The SNP Alliance

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

Executive Summary

2010 SNP Alliance Profile and Advanced Practice Report

Report Demonstrates Evidence of Success

BACKGROUND

Medicare Special Needs Plans (SNPs) served 1,282,188 enrollees as of January 2011. In 2010, the National Health Policy Group (NHPG) engaged The Lewin Group to quantify the performance of Special Needs Plans participating in the SNP Alliance. Comparison statistics were also tabulated on the Medicare FFS population by Ingenix Consulting using the 2008 CMS 5% Sample database, the latest FFS data available at the time of the analysis.[1] This Report represents the third consecutive year of surveying SNP Alliance members and includes operational data from 2007, 2008 and 2009.

The survey includes data from 20 member organizations, including data on demographics, healthcare utilization, costs from the December Monthly Membership Report (MMR), the average number of HCCs from Model Output Reports (MOP), and cost data from Medicare Advantage Price Bid Submissions. The survey includes annualized utilization per 1,000 covered persons for: (1) inpatient admissions and days; (2) readmissions within 30 days; (3) emergency room visits; and (4) total physician office visits. The Report also includes comparisons of FFS data for each SNP type, including a subset of fully-integrated dual SNPs that were national integration demonstration sites prior to transitioning to SNPs. Survey highlights follow:

[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 a commitment to quality standards and shared policy objectives. SNP Alliance members serve approximately 650,000 beneficiaries representing approximately 50% of national SNP enrollment. This includes approximately 45% of Chronic SNP enrollees, 40% of Dual SNP enrollees, and 70% of Institutional SNP enrollees. The membership represents all major SNP types, organizational structures and regions of the United States, as well as involvement from leading State Medicaid Agencies advancing Medicare/Medicaid integration programs.

SNP Alliance health plans continue to serve persons with more complex care needs than beneficiaries in "standard" Medicare (MA) plans, with continued evidence of better health care utilization rates relative to comparable FFS beneficiaries.

- **All SNP Alliance plans reporting data had an average risk score above 1.00 in 2007, 2008 and 2009.** The average risk score for the fully-integrated legacy plans was 1.47, compared to an average risk score of 1.27 for dual beneficiaries in FFS. The average risk score was 2.04 for Institutional SNPs, compared to 1.84 for FFS beneficiaries living in institutions. The average risk score was 1.22 for Chronic SNPs compared to 1.00 in Medicare FFS and an estimated 0.97 for non-SNP MA plans.

- **SNP Alliance plans continue to demonstrate added value by achieving significant and growing reductions in inpatient hospitalization.** The fully-integrated legacy SNPs achieved an inpatient utilization rate of 2,788 days per 1,000, compared to a rate of 3,327 days per 1,000 for duals in FFS, even though their average risk score was 1.47 vs. 1.27. Dual SNPs that were not part of the legacy plan group had a similar risk score to those in FFS but also had a utilization rate well below the rate for duals in FFS (2,821 vs. 3,327). The rate for Institutional SNPs was 2,369 days per 1,000, compared with a rate of 7,497 days per 1,000 for institutional beneficiaries in FFS. The utilization rate for Chronic SNPs was 2,740 per 1,000 versus a rate of 2,063 days per 1,000 for all Medicare beneficiaries in FFS.

- **SNP Alliance health plans continue to demonstrate evidence of the importance of a strong primary care model in serving high-risk beneficiaries.** In 2008, beneficiaries in Medicare FFS had an office visit rate of 6,865 days per 1,000 persons per year. Physician rates for SNP Alliance plans were 8,453 for Chronic SNPs, 8,008 for dual SNPs that were not Legacy FIDESNPs, and 7,847 for the fully-integrated dual plans.

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SNP Alliance Report Demonstrates Evidence of Success *(Continued)*

The survey offers strong evidence of the potential for fully-integrated programs.

- **Special Needs Plans are in a unique position to advance care for dual beneficiaries through integration.** Approximately nine million Americans are dually eligible for Medicare and Medicaid at a cost of more than $300 billion per year. With Medicare and Medicaid programs operating under two different sets of payment methods — rules and oversight structures — there is evidence that this fragmented approach causes significant and unnecessary confusion, medical complications and costs. SNPs are the only federal program, other than PACE, that is mandated to target and improve care for duals. More than 90% of all SNP costs relate to care for dual beneficiaries.

- **The 2010 Report profiles plans with decades of experience in advancing full program integration.** More than one-third of the organizations involved in the SNP Alliance participated in national integration demonstrations in Minnesota, Massachusetts and Wisconsin prior to becoming Special Needs Plans. In 2010, the SNP Alliance collected extensive information from these plans to ascertain quantitative evidence of this particular subgroup's performance.

- **The Report shows these fully-integrated legacy plans are serving a more complicated beneficiary population than what exists in FFS.** The average risk score for the plans' enrollees was 1.62, compared to a rate of 1.27 for Medicare FFS dual eligibles. More than 50% of the enrollees for these plans had at least one mental health diagnosis in 2009, compared with 23% for dual beneficiaries enrolled in Medicare FFS.

- **There is solid evidence of superior performance in managing health care utilization.** Even though the fully-integrated legacy plans' average risk score was 22% higher than dual beneficiaries in FFS, they averaged 2.5 to 3.1 inpatient days per person per year for 2007-2009, compared to 3.3 days per person for duals in FFS. The plans' average inpatient days per 1,000 was 2,778 days, compared with a FFS average of 3,327 days. Their average number and frequency of admissions were also both lower than among FFS duals. Part of the reduction can perhaps be attributed to more extensive use of care management and community-based services as well as more extensive involvement of primary care, where the number of physician visits per 1,000 for Legacy plans was 7,847 days vs. 6,865 days for FFS duals.

There is also strong evidence that all SNP types are targeting a more complex care population than what exists in FFS while achieving superior performance.

- **Excluding the FIDESNPs, D-SNPs averaged 2,821 days/1,000 during 2009, which is 15% below the FFS dual average of 3,327 days/1,000 (based on 2008 FFS data).** The average risk score among older enrollees of D-SNPs (who were not part of the legacy Sample) was 1.34, with 45% of their enrollees under 65, and with an average risk score of 1.05. They also provided evidence of continued improvement in lowering their hospital usage. Their average of 2,821days/1,000 in 2009 was 8% below the 2007 level and 12% below the 2008 level.

- **I-SNPs have achieved extraordinarily low inpatient usage rates compared with Medicare FFS.** Institutional Medicare beneficiaries in FFS have used inpatient care at the rate of 7.0-7.5 days per person per year. The I-SNP members averaged between 2.0 and 2.5 inpatient days per beneficiary per year throughout the 2007-2009 time frame. While I-SNPs serve both nursing home certifiable beneficiaries in the community and in institutions, and the FFS comparison group all live in institutions, the I-SNP members' average risk score of 2.04 is above the average risk score of 1.84 for institutional beneficiaries in FFS.

- **C-SNPs have also achieved superior performance, although benchmarking measures are more difficult to establish as these SNPs serve very different populations, such as persons with diabetes vs. care of persons with severe and persistent mental illness.** While establishing a comparable benchmark in FFS for C-SNPs as a whole is difficult, it is useful to note that inpatient usage for C-SNPs as a group has decreased by 20% from 2007 to 2009 during a time period when the average risk score did not change. The data suggests that C-SNPs are becoming increasingly proficient at reducing hospital usage as they mature.

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