%	14%
Erickson FFS	2%	7%	20%	33%	27%	11%
Erickson other MA	4%	13%	26%	30%	19%	8%
Community controls MA	22%	26%	24%	16%	8%	4%
Community controls FFS	28%	22%	20%	16%	9%	5%

Examining data on gender as well as age, Table 10 shows that Erickson communities have a higher percentage of female residents than the surrounding communities in all age groups, with the exception of age 90 and over.

Table 10
Percentage of female residents by age group (years of age)

Age	Erickson	Community
65-69 years	77%	53%
70-74 years	72%	54%
75-79 years	67%	58%
80-84 years	66%	62%
85-89 years	65%	64%
90 years or older	66%	72%

As shown in Table 11, Erickson communities are predominantly white, with some variation by location. There is considerably greater variation among the community control groups, indicating that in some locations, the Erickson CCRCs have less racial diversity than the surrounding communities.

Table 11
Ethnic background by location

Erickson Community	City	Total Erickson Residents	Non-White Erickson Residents	White Erickson Residents	Total Community Controls	Non-White Community Controls	White Community Controls
Ann's Choice	Warminster, PA	1,157	2%	98%	3,650	4%	96%
Brooksby Village	Peabody, MA	1,554	1%	99%	4,880	3%	97%
Cedar Crest	Pompton Plains, NJ	1,122	2%	98%	3,610	6%	94%
Charlestown	Catonsville, MD	1,903	1%	99%	6,010	28%	72%
Greenspring Village	Springfield, VA	1,719	2%	98%	5,310	15%	85%
Linden Ponds	Hingham, MA	612	2%	98%	1,950	4%	96%
Oak Crest Village	Parkville, MD	1,871	1%	99%	5,860	29%	71%
Riderwood Village	Silver Springs, MD	2,323	6%	94%	7,140	19%	81%
Seabrook Village	Tinton Falls, NJ	1,278	2%	98%	4,000	9%	91%

4.3 HEALTH CHARACTERISTICS OF THE STUDY GROUPS

Using HCC data from CMS, we were able to examine mean scores generated by the HCC model, which are used to adjust Medicare payments to health plans according to the expenditure risk of their enrollees. We were also able to analyze the individual diagnostic categories used to calculate the HCC scores. Examining these individual categories allowed further analysis of key diagnostic indicators and the identification of differences in the rates of key chronic diseases across the study groups. Since there are a number of HCC diagnostic categories, they have been grouped into 16 general categories. The classification scheme used to create these 16 categories is included in Appendix D.

The percentages marked with an asterisk in Table 12 indicate diagnoses that were seen more frequently in the Erickson groups than in the community. These unadjusted data suggest Erickson residents have a higher prevalence (in some cases substantially higher prevalence) of kidney disease; paralysis, neuromuscular disorders, and stroke; vascular disease; and MI/heart disease. EA members were less likely to have cancer than their Erickson FFS counterparts,

although they were not significantly less likely than the community comparison groups. EA members were also less likely to have diabetes than their counterparts in other MA plans.

Table 12
Differences in disease burden in Erickson vs. the community groups

Disease	Erickson Advantage	Erickson FFS	Erickson other MA	Community controls MA	Community controls FFS
Vascular disease	27%*	29%*	23%*	14%	15%
MI/Heart disease	26%*	28%*	28%*	18%	18%
Diabetes	17%	18%	23%	26%	17%
Cancer	13%	18%	17%	12%	13%
Paralysis, neuromuscular disorders, and stroke	16%*	16%	13%*	9%	9%
Congestive Heart Failure	14%	15%*	15%	13%	11%
Respiratory disease	12%	13%	10%	12%	11%
Infections and immune disorders (including Rheumatoid Arthritis)	10%	12%	9%	7%	7%
Other kidney disease	10%	8%	8%*	6%	4%
Injury/Trauma (not hip fracture)	6%*	7%*	6%	4%	5%
Psychiatric illness	4%	6%	4%	3%	3%
Skin ulcers	5%	6%*	4%	2%	3%
Hip fracture	2%	3%*	2%	1%	1%
Pneumonia	1%	1%	1%	1%	1%
Liver disease	0%	0%	1%	1%	0%
Other diseases	6%	7%	5%	5%	5%

*Diagnoses in the Erickson groups that were statistically significant when compared to each of the community control groups.

NOTE: Results are not adjusted for age, gender, or race.

When we adjust for age, race, and gender and examine disease burden for the Erickson study groups as compared to the MA community control group in Table 13, we see that all three Erickson study groups still had a higher odds of having paralysis, neuromuscular disorders, and stroke; and vascular disease than their counterparts in the community. Two of the Erickson groups had higher odds of kidney disease and heart disease than their counterparts in the community. For the remaining diagnostic categories, EA members did not have significantly different odds or had lower odds for these conditions than the community group; whereas, the Erickson FFS group and those Erickson residents enrolled in other MA plans had higher odds for certain conditions than Medicare beneficiaries in the surrounding communities.

Table 13
Odds ratios for disease categories controlling for age, race, and gender as compared to community MA

Disease	Erickson Advantage	Erickson FFS	Erickson Other MA	Community FFS	Community MA
Vascular disease	1.48*	1.69*	1.39*	0.97	Reference
MI/Heart disease	1.11	1.21*	1.34*	0.88*	Reference
Diabetes	0.60*	0.60*	0.87*	0.55*	Reference
Cancer	0.92	1.33*	1.25*	1.02	Reference
Paralysis, neuromuscular disorders, and stroke	1.48*	1.53*	1.33*	0.90*	Reference
Congestive Heart Failure	0.74*	0.85*	0.95	0.74*	Reference
Respiratory disease	0.75*	0.87*	0.67*	0.83*	Reference
Infections and immune disorders (including Rheumatoid Arthritis)	1.19	1.46*	1.24	0.99	Reference
Other kidney disease	1.38*	1.15*	1.27	0.64*	Reference
Injury/Trauma (not hip fracture)	1.22	1.14*	1.20	1.08	Reference
Psychiatric illness	1.12	1.74*	1.22	1.01	Reference
Skin ulcers	1.38	1.76*	1.50*	1.36*	Reference
Hip fracture	1.01	1.61*	1.21	1.20	Reference
Pneumonia	0.51	0.83*	0.98	0.87	Reference
Liver disease	0.63	0.58*	0.98	0.61*	Reference

*****Significant odds ratios.

NOTE: Results were obtained using a logistic regression model with the HCC indicator as the dependent variable. Age, race, gender, and study group were used as predictors.

When we adjust for age, race, and gender and examine disease burden for the Erickson study groups as compared to the FFS community control group in Table 14, we again see variation in terms of disease burden within each Erickson group, with Erickson FFS having more categories with greater disease burden.

Table 14
Odds ratios for disease categories controlling for age, race, and gender as compared to community fee for service

Disease	Erickson Advantage	Erickson FFS	Erickson Other MA	Community FFS	Community MA
Vascular disease	1.53*	1.73*	1.43*	1.03	Reference
MI/Heart disease	1.25*	1.37*	1.52*	1.13*	Reference
Diabetes	1.08	1.09*	1.58*	1.81*	Reference
Cancer	0.91	1.31*	1.22*	0.98	Reference
Paralysis, neuromuscular disorders, and stroke	1.65	1.70*	1.49*	1.12	Reference
Congestive Heart Failure	0.99	1.14*	1.28*	1.34*	Reference
Respiratory disease	0.91	1.05	0.81	1.21*	Reference
Infections and immune disorders (including Rheumatoid Arthritis)	1.20	1.48*	1.26*	1.01	Reference
Other kidney disease	2.17*	1.81*	1.99*	1.57*	Reference
Injury/Trauma (not hip fracture)	1.13	1.31*	1.11	0.93	Reference
Psychiatric illness	1.11	1.73*	1.21	0.99	Reference
Skin ulcers	1.01	1.29*	1.10	0.73*	Reference
Hip fracture	0.84	1.34*	1.01	0.83	Reference
Pneumonia	0.58	0.95	1.12	1.14	Reference
Liver disease	1.03	0.96	1.62	1.65*	Reference

*****Significant odds ratios.

NOTE: Results were obtained using a logistic regression model with the HCC indicator as the dependent variable. Age, race, gender, and study group were used as predictors.

In addition to looking for the presence or absence of a particular condition, we also examined the HCC scores themselves to understand the severity of an individual's total disease burden. These scores characterize a person's expected cost levels as a function of age, sex and illness level for each of the specified conditions, while also accounting for other unrelated illnesses that contribute to a cumulative disease burden. When we adjust for age, race, and gender, all Erickson groups and the community MA group had significantly higher HCC scores than the community FFS group (see Table 15). The difference between the mean scores of the EA group and the community MA group is no longer significant, but the EA group does have a significantly lower mean score than the other two Erickson groups.

Table 15
Mean HCC scores adjusted by age, race, and gender

Study Group	2006 Community HCC Score Adjusted Means
Erickson Advantage	1.15*
Erickson FFS	1.25*
Erickson Other MA	1.22*
Community Controls MA	1.16*
Community Controls FFS	1.09

*Statistically significant when compared to the reference group (community FFS).

NOTE: Results were obtained using ANOVA analysis controlling for age, race, and gender.

4.4 PAST ENROLLMENT EXPERIENCE WITH OTHER MEDICARE ADVANTAGE PLANS

To better understand the characteristics of the enrollees in the EA plans, we wanted to understand whether EA members had prior experience in MA plans or whether these members were new to Medicare managed care. We examined eligibility data which contained monthly enrollment information for each person for each of the years 2004–2006. From these data, we were able to determine if a particular study group participant in 2006 was enrolled in an MA plan at any point in 2005 or 2004. Table 16 shows the 2004 and 2005 MA enrollment history of the study group members according to their 2006 enrollment status. It should be noted that because the Baltimore-area EA plan was active in October through November of 2005, this was not counted in the calculation of the MA enrollment history in 2005. This table only denotes whether someone was enrolled in a non-EA managed care plan at any point in 2005, and not the length of their enrollment.

We found that only 23% of EA members in 2006 were enrolled in another MA plan in 2005, indicating that only a small portion of EA members had prior experience with a Medicare managed care plan before enrolling in EA, and the majority had moved from traditional FFS Medicare. In contrast, most Erickson and community residents enrolled in other MA plans in 2006 were enrolled in MA plans in prior years.

Table 16
Previous enrollment in a Medicare Advantage plan

Year previously enrolled in an MA Plan (excluding EA)	Erickson Advantage 2006	Erickson FFS 2006	Erickson Other MA 2006	Community Controls MA 2006	Community Controls FFS 2006
2005	23%	2%	95%	87%	1%
2004	19%	1%	82%	71%	1%

4.5 PRIOR UTILIZATION OF HOSPITAL SERVICES

To further understand the characteristics of the study groups and to identify possible differences between EA members and their counterparts within Erickson and in the surrounding communities, we examined hospital utilization among the study groups using the MedPAR files from 2004–2005. This proved particularly challenging as hospitalization data are not available for the periods during which an individual is enrolled in a MA plan, which meant that data were not available in 2006 for any of the EA members or for the Erickson residents and community residents enrolled in other MA plans.

For this reason, we limited our analysis to an examination of prior hospitalizations occurring in 2004 and 2005, prior to the point at which most Erickson residents made the decision to enroll in EA. Again, data were not available for most of the Erickson and community residents enrolled in other MA plans for the years 2004 or 2005; therefore, we limited our analysis to those study group members who were in traditional FFS Medicare for the full 12 months of 2004 or 2005.

Because of these limitations, the data presented in Table 17 show comparisons between the EA, Erickson FFS, and community FFS groups only. As shown in this table, the distribution of hospital days are similar across the groups for both 2004 and 2005, although a higher percentage of the community FFS group had zero hospital days in both years as compared to both Erickson groups.

Table 17
Differences in hospital days for prior years by 2006 enrollment status

	Erickson Advantage	Erickson FFS	Community FFS
Total Hospital Days for 2005			
0 Days	82%	80%	86%
1-2 Days	5%	5%	4%
3-4 Days	5%	6%	3%
5 or More Days	7%	9%	7%
Total	100%	100%	100%
Total Hospital Days for 2004			
0 Days	81%	81%	88%
1-2 Days	8%	5%	4%
3-4 Days	3%	5%	3%
5 or More Days	8%	9%	6%
Total	100%	100%	100%

NOTE: Results are not age or gender adjusted. Beneficiaries who were enrolled in a MA plan for any number of months in 2004 or 2005 were excluded since hospitalization data were not available for the months they were enrolled in MA. For this reason, EA members who enrolled in 2005 were also excluded. Due to rounding, not all percentages add to 100%.

When we adjust for age, race, and gender in Table 18, the Erickson FFS group is shown to have a greater likelihood of one or more hospital days when compared to their FFS counterparts in the community; however, the EA members did not appear to have an increased likelihood as compared to the community FFS residents.

Table 18
Differences in hospital days for prior years adjusted for age, race, and gender by 2006 enrollment status

Hospital days	Erickson Advantage	Erickson FFS	Community FFS
1 or more hospital days in 2005	0.89	1.09*	Reference
1 or more hospital days in 2004	1.16	1.18*	Reference

*Statistically significant when compared to the reference group (community FFS).

NOTE: Beneficiaries who were enrolled in a MA plan for any number of months in 2004 or 2005 were excluded since hospitalization data were not available for the months they were enrolled in MA. For this reason, EA members who enrolled in 2005 were also excluded.

5.0 LIMITATIONS

A number of limitations should be noted with respect to the focus groups and the secondary data analysis. As is the case with all focus groups, it is important to highlight that participation in the groups was voluntary and that likely there is bias due to self-selection. For example, participants must be physically able to attend the group, and so may be healthier or more active than non-participants. Also, those willing to take time to participate in a discussion about Erickson may be more satisfied with Erickson than non-participants. While efforts were made to recruit a representative group of respondents, the views of focus group participants may not be representative of residents as a whole.

Holding the focus groups on-site was another potential limitation. The on-site location was chosen to minimize the transportation burden for participants and reduce any bias that may occur if only those who were able to drive or use public transportation participated. Since focus groups were held at the provider site, participants may not have been as open about negative experiences as they would have been at an off-site location. In order to encourage an open discussion, participants were assured that the moderators were not employed by Erickson, and that their individual responses would not be shared with Erickson personnel and would not affect any services they are receiving from Erickson or Medicare.

There were a number of anecdotal findings reported in the focus groups and site visits that we were unable to confirm in our secondary data analysis due to lack of available data. We were unable to investigate differences in income and assets between the Erickson residents and their community counterparts. We know that Erickson residents must provide a deposit and monthly payments when they move to an Erickson community; however, we were unable to determine whether Erickson residents have significantly greater income and assets than their community counterparts, and therefore we could not adjust for this in our analyses. We were also unable to identify study group members who received retiree health care benefits, which we learned was a major determining factor for enrollment in EA from the focus groups.

Certainly, this analysis is limited by the absence of utilization data from the health plans. While we were able to examine HCC data and hospital utilization records from the MedPAR files for years prior to enrollment in EA, not having hospital admission or length of stay data from the health plan made any comparisons of utilization between EA members and their FFS counterparts impossible. In addition, electronic medical record data were not available for Erickson residents; therefore, examination of EHMG-based service utilization or care management records for EA enrollees is also not possible. Therefore we were not able to address the question of how service utilization may differ for EA members.

Without geriatric assessment data, the question of whether health outcomes are improved in the Erickson setting also cannot be addressed, and without Erickson EMR data, we cannot address whether EA provides more options when members need additional services as compared to other residents. Finally, without a detailed accounting of the Erickson monthly fees, the financing of the extended 25-minute EHMG visit remains in question.

6.0 CONCLUSIONS

The case study findings regarding the EA plan suggest that the merits of this plan are tied in large part to the unique system of care at the Erickson communities, specifically the EHMG. The EA plan encompasses a medical model that supports a strong geriatric focus and continuity of care, which offers a significant advantage over other MA plans that do not have a similar focus in their provider network. However, much of this benefit is already available to Erickson residents without MA status. While this is attributable more to the Erickson model than to the EA plan itself, to the extent that the EA plan supports this model by enabling Erickson to recoup the cost of the investment they have made in better geriatric care, it represents a benefit to its members. It is not clear whether the availability of a waiver would be sufficient to induce a CCRC to develop a model like Erickson's, whether all CCRCs would choose to invest their resources in the same way, or whether the investment is sustainable over the long run.

It is important to point out that almost all Erickson residents (regardless of MA status) may benefit from the services provided at the EHMG (some MA plans do not use EHMG providers and vice versa), with the exception of the care coordinator services. In effect, the extended visits and on-site services represent benefits to Medicare beneficiaries that are not reflected in Medicare payments to EHMG. While EA members may benefit from this model of care as compared to their counterparts in the community at large, the added benefit of EA membership compared to what is already received as an Erickson resident remains a question. Our findings suggest that beyond the services provided in the Erickson communities, the added benefit of EA membership from the beneficiary perspective is threefold: (1) allowing the Erickson MA plan to admit a patient directly to the SNF without a three-day hospital stay gives EHMG more flexibility to address the needs of EA members without having to conform to Medicare regulations; (2) it increases member access to certain services by lowering or eliminating out-of-pocket costs; and (3) the availability of the care coordinator helps to maintain good continuity of care. To the extent that members use these services, it represents an advantage, although the residents already receive a great deal of benefit from the existing resources.

7.0 POLICY IMPLICATIONS

The benefits of EA depend on one's perspective. The Erickson program offers a very convenient and extensive set of services. Patients treated in the Erickson clinics receive much longer visits than is traditionally afforded under Medicare. These visits may be subsidized under a payment system that pays the clinic staff a salary and recoups what it can from Medicare fee-for-service payments. Erickson may also recoup this subsidy from the monthly fees applied to all residents regardless of whether or not they use the clinic, or it may come from revenue generated by investing the entrance deposits. From Erickson's perspective, EA provides the revenue they need to support their clinical operation, as well as an additional service (care coordination and an on-site member services representative, discussed in detail below) that complements Erickson's "full-service" model and adds to the marketability of the Erickson retirement housing package. It is a way to recoup the savings they achieve from better geriatric care. Reduced hospitalizations, for example, would otherwise go unrewarded.

For members, EA offers the services outlined above, as well as care coordination, with no additional out-of-pocket costs. For some members, EA offers a lower premium, and with the included services, this represents a significant cost savings. For residents with other low-cost insurance options, the benefits of EA may be only marginal, as residents without EA still benefit from the geriatric care model and the longer visits the EHMG provides, as well as the acute care coordinator. From the residents' perspective, the benefit of EA membership depends on their access to other insurance options (such as retiree benefits) and their need for the additional services provided through EA. Additional work would be needed to determine whether enrollment in EA produces a measurable improvement in terms of utilization patterns or health outcomes.

From the CMS perspective, the benefit of a specific waiver is less evident. The rationale for a CCRC-specific MA plan in an environment with a generous geriatric care model similar to what Erickson provides is less clear, as the residents already receive a great deal of benefit in terms of more time and attention from the existing resources. The waiver may encourage CCRCs to support their clinical operations and provide additional services. It is not clear whether the availability of a waiver would be sufficient to induce a CCRC to develop a model like Erickson's or whether all CCRCs would choose to invest their resources in the same way. If CCRCs can demonstrate the availability of a medical clinic with a geriatric model similar to the EHMG, and depending on how the reimbursement rates are set, there would seem to be no negative consequences of supporting the Special Needs Plan (SNP) status of MA plans within CCRCs. It is less clear how much support from an organization like UnitedHealth Group is required. It remains to be determined whether other CCRCs with different organizational and financial arrangements can support this type of model. From a regulatory perspective, CMS must develop criteria to use when determining whether to waive the county integrity rule for these types of plans. Some consideration should be given to what these criteria should be. Ultimately, whether to waive the rule or not may come down to whether the proposed model provides better services or other factors that would benefit Medicare beneficiaries.

As this phase of the Erickson Advantage demonstration comes to a close, CMS has four options:

1. Terminate the project with sufficient advance notice to allow enrollees to make alternative arrangements.

2. Provide the county waiver and allow the program to become an MA program.

3. Allow the program to become an MA program but without the county waiver (i.e., the would have to allow all county residents to join).

4. Continue the demonstration status.

Presumably if CMS terminated the demonstration, EA could apply to be a traditional MA program without the county waiver (option #3).

The arguments in favor of granting the waiver are that minimal real harm is done; granting a special status to CCRCs would mean that their residents would have access to a set of services not available to other residents in the same county. The program could allow more CCRC residents to enroll in such programs. These programs might encourage other CCRCs to develop the same type of on-site geriatric capacity because they would have a business case for creating such services. Granting such a waiver would mean developing a set of eligibility criteria. In addition to meeting standard MA criteria, should CCRCs be required to show the capacity to deliver on-site geriatric care? This is a higher standard than is imposed on other MA vendors.

Continuing the demonstration status would temporize until managed care CMS policies are solidified. It could also provide an opportunity to see how the program operates in a more mature state. Further evaluation could assess the effects on utilization and quality. Such an evaluation could rely solely on administrative data (there is good reason to expect that United HealthCare Group and Erickson would cooperate in providing such data), or it could combine administrative data analysis with beneficiary surveys to address quality in more depth and test the effects of this care on functioning and quality of life.

References

Commission on Accreditation of Rehabilitation Facilities. Consumer Guide to Understanding Financial Performance and Reporting in Continuing Care Retirement Communities. http://www.carf.org/pdf/ccrc.pdf, 2007.

Cohen, M.A., Tell, E.J., Bishop, C.E., et al: Patterns of Nursing Home Use in a Pre-Paid Managed Care System: The Continuing Care Retirement Community, Gerontologist, 29(1):74-80, Feb. 1989.

Erickson Retirement Communities. Charlestown Information Kit. February 2007.

Kaiser Family Foundation. Medicare Health and Prescription Drug Plan Tracker http://www.kff.org/medicare/healthplantracker/topicresultspf.jsp?I=8&rt=2&sr=45.

Sloan, F.A, Conover, C.J., Shayne, M.W.: Continuing Care Retirement Communities: Prospects for Reducing Institutional Long-Term Care. Journal of Health Politics, Policy and Law 20(1):75-98, 1995.

Pope et al.: Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. Health Care Financing Review 25(4):119-141, Summer 2004.

Appendix A

Case Study Interview Guides

Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration

Erickson Health Interview Guide

Introductions…

Study Objectives:

We have a contract with CMS to develop a better understanding of how services are provided within the Erickson CCRCs and specifically, the innovations in the organization and delivery of care by the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

We have a contract with CMS to develop a better understanding of the services provided within the Erickson CCRCs and specifically, the benefits of the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

Do you have any questions for me before we get started?

May I record our conversation? This will help facilitate the interview process. I will not quote you directly without your permission. The notes from these interviews will be presented in a summary report, and I will not attribute any comments to a specific individual.

May I continue?

Campus Overview

Describe the Brooksby population:
What proportion of residents are in the SNF? The assisted living facility?

How is care delivered differently in the CCRC than in the community? What features of the CCRC allow you to do this?

Erickson Advantage

From an enrollee's perspective, how would you describe the benefits of Erickson Advantage?
Probe:

- Medical
- Non-Medical
- Financial

2.5 How do the services provided on campus by the CCRC differ for Erickson Advantage enrollees and other residents who are not enrolled?

2.5.1 PROBE:

- What types of benefits or services are unique to the Erickson Advantage plan?

What attributes of Erickson Advantage appeal to Erickson residents that they would not have access to if they were not an enrollee?

What services are unique to Erickson Advantage that are not available through other plans in the area? PROBE: Are on-site providers part of other plan networks (other than Erickson Advantage)?

Medical Clinic

What percentage of residents are cared for on-site by Erickson Health?

- How many _____ are there?
    - Geriatricians
        - How many full-time?
        - How many part-time?
    - Primary care docs?
        - How many full-time?
        - How many part-time?
    - Nurse practitioners?
    - Specialty care providers
        - How many full-time?
        - How many part-time?

Is there a particular hospital or hospitals in the area where Brooksby has a particular relationship?

How are referrals handled?

- Into clinic
- Out of clinic to other providers

Who chooses the specialist when one is needed?

Do specialists staff the clinic? How often do they hold special clinics?

What kinds of clinical support staff work in the clinic?

How much of each physician's caseload is comprised of EA enrollees?

5.2. Are there services available in the clinic that may not be available off site?

5.3 Approximately what percentage of residents see a primary provider who is off site?

5.3.1 Approximately what percentage of residents see a specialist who is off site?

5.3.2 How often do residents seek off-site care? For what reasons?

How is care coordinated…

- Within the medical clinic?
- With outside providers?
- With residential (non-medical clinic) staff?

5.4.1 Is there any difference in how this is coordinated for Erickson Advantage enrollees?

5.5 Does the medical clinic treat residents that are in other MA plans? How is care coordination and management handled for these patients?

How is medical record data captured?

- What kind of information is captured?
- How is this information shared and with whom?

How are clinical services coordinated with other services in the CCRC?

- How are they coordinated with case management and care planning activities?
- Are any resident/patients monitored closely on a daily basis? If so, by whom? (PROBE: are any residential (non-medical clinic) staff involved in monitoring or care coordination?

What other services are available within the clinic (podiatry, hearing, ophthalmic)?

Is there a proactive preventive program?

- What does it consist of?
- Who provides it?
- How is it overseen?

How is the utilization of services within the clinic monitored?

Case Management/Care Coordination

How are case management and care planning handled?

- Is it mandated?
- Is it directed to all members or only those with the highest risk? How is risk determined?

What kind of care management and planning activities are conducted?

- Is there a standard geriatric assessment protocol? How are patients assessed for overall needs?
- How are they monitored?

- Is there follow-up for the care planning activities? How?
- How are care planning and case management activities tracked within the EMR system?
- How are these case management activities associated with the medical clinic?
- Are these activities different for EA enrollees and non-enrollees? How so?

Is there a system of disease management? How does it work?

What is the role of the nurse practitioner?

What is the role of the care coordinator? Is this different from the nurse practitioner?

How is the physician involved?

- How does this differ if the physician is off-site?

How is specialty care coordinated?

Challenges/Limitations of the CCRC

Are there any challenges or limitations at [SITE] in terms of marketing or administration? Please describe.

Challenges/Limitations of Erickson Advantage

Are there any challenges or limitations that Erickson Advantage faces at [SITE] in terms of marketing or administration? Please describe.

Those are all the questions I have. Do you have any comments or anything else you would like to add?

Thank you for your time today…

Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration

Ann's Choice Executive Director Interview Guide

Introductions…

Study Objectives:

We have a contract with CMS to develop a better understanding of how services are provided within the Erickson CCRCs and specifically, the innovations in the organization and delivery of care by the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

We have a contract with CMS to develop a better understanding of the services provided within the Erickson CCRCs and specifically, the benefits of the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

Do you have any questions for me before we get started?

May I record our conversation? This will help facilitate the interview process. I will not quote you directly without your permission. The notes from these interviews will be presented in a summary report, and I will not attribute any comments to a specific individual.

May I continue?

Campus Overview

Describe the Brooksby population: how many residents? Are they from the local area? When did the campus open?

What proportion of residents are in the SNF? The assisted living facility?

How is care delivered differently in the CCRC than in the community? What features of the CCRC allow you to do this?

Erickson Advantage

What is the proportion of Erickson residents are EA enrollees as compared to traditional Medicare and other MA plans?

Has enrollment for Erickson Advantage met your expectations?

What proportion of residents have retiree health insurance? How does this differ from other sites? Is this a challenge in terms of marketing Erickson Advantage?

What has been Brooksby's experience with other MA plans in the area? Any experience with MA plans that left the market? How has this affected marketing efforts for Erickson Advantage?

From an enrollee's perspective, how would you describe the benefits of Erickson Advantage? Probe:

- Medical
- Non-Medical
- Financial

2.6 How do the services provided on campus by the CCRC differ for Erickson Advantage enrollees and other residents who are not enrolled?

2.6.1 PROBE:

- What types of benefits or services are unique to the Erickson Advantage plan?

What attributes of Erickson Advantage appeal to Erickson residents that they would not have access to if they were not an enrollee?

What services are unique to Erickson Advantage that are not available through other plans in the area? PROBE: Are on-site providers part of other plan networks (other than Erickson Advantage)?

Medical Clinic

What percentage of residents are cared for on-site by Erickson Health?

Is there a particular hospital or hospitals in the area where Brooksby has a particular relationship?

Challenges/Limitations of the CCRC

Are there any challenges or limitations at [SITE] in terms of marketing or administration? Please describe.

Challenges/Limitations of Erickson Advantage

Are there any challenges or limitations that Erickson Advantage faces at [SITE] in terms of marketing or administration? Please describe.

Those are all the questions I have. Do you have any comments or anything else you would like to add?

Thank you for your time today…

Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration

Ann's Choice Member Services Interview Guide

Introductions…

Study Objectives:

We have a contract with CMS to develop a better understanding of how services are provided within the Erickson CCRCs and specifically, the innovations in the organization and delivery of care by the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

We have a contract with CMS to develop a better understanding of the services provided within the Erickson CCRCs and specifically, the benefits of the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

Do you have any questions for me before we get started?

May I record our conversation? This will help facilitate the interview process. I will not quote you directly without your permission. The notes from these interviews will be presented in a summary report, and I will not attribute any comments to a specific individual.

May I continue?

Campus Overview

Describe the Brooksby Erickson Advantage population: Are they from the local area? Average age, health status, activity level, etc.

Describe your role: what kinds of services/activities to you provide?

How many enrollees do you serve?

Erickson Advantage

What is the proportion of Erickson residents are EA enrollees as compared to traditional Medicare and other MA plans?

What has been Brooksby's past experience with other MA plans in the area? Any experience with MA plans that left the market? How has this affected your service efforts for Erickson Advantage?

From an enrollee's perspective, how would you describe the benefits of Erickson Advantage? Probe:

- Medical
- Non-Medical
- Financial

From your perspective, how would you describe the benefits of Erickson Advantage? (PROBE: things that enrollees may not be aware of or think about, but that you see as providing value).

2.7 How do the services provided on campus by the CCRC differ for Erickson Advantage enrollees and other residents who are not enrolled?

2.7.1 PROBE:

- What types of benefits or services are unique to the Erickson Advantage plan?

What attributes of Erickson Advantage appeal to Erickson residents that they would not have access to if they were not an enrollee?

What services are unique to Erickson Advantage that are not available through other plans in the area? PROBE: Are on-site providers part of other plan networks (other than Erickson Advantage)?

What are the top three most common questions or problems that you receive from enrollees?

What kinds of issue resolution activities are you involved in? Can you give an example of a typical issue?

What would expand the market for Erickson Advantage? What would make EA more attractive to non-enrollees?
PROBE:

- Coverage in donut hole?
- Lower deductible?

What services are not currently offered by EA that members might want?

How is the transition to/from the SNF handled? Are you involved in this process?

- How is this different for Erickson Advantage enrollees?

Please describe some of the Erickson Advantage marketing activities. How are the Member Services representative and the care coordinator involved?

Are you involved in utilization review activities? What kinds of trends have you seen?

Challenges/Limitations of the CCRC

Are there any challenges or limitations at [SITE] in terms of marketing or administration? Please describe.

Challenges/Limitations of Erickson Advantage

Are there any challenges or limitations that Erickson Advantage faces at [SITE] in terms of marketing or administration? Please describe.

Those are all the questions I have. Do you have any comments or anything else you would like to add?

Thank you for your time today…

Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration

Ann's Choice Resident Life Interview Guide

Introductions…

Study Objectives:

We have a contract with CMS to develop a better understanding of how services are provided within the Erickson CCRCs and specifically, the innovations in the organization and delivery of care by the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

We have a contract with CMS to develop a better understanding of the services provided within the Erickson CCRCs and specifically, the benefits of the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

Do you have any questions for me before we get started?

May I record our conversation? This will help facilitate the interview process. I will not quote you directly without your permission. The notes from these interviews will be presented in a summary report, and I will not attribute any comments to a specific individual.

May I continue?

Campus Overview

Describe the Brooksby population:
What proportion of residents are in the SNF? The assisted living facility? What proportion are using home care services?

How many resident life staff provide services here at Brooksby?
Specify by:

- Home health
- Social work
- Home care

How is care delivered differently in the CCRC than in the community? What features of the CCRC allow you to do this?

Erickson Advantage

From an enrollee's perspective, how would you describe the benefits of Erickson Advantage? Probe:

- Medical
- Non-Medical
- Financial

From your perspective, how would you describe the benefits of Erickson Advantage? (PROBE: how does it change what you do/how you handle a case?)

2.8 How do the services provided on campus by the CCRC differ for Erickson Advantage enrollees and other residents who are not enrolled?

2.8.1 PROBE:

- What types of benefits or services are unique to the Erickson Advantage plan?

What attributes of Erickson Advantage appeal to Erickson residents that they would not have access to if they were not an enrollee?

What services are unique to Erickson Advantage that are not available through other plans in the area? PROBE: Are on-site providers part of other plan networks (other than Erickson Advantage)?

Care Coordination

How is the transition to/from the SNF handled?

- How is this different for Erickson Advantage enrollees?

How is care coordinated…

- Within the medical clinic?
- With outside providers?
- With residential (non-medical clinic) staff?

5.4.1 Is there any difference in how this is coordinated for Erickson Advantage enrollees?

5.5 Does Resident Life treat residents that are in other MA plans? How is care coordination and management handled for these patients?

Are any resident/patients monitored closely on a daily basis? If so, by whom? (PROBE: Is this different for EA vs. non-EA enrollees?

Case Management

How are case management and care planning handled?

- Is it mandated?

- Is it directed to all members or only those with the highest risk? How is risk determined?

What kind of care management and planning activities are conducted?

- Is there a standard geriatric assessment protocol? How are patients assessed for overall needs?
- How are they monitored?
- Is there follow-up for the care planning activities? How?
- How are care planning and case management activities tracked within the EMR system?
- How are these case management activities associated with the medical clinic?
- Are these activities different for EA enrollees and non-enrollees? How so?

Is there a system of disease management? How does it work?

What is the role of the care coordinator?

How is the physician involved?

- How does this differ if the physician is off-site?

Challenges/Limitations of the CCRC

Are there any challenges or limitations at [SITE] in terms of marketing or administration? Please describe.

Challenges/Limitations of Erickson Advantage

Are there any challenges or limitations that Erickson Advantage faces at [SITE] in terms of marketing or administration? Please describe.

Those are all the questions I have. Do you have any comments or anything else you would like to add?

Thank you for your time today…

Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration

Ann's Choice Sales and Marketing Interview Guide

Introductions…

Study Objectives:

We have a contract with CMS to develop a better understanding of how services are provided within the Erickson CCRCs and specifically, the innovations in the organization and delivery of care by the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

We have a contract with CMS to develop a better understanding of the services provided within the Erickson CCRCs and specifically, the benefits of the Erickson Advantage plan. As part of this effort, we are interviewing a number of executives and on-site staff to capture information about goals and planning, marketing efforts, staff roles, clinical services and case management activities for Erickson Advantage enrollees and Erickson residents as a whole.

Do you have any questions for me before we get started?

May I record our conversation? This will help facilitate the interview process. I will not quote you directly without your permission. The notes from these interviews will be presented in a summary report, and I will not attribute any comments to a specific individual.

May I continue?

Campus Overview

Describe the Brooksby population: how many residents? Are they from the local area?

What proportion of residents have retiree health insurance? How does this differ from other sites? Is this a challenge in terms of marketing Erickson Advantage?

Erickson Advantage

What is the proportion of Erickson residents are EA enrollees as compared to traditional Medicare and other MA plans?

Has enrollment for Erickson Advantage met your expectations?

What has been Brooksby's past experience with other MA plans in the area? Any experience with MA plans that left the market? How has this affected marketing efforts for Erickson Advantage?

From an enrollee's perspective, how would you describe the benefits of Erickson Advantage? Probe:

- Medical
- Non-Medical
- Financial

2.9 How do the services provided on campus by the CCRC differ for Erickson Advantage enrollees and other residents who are not enrolled?

2.9.1 PROBE:

- What types of benefits or services are unique to the Erickson Advantage plan?

What attributes of Erickson Advantage appeal to Erickson residents that they would not have access to if they were not an enrollee?

What services are unique to Erickson Advantage that are not available through other plans in the area? PROBE: Are on-site providers part of other plan networks (other than Erickson Advantage)?

What would expand the market for Erickson Advantage?
PROBE:

- Coverage in donut hole?
- Lower deductible?

Please describe some of the Erickson Advantage marketing activities. How are the Member Services representative and the care coordinator involved?

Challenges/Limitations of the CCRC

Are there any challenges or limitations at [SITE] in terms of marketing or administration? Please describe.

Challenges/Limitations of Erickson Advantage

Are there any challenges or limitations that Erickson Advantage faces at [SITE] in terms of marketing or administration? Please describe.

Those are all the questions I have. Do you have any comments or anything else you would like to add?

Thank you for your time today…

Appendix B

Focus Group Moderator Guides

Enrollee Moderator Guide

Moderator's Guide
[Notes to the moderator are in CAPS]

Overview (Welcome):

Hello, I'm (NAME) from Pacific Consulting Group. I will be leading our discussion today.

I would also like to introduce my co-moderator (NAME) who will be taking notes during our discussion.

We are conducting a research study for the Centers for Medicare and Medicaid services to help them learn from Erickson Retirement Community residents about their experiences with and perceptions of the health care provided within the Erickson Retirement Community and the Erickson Advantage managed care plan. We will ask you to talk about your experiences here at [SITE] and your decisions around enrollment in the Erickson Advantage plan. Your input will help inform Medicare as they develop new and innovative programs for you and others like you.

I understand that you are all residents of [SITE NAME], and you have chosen to enroll in Erickson Advantage, the Medicare Advantage plan offered to Erickson residents. If this is not the case, and you are not enrolled in an Erickson Advantage plan, please let me know now.

[IF ANYONE IS CURRENTLY NOT ENROLLED IN ERICKSON ADVANTAGE, DISMISS THEM FROM THE GROUP. IF THEY WERE PREVIOUSLY ENROLLED AND THEN DISENROLLED, DISMISS THEM FROM THE GROUP.]

I would like to thank all of you for coming in today. Our discussion will take about one and a half hours. Your input is really important to us.

Consent and Guidelines:

Before we begin, I would like to review the consent form and go over some ground rules for our discussion:

- All comments are strictly confidential. We will use first names only, and no names will be used in this report.
- My role as moderator will be to guide discussion.
- The session is tape recorded to allow us to write a comprehensive report. The recordings are for note taking purposes.
- I need to hear from all of you, but that doesn't mean that everyone must speak to every issue.
- Please speak clearly and in a loud voice. This ensures that the tape recorder will pick up everything accurately.
- Also, please speak one at a time. I want to hear everything you have to say, and this is difficult to do if many people are speaking at once.

- There are no right or wrong answers. I'm here to gather all points of view. Please feel free to ask each other or me questions if something is not clear. However, I want to let you know that I am not an expert on Medicare nor can I answer questions about the Erickson Advantage plan.
- Please remember everyone has something to contribute based on their experience.

Warm-up:

Now, let's go around and quickly introduce ourselves.

1. Please tell us your first name only;
2. How long you have lived at [SITE NAME]; and
3. How long you have been enrolled in Erickson Advantage

Discussion Topics:

Questions about the Erickson Retirement Community

I would like to start our discussion by asking you some questions about your decision to move to [SITE NAME].

- What made you decide to move to a retirement community?

- What characteristics attracted you to [SITE]? [PROMPT: ASK ABOUT ON-SITE SERVICES, SUCH AS THE MEDICAL CLINIC AND OTHER TYPES OF CARE (NURSING, HOME HEALTH) PROVIDED IN THE ERICKSON RETIREMENT COMMUNITY]

    - How important was on site care in making that decision?

- Did you look at other communities before you moved here?
    - What are some characteristics of [SITE] that distinguish it from other retirement communities in the area? Why was this important to you?

- Did you move from somewhere local, or from somewhere out of state?
    - Did you have to change health insurance arrangements?
    - Did you have to change your medical care arrangements?

Now I would like to ask you some questions about the Erickson Advantage program.

Erickson Advantage Marketing

- How did you first become aware of the Erickson Advantage program?

- Who told you about it? [PROMPT: RESIDENCE MANAGER, DOCTOR, OTHER STAFF, OTHER RESIDENTS]

- What were you told about the types of services covered? Was this attractive to you? Why? Why not?

- What would you describe as the benefits of the Erickson Advantage plan? What are the potential drawbacks of the plan?

- Are there any other services or benefits that you would like Erickson Advantage to offer?

- Did you feel under any pressure to join? If yes, how so?

Enrollment in Erickson Advantage

- Why did you enroll in Erickson Advantage? [LEAVE OPEN-ENDED, THEN FOLLOW WITH UNMENTIONED ITEMS ON THE LIST BELOW.]
  PROMPT:
  - Cost
  - Convenience
  - Covered services [PROMPT: INCLUDING DRUG BENEFITS?]
  - On-site providers
  - Off-site providers
  - Care coordination/management [PROMPT: THIS WOULD BE SOMEONE WHO COORDINATES YOUR CARE ACROSS MULTIPLE PROVIDERS]

- Did you consider joining another Medicare Advantage plan?
  - [PROMPT: IF NO]
    - Why not?
  - [PROMPT : IF YES]
    - Why did you choose Erickson Advantage over other plans?

- Are you satisfied with your enrollment decision? Why or why not?
  - Have you had any issues obtaining coverage for the things you need? [PROMPT: PLEASE DESCRIBE]
  - Will you re-enroll in this plan again next year?

- What kind of coverage did you have prior to enrolling in Erickson Advantage? Were you enrolled in another managed care plan? Were you enrolled in a Medi-gap plan?

  - Did you have prescription drug coverage in your prior plan?

- Did you have a primary care provider before joining Erickson Advantage? Is this person still your primary care provider?

- Have you had any difficulty seeing the providers you wanted to see?

- Some of you may have some chronic health issues, such as diabetes, heart disease, arthritis, etc. Does the Erickson Advantage plan provide you with any special services to help you manage these problems? [PROMPT: What are they?]

    - Are you satisfied with these services? Why or why not?
    - Would you be willing to pay a little more money to retain these services?

Now I have some questions for you about the care you receive here at [SITE] or at other locations. This may include care from a physician, a nurse practitioner, or other clinical staff in the on-site medical clinic or elsewhere.

HEALTH CARE SERVICES

- Who is responsible for your primary care? [PROMPT: PRIMARY CARE IS YOUR FIRST POINT OF CONTACT FOR MEDICAL CARE, PROVIDING CHECK-UPS AND REFERRALS IF YOU NEED ADDITIONAL CARE]. Is it someone on-site?

    - Are you satisfied with the care you have received from your on-site provider? Why or why not?

- Do you see any health care providers at another location? For what kinds of care? Why or why not?

    - If you have an on-site primary care provider, is he or she up to date on the outcome of the off-site visits?

- Is there someone here at [SITE] who helps you manage your care? [PROMPT: someone who makes sure that any necessary follow-up appointments are scheduled, or that providers here at [SITE] are aware of visits you have had with providers at another location. This person may also follow-up to make sure certain types of chronic conditions are being monitored (weight, blood-sugar)]

- Have you had any issues obtaining the care you need here at [SITE]? [PROMPT: PLEASE DESCRIBE]

- Have you had any difficulties scheduling appointments with on-site providers? How long have you had to wait for an appointment?

- For those of you who have chronic conditions such as diabetes, heart disease, arthritis, etc., does the clinic do anything special to monitor your condition or teach you about ways to cope with your disease?

- Do you notice any difference in the health care you receive as compared to those people you know who are not enrolled in Erickson Advantage?

- Do you see any benefit of being managed in your home rather than going to the hospital?

SHOW OF HANDS

- How many of you have long-term care insurance?
- How many of you engage in regular exercise?
- How many of you currently smoke?
- How many would say you have more than 2-3 drinks per day?

WRAP UP

Are there any final comments or suggestions you would like to make regarding [SITE], the medical clinic, or Erickson Advantage?

These are all the questions I have for you today. Thank you again for taking the time to share your insights and experiences with us today.

Non-Enrollee Moderator Guide

Moderator's Guide
[Notes to the moderator are in CAPS]

Overview (Welcome):

Hello, I'm (NAME) from Pacific Consulting Group. I will be leading our discussion today.

I would also like to introduce my co-moderator (NAME) who will be taking notes during our discussion.

We are conducting a research study for the Centers for Medicare and Medicaid services to help them learn from Erickson Retirement Community residents about their experiences with and perceptions of the health care provided within the Erickson Retirement Community and the Erickson Advantage managed care plan. We will ask you to talk about your experiences here at [SITE] and your decisions around enrollment in the Erickson Advantage plan. Your input will help inform Medicare as they develop new and innovative programs for you and others like you.

I understand that while you are all residents of [SITE NAME] you have chosen not to enroll in Erickson Advantage, the Medicare Advantage plan offered to Erickson residents. If this is not the case, and you are enrolled in an Erickson Advantage plan, please let me know now.

[IF ANYONE IS CURRENTLY ENROLLED IN ERICKSON ADVANTAGE, DISMISS THEM FROM THE GROUP. IF THEY WERE PREVIOUSLY ENROLLED AND THEN DISENROLLED, KEEP THEM IN THE GROUP.]

I would like to thank all of you for coming in today. Our discussion will take about one and a half hours. Your input is really important to us.

Consent and Guidelines:

Before we begin, I would like to review the consent form and go over some ground rules for our discussion:

- All comments are strictly confidential. We will use first names only, and no names will be used in this report.
- My role as moderator will be to guide discussion.
- The session is tape recorded to allow us to write a comprehensive report. The recordings are for note taking purposes.
- I need to hear from all of you, but that doesn't mean that everyone must speak to every issue.
- Please speak clearly and in a loud voice. This ensures that the tape recorder will pick up everything accurately.
- Also, please speak one at a time. I want to hear everything you have to say, and this is difficult to do if many people are speaking at once.

- There are no right or wrong answers. I'm here to gather all points of view. Please feel free to ask each other or me questions if something is not clear. However, I want to let you know that I am not an expert on Medicare nor can I answer questions about the Erickson Advantage plan. Please remember everyone has something to contribute based on their experience.

Warm-up:

Now, let's go around and quickly introduce ourselves.

4. Please tell us your first name only;
5. How long you have lived at [SITE NAME]

Discussion Topics:

I would like to start our discussion by asking you some questions about your decision to move to [SITE NAME].

Questions about the Erickson Retirement Community

- What made you decide to move to a retirement community?

- What characteristics attracted you to [SITE]? [PROMPT: ASK ABOUT ON-SITE SERVICES, SUCH AS THE MEDICAL CLINIC AND OTHER TYPES OF CARE (NURSING, HOME HEALTH) PROVIDED IN THE ERICKSON RETIREMENT COMMUNITY]

    - How important was on site care in making that decision?

- Did you look at other communities before you moved here?
    - What are some characteristics of [SITE] that distinguish it from other retirement communities in the area? Why was this important to you?

- Did you move from somewhere local, or from somewhere out of state?
    - Did you have to change health insurance arrangements?
    - Did you have to change your medical care arrangements?

Now I would like to ask you some questions about the Erickson Advantage program.

Erickson Advantage Marketing

- How did you first become aware of the Erickson Advantage program?

- Who told you about it? [PROMPT: RESIDENCE MANAGER, DOCTOR, OTHER STAFF, OTHER RESIDENTS]

- What were you told about the types of services covered? Were there any that were especially attractive to you? Why? Why not?

- What would you describe as the benefits of the Erickson Advantage plan? What are the potential drawbacks of the plan?

- Is there any service that Erickson Advantage could offer that would make it more attractive to you?

- Did you feel any pressure to join? If yes, how?

Non-Enrollment in Erickson Advantage

- Why did you choose not to enroll in Erickson Advantage? [LEAVE OPEN-ENDED, THEN FOLLOW WITH UNMENTIONED ITEMS ON THE LIST BELOW.]
  PROMPT:
  - Cost
  - Convenience
  - Covered services [PROMPT: INCLUDING DRUG BENEFITS?]
  - On-site providers
  - Off-site providers
  - Have other retiree plan
  - Care coordination/management [PROMPT: THIS WOULD BE SOMEONE WHO COORDINATES YOUR CARE ACROSS MULTIPLE PROVIDERS]

- Are you enrolled in another managed care plan?
  - [PROMPT: IF NO]
    - Why not?
    - Did you consider enrolling in any other Medicare Advantage plan? Why or why not?
    - What kind of health care coverage do you currently have?

  - [PROMPT: IF YES]
    - Why did you choose this plan over the Erickson Advantage plan?
    - Will you re-enroll in this plan again next year? Why or why not?

- Did you enroll in Erickson Advantage and then dis-enroll at a later date? Why did you choose to dis-enroll?

- Are you satisfied with your enrollment decision? Why or why not?
  - Have you had any issues obtaining coverage for the things you need? [PROMPT: PLEASE DESCRIBE]

  - Did you have prescription drug coverage?

- Some of you may have some chronic health issues, such as diabetes, heart disease, arthritis, etc. Does your plan provide you with any special services to help you manage these problems? [PROMPT: What are they?]

    - Are you satisfied with these services? Why or why not?
    - Would you be willing to pay a little more money to obtain/retain these services?

Now I have some questions for you about the care you receive here at [SITE] or at other locations. This may include care from a physician, a nurse practitioner, or other clinical staff in the on-site medical clinic or elsewhere.

HEALTH CARE SERVICES

- Who is responsible for your primary care? [PROMPT: PRIMARY CARE IS YOUR FIRST POINT OF CONTACT FOR MEDICAL CARE, PROVIDING CHECK-UPS AND REFERRALS IF YOU NEED ADDITIONAL CARE]. Is it someone on-site?

    - Are you satisfied with the care you have received from your on-site provider? Why or why not?

- Do you see any health care providers at another location? For what kinds of care? Why or why not?

    - If you have an on-site primary care provider, is he or she up to date on the outcome of the off-site visits?

- Is there someone here at [SITE] who helps you manage your care? [PROMPT: someone who makes sure that any necessary follow-up appointments are scheduled, or that providers here at [SITE] are aware of visits you have had with providers at another location. This person may also follow-up to make sure certain types of chronic conditions are being monitored (weight, blood-sugar)]

- Have you had any issues obtaining the care you need here at [SITE]? [PROMPT: PLEASE DESCRIBE]

- Have you had any difficulties scheduling appointments with on-site providers? How long have you had to wait for an appointment?

- For those of you who have chronic conditions such as diabetes, heart disease, arthritis, etc., does the clinic do anything special to monitor your condition or teach you about ways to cope with your disease?

- Do you notice any difference in the health care you receive as compared to those people you know who are enrolled in Erickson Advantage?

- Do you see any benefit of being managed in your home rather than going to the hospital?

SHOW OF HANDS

- How many of you have long-term care insurance?
- How many of you engage in regular exercise?
- How many of you currently smoke?
- How many would say you have more than 2-3 drinks per day?

WRAP UP

Are there any final comments or suggestions you would like to make regarding [SITE], the medical clinic, or Erickson Advantage?

These are all the questions I have for you today. Thank you again for taking the time to share your insights and experiences with us today.

Appendix C

Plan Comparison Chart

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Ann's Choice in Warminister, PA

This, and the following tables in this appendix,

- Does not include stand alone plans.
- Includes only those plans with more than 5% enrollment at an Erickson CCRC site in 2006.
- Includes plan data from 2008 HPMS fact sheets unless otherwise noted.
- Includes in-network costs unless otherwise noted.

Comparison Category	Erickson Advantage H5697	Keystone Health Plan East, Inc. H3952	Independence Blue Cross H3909	Aetna Health Inc. H3931
Total Erickson enrollment in 2006	99	765	201	136
% of Erickson enrollees in 2006	5%	36%	10%	6%
Part C premium	$102.70	$87.00	$197.00	$57 (Parts C and D)
Part D premium	$30.30	$35.40	$20.80	$57 (Parts C and D)
Out of pocket limit	$1500	Not applicable	$500 yearly deductible	Not applicable
Inpatient hospital care	$0; Unlimited days	$150 /day (days 1-10); $0 after day 10; $1500 Out of pocket limit; Unlimited days	$150 /day (days 1-10); $0 after day 10; $1500 Out of pocket limit; Unlimited days	$850 / stay; Unlimited days
Doctor office visit copayments				
Primary	$0-20	$5	$25	$20
Specialist	$20	$30	$40	$35
ESRD				
In-area dialysis	0%	$0	$0	$30
Out-of-area dialysis	30%	$0	$0	$30
Nutrition therapy copayment	$0	$0	$0	$0
Prescription drugs				
Step therapy	Yes	No	No	Yes
Deductible	$0	$0	$200 /year	$275 /year

Source: Data Aetna Health Inc. H3931 is from the Medicare Options Compare Web site.

Comparison Category	Erickson Advantage H5697	Keystone Health Plan East Inc. H3952	Independence Blue Cross H3909	Aetna Health Inc. H3931
Prescription drug copayment (30-day supply; preferred pharmacy)				
Preferred generic	$3	$5	$6	$6.25
Preferred brand	$29	$30	$30	$34
Non preferred	$60	$50	$50	$79
Specialty	33%	Not applicable	Not applicable	25%
Gap coverage	No	No	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$2.25 or 5% coinsurance	$2.25 or 5% coinsurance	$2.25 or 5% coinsurance
Dental visit				
Dental benefit copayment	$20	$0	$0	$35
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	$15 (does not include X-ray)	Not covered	$5
Hearing				
Diagnostic hearing exam copayment	$20	$30	$40	$35
Hearing aid copayment	$0	$0 copayment for 1 hearing aid every 3 years	Not applicable	$0
Hearing aid copayment limit	$160 limit every two years	$500 limit every 3 years	Not applicable	$800 limit every three years

Source: Data Aetna Health Inc. H3931 is from the Medicare Options Compare Web site.

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Brooksby Village in Peabody, MA

Comparison Category	Erickson Advantage H5754	Tufts associated HMO, Inc. H2256	Blue Cross & Blue Shield MA HMO Blue H2261
Total Erickson enrollment in 2006	95	379	182
% of Erickson enrollees in 2006	4%	14%	7%
Part C premium	$103.10	$96.00	$79.50
Part D premium	$29.90	$22.00	$27.50
Out of pocket limit	$1500	Not applicable	Not applicable
Inpatient hospital care	$0; Unlimited days	$0; Unlimited days; $200 deductible; $200 Out of pocket limit	$100 /day (days 1-5); $0 /day (days 6-90); $500 Out of pocket limit
Doctor office visit copayments			
Primary	$0-20	$10	$10-20
Specialist	$0-20	$15	$20
ESRD			
In-area dialysis	0%	$0	$0
Out-of-area dialysis	30%	$0	$0
Nutrition therapy copayment	$0	$0	$20
Prescription Drugs			
Step therapy	Yes	Yes	Yes
Deductible	$0	$0	$0
Copayment (30-day supply; preferred pharmacy)			
Preferred generic	$3	$10	$10
Preferred brand	$29	$30	$35
Non preferred	$60	$55	$65
Specialty	33%	Not applicable	Not applicable
Gap coverage	No	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$2 Tier 1; $8 Tier 2; $14 Tier 3;	$2.25 or 5% coinsurance
Dental visit			
Dental benefit copayment	$20	$15	$0
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	Not covered	$20
Hearing			
Diagnostic hearing exam copayment	$20	$15	$0
Hearing aid copayment	$0	Not covered	$0
Hearing aid copayment limit	$160 limit/2 yrs	Not covered	$400 limit/3 yrs

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Cedar Crest in Pompton Plains, NJ

Comparison Category	Erickson Advantage H5918	Horizon Healthcare of New Jersey, Inc. H3154
Total Erickson enrollment	71	220
% of Erickson enrollees	4%	12%
Part C premium	$101.40	$25.50
Part D premium	$31.60	$35.50
Out of pocket limit	$1500	$5000; $900 yearly deductible
Inpatient hospital care	$0; Unlimited days	$75 /day (days 1-10); $0 for additional days; $750 out of pocket limit per stay; Unlimited days
Doctor office visit copayments		
Primary	$0-20	$15
Specialist	$20	$35
ESRD		
In-area dialysis	0%	$0
Out-of-area dialysis	30%	$0
Nutrition therapy copayment	$0	$15-35
Prescription drugs		
Step therapy	Yes	Yes
Deductible	$0	$275
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$5
Preferred brand	$29	$33
Non preferred	$60	$55
Specialty	33%	25%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$2.25 or 5% coinsurance
Dental visit		
Dental benefit copayment	$20	$0
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	Not covered
Hearing		
Diagnostic hearing exam copayment	$20	$15-35
Hearing aid copayment	$0	$0
Hearing aid copayment limit	$160 limit every two years	$750 limit every three years

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Charleston in Catonsville, MD

Comparison Category	Erickson Advantage H5652	Kaiser Foundation Health Plan of the Mid-Atlantic States H2150
Total Erickson enrollment in 2006	174	194
% of Erickson enrollees in 2006	6%	7%
Part C premium	$102.90	$34.60
Part D premium	$30.10	$24.40
Out of pocket limit	$1500	$3250
Inpatient hospital care	$0; Unlimited days	$500 Copayment/Medicare stay; $0 Copayment for additional days (unlimited)
Doctor office visit copayments		
Primary	$0-20	$20
Specialist	$0-20	$20
ESRD		
In-area dialysis	0%	0%
Out-of-area dialysis	30%	100%
Nutrition Therapy Copayment	$0	$20
Prescription drugs		
Step therapy	Yes	No
Deductible	$0	$0
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$11
Preferred brand	$29	$37
Non preferred	$60	Not applicable
Specialty	33%	10%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$4
Dental visit		
Dental benefit copayment	$20	$20
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	$30 (including 1 fluoride treatment/6 months)
Hearing		
Diagnostic hearing exam copayment	$20	$20
Hearing aid copayment	$0	Not covered
Hearing aid copayment limit	$160 limit every two years	Not covered

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Greenspring Village in Springfield, VA

Comparison Category	Erickson Advantage H5754	Kaiser Foundation Health Plan of the Mid-Atlantic States H2150
Total Erickson enrollment in 2006	79	478
% of Erickson enrollees in 2006	5%	28%
Part C premium	$98.40	$34.60
Part D premium	$34.60	$24.40
Out of pocket limit	$1500	$3250
Inpatient hospital care	$0; Unlimited days	$500 Copayment/Medicare stay; $0 Copayment for additional days (unlimited)
Doctor office visit copayments		
Primary	$0-20	$20
Specialist	$0-20	$20
ESRD		
In-area dialysis	0%	0%
Out-of-area dialysis	30%	100%
Nutrition therapy copayment	$0	$20
Prescription drugs		
Step therapy	Yes	No
Deductible	$0	$0
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$11
Preferred brand	$2	$37
Non preferred	$60	Not applicable
Specialty	33%	10%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$4
Dental visit		
Dental benefit copayment	$20	$20
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	$30 (including 1 fluoride treatment/6 months)
Hearing		
Diagnostic hearing exam copayment	$20	$20
Hearing aid copayment	$0	Not covered
Hearing aid copayment limit	$160 limit every two years	Not covered

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Linden Ponds in Hingham, MA

Comparison Category	Erickson Advantage H5754	Tufts Associated HMO, Inc. H2256	Blue Cross & Blue Shield MA HMO Blue, Inc. H2261
Total Erickson enrollment in 2006	62	192	98
% of Erickson enrollees in 2006	6%	20%	10%
Part C premium	$103.10	$96.00	$79.50
Part D premium	$29.90	$22.00	$27.50
Out of pocket limit	$1500	Not applicable	Not applicable
Inpatient hospital care	$0; Unlimited days	$0; Unlimited days; $200 deductible; $200 Out of pocket limit	$100 /day (days 1-5); $0 /day (days 6-90); $500 Out of pocket limit
Doctor office visit copayments			
Primary	$0-20	$10	$10-20
Specialist	$0-20	$15	$20
ESRD			
In-area dialysis	0%	$0	$0
Out-of-area dialysis	30%	$0	$0
Nutrition therapy copayment	$0	$0	$20
Prescription drugs			
Step therapy	Yes	Yes	Yes
Deductible	$0	$0	$0
Copayment (30-day supply; preferred pharmacy)			
Preferred generic	$3	$10	$10
Preferred brand	$29	$30	$35
Non preferred	$60	$55	$65
Specialty	33%	Not applicable	Not applicable
Gap coverage	No	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$2 Tier 1; $8 Tier 2; $14 Tier 3;	$2.25 or 5% coinsurance
Dental visit			
Dental benefit copayment	$20	$15	$0
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	Not covered	$20
Hearing			
Diagnostic hearing exam copayment	$20	$15	$0
Hearing aid copayment	$0	Not covered	$0
Hearing aid copayment limit	$160 limit/2 yrs	Not covered	$400 limit/3 yrs

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Oak Crest Village in Parkville, MD

Comparison Category	Erickson Advantage H5652	Kaiser Foundation Health Plan of the Mid-Atlantic States H2150
Total Erickson enrollment in 2006	126	194
% of Erickson enrollees in 2006	5%	7%
Part C premium	$102.90	$34.60
Part D premium	$30.10	$24.40
Out of pocket limit	$1500	$3250
Inpatient hospital care	$0; Unlimited days	$500 Copayment/Medicare stay; $0 Copayment for additional days (unlimited)
Doctor office visit copayments		
Primary	$0-20	$20
Specialist	$0-20	$20
ESRD		
In-area dialysis	0%	0%
Out-of-area dialysis	30%	100%
Nutrition therapy copayment	$0	$20
Prescription drugs		
Step therapy	Yes	No
Deductible	$0	$0
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$11
Preferred brand	$29	$37
Non preferred	$60	Not applicable
Specialty	33%	10%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$4
Dental visit		
Dental benefit copayment	$20	$20
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	$30 (including 1 fluoride treatment/6 months)
Hearing		
Diagnostic hearing exam copayment	$20	$20
Hearing aid copayment	$0	Not covered
Hearing aid copayment limit	$160 limit every two years	Not covered

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Riderwood Village in Silver Springs, MD

Comparison Category	Erickson Advantage H5652	Kaiser Foundation Health Plan of the Mid-Atlantic States H2150
Total Erickson enrollment in 2006	132	698
% of Erickson enrollees in 2006	5%	27%
Part C premium	$102.90	$34.60
Part D premium	$30.10	$24.40
Out of pocket limit	$1500	$3250
Inpatient hospital care	$0; Unlimited days	$500 Copayment/Medicare stay; $0 Copayment for additional days (unlimited)
Doctor office visit copayments		
Primary	$0-20	$20
Specialist	$0-20	$20
ESRD		
In-area dialysis	0%	0%
Out-of-area dialysis	30%	100%
Nutrition therapy copayment	$0	$20
Prescription drugs		
Step therapy	Yes	No
Deductible	$0	$0
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$11
Preferred brand	$29	$37
Non preferred	$60	Not applicable
Specialty	33%	10%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$4
Dental visit		
Dental benefit copayment	$20	$20
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	$30 (including 1 fluoride treatment/6 months)
Hearing		
Diagnostic hearing exam copayment	$20	$20
Hearing aid copayment	$0	Not covered
Hearing aid copayment limit	$160 limit every two years	Not covered

Evaluation of the Erickson Advantage CCRC Demonstration
Health Plan Comparisons for Seabrook Village in Tinton Falls, NJ

Comparison Category	Erickson Advantage H5918	Horizon Healthcare of New Jersey, Inc. H3154
Total Erickson enrollment in 2006	94	183
% of Erickson enrollees in 2006	4%	9%
Part C premium	$101.40	$25.50
Part D premium	$31.60	$35.50
Out of pocket limit	$1500	$5000 $900 yearly deductible
Inpatient hospital care	$0; Unlimited days	$75 /day (days 1-10); $0 for additional days; $750 out of pocket limit per stay; Unlimited days
Doctor office visit copayments		
Primary	$0-20	$15
Specialist	$20	$35
ESRD		
In-area dialysis	0%	$0
Out-of-area dialysis	30%	$0
Nutrition therapy copayment	$0	$15-35
Prescription drugs		
Step therapy	Yes	Yes
Deductible	$0	$275
Copayment (30-day supply; preferred pharmacy)		
Preferred generic	$3	$5
Preferred brand	$29	$33
Non preferred	$60	$55
Specialty	33%	25%
Gap coverage	No	No
Cost-sharing after gap for generic	$2.25 or 5% coinsurance	$2.25 or 5% coinsurance
Dental visit		
Dental benefit copayment	$20	$0
Office visit copayment (1 cleaning/6 months; 1 exam/ 6 months; 1 X-ray/year)	$20	Not covered
Hearing		
Diagnostic hearing exam copayment	$20	$15-35
Hearing aid copayment	$0	$0
Hearing aid copayment limit	$160 limit/two years	$750 limit every three years

Appendix D

Classification Scheme for HCC Diagnostic Categories

Classification Scheme for HCC Diagnostic Categories

Cancer

Metastatic Cancer and Acute Leukemia
Lung, Upper Digestive Tract, and Other Severe Cancers
Lymphatic, Head and Neck, Brain, and Other Major Cancers
Breast, Prostate, Colorectal and Other Cancers and Tumors

Diabetes

Diabetes with Renal or Peripheral Circulatory Manifestation
Diabetes with Neurologic or Other Specified Manifestation
Diabetes with Acute Complications
Diabetes with Ophthalmologic or Unspecified Manifestation
Diabetes without Complication
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage

Other Kidney Disease

Dialysis Status
Nephritis
Renal Failure

Liver Disease

End-Stage Liver Disease
Cirrhosis of Liver
Chronic Hepatitis

Psychiatric Illness

Drug/Alcohol Psychosis
Drug/Alcohol Dependence
Schizophrenia
Major Depressive, Bipolar, and Paranoid Disorders

Paralysis or other Neuromuscular Disorders and Stroke

Quadriplegia, Other Extensive Paralysis
Paraplegia
Spinal Cord Disorders/Injuries
Muscular Dystrophy
Polyneuropathy

Multiple Sclerosis
Parkinsons and Huntingtons Diseases
Cerebral Palsy and Other Paralytic Syndromes
Cerebral Hemorrhage
Ischemic or Unspecified Stroke

Vascular Disease

Vascular Disease with Complications
Vascular Disease

Respiratory Diseases

Cystic Fibrosis
Respirator Dependence/Tracheostomy Status
Respiratory Arrest
Chronic Obstructive Pulmonary Disease

CHF

Congestive Heart Failure
Cardio-Respiratory Failure and Shock

Pneumonia

Aspiration and Specified Bacterial Pneumonias
Pneumococcal Pneumonia, Emphysema, Lung Abscess

Skin Ulcers

Decubitus Ulcer of Skin
Chronic Ulcer of Skin, Except
Decubitus

Injury/Trauma (not Hip Fracture)

Extensive Third-Degree
Burns
Severe Head Injury
Major Head Injury
Vertebral Fractures without Spinal Cord Injury
Traumatic Amputation
Major Complications of Medical Care and Trauma
Amputation Status, Lower Limb/Amputation Complications
Coma, Brain Compression/Anoxic Damage

Hip Fracture

Hip Fracture/Dislocation

Infections and Immune Disorders (Including Rheumatiod Arthritis)

HIV/AIDS
Septicemia/Shock
Opportunistic Infections
Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
Severe Hematological Disorders
Disorders of Immunity
Hemiplegia/Hemiparesis
Bone/Joint/Muscle Infections/Necrosis

MI/Heart Disease

Acute Myocardial Infarction
Specified Heart Arrhythmias
Unstable Angina and Other Acute Ischemic Heart Disease
Angina Pectoris/Old Myocardial Infarction

Other

Intestinal Obstruction/Perforation
Pancreatic Disease
Inflammatory Bowel Disease
Seizure Disorders and Convulsions
Protein-Calorie Malnutrition
Major Organ Transplant Status
Artificial Openings for Feeding or Elimination