MEDICARE ADVANTAGE SPECIAL NEEDS PLANS REAUTHORIZATION: WHAT SHOULD CONGRESS CONSIDER?

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Acknowledgments

- The Kaiser Family Foundation (KFF) has commissioned Mathematica to prepare a paper on SNPs that will provide more detail on the issues discussed here
  - Marsha Gold and Sarah Davis are co-authors
  - The paper will be available soon
- This Kaiser paper is entirely separate from the Mathematica evaluation of SNPs for CMS, and does not rely on any of the data and analysis prepared for that evaluation

Special Needs Plans

- Total number of SNPs in November 2007 – 477
  - Dual eligible – 320
  - Chronic or disabling condition – 73
  - Institutional – 84
- Total SNP enrollment in November 2007 – 1,080,593
  - Dual eligible – 751,784
  - Chronic or disabling condition – 183,881
  - Institutional – 144,928
- Total SNPs approved for 2008 – 775
  - Dual eligible – 441
  - Chronic or disabling condition – 245
  - Institutional – 89

SOURCE: SNP Comprehensive Reports on CMS web site

Growth in SNP Enrollment

- 532,507 in July 2006, 1,080,593 in November 2007
- Major sources of current SNP enrollment
  - Over 240,000 enrollees in Puerto Rico
  - Over 200,000 from "passive enrollment" of dual eligibles from Medicaid managed care plans into SNPs in 2005-2006
  - Over 100,000 from conversion of five existing Social HMO demonstrations in CA and NY to SNPs in 2007
  - Over 50,000 from conversion of existing Kaiser plans in CA, CO, and GA to SNPs in 2007
- Apart from PR, "active choices" by beneficiaries to enroll in SNPs appear to account for a little over half of current enrollment

Growth in Chronic Condition SNPs

- In 2008, chronic condition SNPs will be operating in all but six states
- Will be offered by approximately 40 companies
- United will have 66 chronic condition SNPs in 34 states and DC
- Humana will have 30 in 24 states
- Care Improvement Plus will have 28 in 6 states
- Some specialize in one condition (diabetes, ESRD, HIV, pulmonary disease, hypercholesteremia) while others include multiple conditions

Concentration of SNP Enrollment

- 82% of total SNP enrollment in November 2007 was in 9 states and Puerto Rico
  - PR, CA, PA, NY, FL, TX, AZ, MN, TN, and AL
    - Except for AL, all these states have included dual eligibles in Medicaid managed care, now contract with SNPs, or both
- 66% of November 2007 enrollment was in 13 companies
  - Outside of companies in Puerto Rico, largest enrollment is in United, SCAN, Care Improvement Plus, Kaiser, Managed Health, Inc., HealthSpring, Keystone, Gateway, WellCare, and Humana
    - All these companies have experience in Medicare, Medicaid, or both

Low Enrollment in Many SNPs

- Out of 477 SNPs in November 2007:
  - 249 (52%) had fewer than 500 enrollees
  - 129 (27%) had fewer than 100
  - 62 (13%) had fewer than 10
- What will happen to these low-enrollment SNPs and their enrollees if enrollment does not increase?
  - Many SNPs are part of larger MA plans, which may be able to offer other options to SNP enrollees

SNPs In The Broader MA Context

- SNP enrollment is 11 percent of total MA enrollment
  - MA enrollment is 20 percent of total Medicare enrollment
- Almost half of total MA contracts include one or more SNP plans
  - Almost three-fourths of total SNP enrollment is in contracts that include non-SNP MA products
  - Remainder of SNP enrollment is in SNP-only contracts
  - Chronic condition SNPs have somewhat more enrollment in SNP-only contracts, but this may change in 2008 with entry of United and Humana

SNP Payment

- SNPs are paid the same way as other MA plans for enrollees with comparable conditions
- Relationship of MA payments to FFS expenditures

– SNPs (excluding Puerto Rico)	111%
– HMOs	110%
– Local PPOs	117%
– Regional PPOs	110%
– PFFS	119%

SOURCE: MedPAC, November 2007

SNPs and States

- Why would states want to contract with SNPs?
  - Improve care coordination for dual eligibles
  - Achieve administrative efficiencies
  - Reduce Medicare-Medicaid cost shifting
  - Save state money
  - Move toward fuller integration
- Which states currently contract with SNPs?
  - AZ, CA, KY, MA, MN, NY, OR, TX, UT, WA, WI
  - Considerable variation in how extensive contracts are
- For more detail on state contracting with SNPs, see October 2006 Center for Health Care Strategies primer for states at: http://www.chcs.org/usr_doc/Medicare_Advantage_State_Primer.pdf

SNP Monitoring and Reporting

- How to tell whether SNPs are special?
- Require SNP-specific quality and performance reporting
  - HEDIS, CAHPS, and other measures are currently reported only at the contract level
    - Sample sizes in low-enrollment SNPs may be too small
  - CMS is working with NCQA to develop additional SNP-specific quality and performance measures
- Report "model of care" information from SNP applications, and monitor SNP implementation of these models
- Use Part D Rx data to measure Rx use and cost in SNPs, other MA plans, and PDPs
  - Compare to prior Rx use by duals under Medicaid

Dual Eligible SNPs

- Issues for plans
  - How to get enrollment?
    - Over 90% of dual eligibles are auto-enrolled in stand-alone PDPs
    - Duals are hard to identify and market to
    - Large share of current enrollment is rollover from existing Medicaid and MA plans
  - How to make plan "special"?
    - Add extra benefits or services?
    - Coordinate with Medicaid?
- Issues for beneficiaries
  - How to know up-front whether plan is special?
  - Do provider networks, benefits, and services meet their needs?
  - Is option to disenroll at any time a sufficient protection for beneficiaries?

Chronic Condition SNPs

- Issues for plans
  - How to get enrollment?
  - Will recorded diagnoses support risk scores and payment needed to cover costs?
  - How to change care patterns to improve quality and reduce costs?
  - Major national MA plans (United and Humana) are offering many new chronic condition SNPs in 2008
- Issues for beneficiaries
  - What do chronic condition SNPs add to traditional Medicare or regular MA-PD plans?
  - Are needed specialty providers in the network?
  - Non-duals (about half of enrollees) must wait up to a year to disenroll

Institutional SNPs

- Issues for plans
  - How to get enrollment?
    - Most current enrollment is in Evercare and converted Social HMO demos
    - SNPs must market to individual facilities, then individual residents
  - How to add value?
    - Savings from reduced hospitalizations can fund improvements in nursing facility care (on-site nurse practitioners, e.g.)
  - How to work with nursing facilities?

- Issues for beneficiaries
  - How to choose between SNPs and traditional Medicare?
  - How to tell if SNP is adding value?
  - Many residents have cognitive impairments

Conclusions

- All three SNP types have potential to add value
  - Since SNPs are paid the same as other MA-PD plans, added value must be financed by greater efficiencies or better focus (assuming reasonably accurate risk adjustment)
- It is hard to tell from currently available information whether SNPs are in fact adding value
- Risks to beneficiaries may be mitigated by option to disenroll
  - But non-dual enrollees can disenroll only once a year
  - Changing plans can also be time-consuming and burdensome, and new plan may not be better