

The SNP Alliance



A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

Executive Summary

2009 SNP Alliance Profile and Advanced Practice Report Report Provides Evidence of Success

BACKGROUND

In 2009, the National Health Policy Group (NHPG) engaged The Lewin Group to conduct a comprehensive survey of Special Needs Plans (SNPs) participating in the SNP Alliance. The Lewin Group “benchmarked” data with Medicare fee-for-service, drawing upon an analysis done by Ingenix using the CMS 5 Percent Sample data sets, as well as a general survey of standard Medicare Advantage plans.¹

The Lewin Group collected qualitative and quantitative data from twenty-three SNP Alliance member organizations. As of December 2008, these organizations provided SNP services to nearly 500,000 beneficiaries in 41 states, or 34% of the nationwide SNP enrollment. The organizations served 68% of Chronic SNP enrollees, 22% of Dual SNP enrollees, and 42% of Institutional SNP enrollees. The plans provided data regarding the number and types of beneficiaries served, risk scores, program expenditures, service utilization and operating methods. The data included annualized utilization per 1,000 covered persons for: inpatient days; skilled nursing facility days; total physician office visits; and number of prescriptions. The plans also provided qualitative information related to advanced practices and member-specific case examples of SNP Alliance plans’ care coordination efforts.

The purpose of the survey was to build on and update a similar 2008 Report with more recent and comprehensive data for the SNP Alliance and Medicare Advantage Special Needs Plans. Both Reports sought to answer three questions: (1) “Are SNPs targeting high-risk beneficiaries?,” (2) “Are SNPs doing anything special?,” and (3) “Are SNPs making a positive difference for their enrollees?” The 2009 Report’s key findings are:

¹ The NHPG founded and manages the SNP Alliance. The SNP Alliance is the only national organization exclusively dedicated to improving policy and practice for Special Needs Plans. Membership is by invitation only, with all members required to provide evidence of high-quality standards and a commitment to working together to improve policy and practice in serving high-risk beneficiaries. SNP Alliance members represent over 250 SNPs serving nearly 600,000 beneficiaries. The membership represents all major SNP types, organizational structures and regions of the US, as well as involvement from leading State Medicaid Agencies advancing Medicare/Medicaid integration programs.

SNP Alliance members do target high-risk beneficiaries.

- **The weighted average risk score for participating SNPs is 1.34, 40% above the Medicare fee-for-service average.** The median risk score for Dual SNPs was 1.51, with a high of 2.37, compared to an average risk score of 1.24 for dual beneficiaries in fee-for-service. An average risk score of 2.04 for Institutional SNPs, compared to 1.78 for fee-for-service beneficiaries living in institutions. Lewin reports that even with correcting for coding differences between SNPs and fee-for-service settings, an average risk score differential of more than 30 percentage points would likely still exist.
- **The SNP Alliance enrollees average roughly twice the co-morbidities as the overall Medicare population.** On average the SNPs reported 2.93 HCCs per enrollee, versus the estimated Medicare program-wide average of 1.48. These statistics exclude the many chronic conditions absent from the HCC list used in calculating the number of co-morbidities. Several SNP Alliance plans serve members with exceptionally high numbers of co-morbidities, including 3.95 HCCs per enrollee for one Dual SNP, 4.60 for one Institutional SNP and 4.32 for one Chronic SNP.
- **Risk scores for SNP Alliance enrollees “new to Medicare” are roughly 55% of those for the SNPs’ remaining membership.** For the dually eligible SNPs, the average risk score for “new to Medicare” enrollees is 70% of the remaining SNP Alliance enrollees and 55% of the remaining enrollees for Chronic SNPs. The “new to Medicare” subgroup represents 8% of overall SNP Alliance organizational enrollment, and 12% of enrollment for Chronic SNPs. This differential is important in that SNP payment does not take into account the condition of a SNP enrollee new to Medicare for the first 12 months of enrollment. Since all C-SNP enrollees are required to have a condition for purposes of enrollment and

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SNP Alliance Report Provides Evidence of Success Continued

enrollees for other SNP type enrollees have higher risk scores than the average Medicare beneficiary with a comparable demographic profile, the underpayment can potentially be significant.

There is considerable evidence that SNP Alliance members significantly reduced utilization of inpatient and SNF services.

- **The SNPs substantially lowered inpatient and SNF usage compared to FFS Medicare.** The dual eligible SNPs collectively achieved an inpatient usage rate of 2,545 days/1,000 in CY2008, which is 25% below the FFS average usage rate for dual eligibles (3,387). The institutional SNPs appear to have lowered inpatient hospitalization by more than 50% from what would have occurred for their enrollees in the FFS setting. While no specific impact estimates can be made for chronic SNPs without more detailed data on the chronic SNP enrollment mix and creating a well-matched FFS comparison group, it is important to note that the utilization rates for the chronic SNPs is well below the estimates in fee-for-service for persons with congestive heart failure or diabetes, two chronic conditions commonly found among chronic SNPs.
- **The SNPs, on average, also significantly reduced skilled nursing facility (SNF) use.** The FFS comparison figures for beneficiaries with diabetes (3,437) and congestive heart failure (7,812) suggest that SNF usage may well have been reduced by more than half by the chronic care SNP Alliance Plans with an average SNF usage of 1,887 days/1,000. The dual eligible SNP enrollees collectively used 2,622 SNF days/1,000 in CY2008, 23% below FFS average usage rates for dual eligibles (3,407).
- **A high volume of office visits occurred across the SNP Alliance plans, which suggests improved levels of access to “front-line” primary care services is occurring for their enrollees.** Chronic SNP enrollees averaged 16 office visits per person during 2008. The comparison group of diabetic beneficiaries and beneficiaries with CHF averaged roughly 10 annual office visits per enrollee in FFS. Dual eligible SNP enrollees had nearly twice as many office visits compared with FFS dual eligibles, with Dual SNP enrollees averaging 12.8 office visits per person during CY2008, compared to 6.7 office visits for FFS dual eligibles.

SNP Alliance plans offer services that go well beyond what is available in the traditional Medicare fee-for-service setting.

- **SNPs typically provide ongoing care coordination to all enrollees.** The SNPs typically deploy interdisciplinary teams (including social workers, nutritionists, registered nurses, etc.) to implement a holistic approach to treatment, education and support. They regularly develop person-centered care plans, and routinely work with enrollees on an ongoing basis. They consider caregivers a key stakeholder in the care planning process and make more extensive use of home assessments and related care management activity. They frequently help beneficiaries manage both medical and non-medical needs, with more personal and ongoing support than typically occurs in the FFS setting.
- **SNP Alliance plans’ staff, benefits and administrative processes are configured to address the unique needs of their enrollee populations.** They have a strong capacity to address complex issues surrounding co-morbidity, frailty, disability and poly pharmacy, and to integrate mental and behavioral health issues into the ongoing plan of care. Primary care and related multi-disciplinary care teams provide a “medical home” component, with a more extensive set of benefits and services for the populations served than traditional MA plans.
- **The SNP care networks go well beyond a traditional health network definition.** The SNPs have systems in place for simplifying care transitions and improving care continuity among related care providers. They appear to contract more frequently with and/or closely interact with social services agencies, housing programs and agencies, nutritional programs, transportation providers, and other non-medical organizations. Their quality improvement methods are targeted to the needs of special population segments, with opportunities for related care providers to share information and work together as a team in managing care across the continuum.