



The LEWIN GROUP®

2010 SNP Alliance Profile and Advanced Practice Report

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A Lewin Group Report Sponsored
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2010 SNP Alliance Profile and Advanced Practice Report

A Report Prepared for The SNP Alliance by The Lewin Group

Table of Contents

I. Executive Summary	5
II. Background of the SNP Alliance & the Profile Report	6
III. National Overview of Medicare Special Needs Plans (SNPs)	7
Enrollment Trends by Type of SNP	7
Geographic Distribution of SNP Enrollment.....	11
IV. Data Collection Approach	12
V. Overview of Survey Respondents and Their SNP Enrollment	13
Organizations Contributing Data.....	13
SNP Alliance Enrollment Overview	15
Demographic Mix of SNP Alliance Enrollees.....	17
VI. Risk Score Assessment	18
Enrollment-Weighted Mean Risk Scores	18
Median Risk Scores and Ranges of Average Risk Scores	20
Risk Scores for Selected Enrollees Subgroups	21
Risk Score Distribution	22
VII. Health Care Conditions Assessment	23
Hierarchical Condition Categories.....	23
Mental Health Conditions.....	26
VIII. Health Care Utilization	28
Inpatient Utilization.....	28
Physician Visits.....	33
Emergency Room Utilization	34
Prescription Drugs	36
APPENDIX A: SNP Alliance Members as of January 2011	37

I. Executive Summary

Medicare Special Needs Plans (SNPs) serve 1,282,188 enrollees as of January 2011. The SNP Alliance is a group of 29 organizations collectively holding 46 percent of national SNP enrollment. The SNP Alliance is the only national organization exclusively dedicated to improving policy and practice for SNPs. The overall purpose of the SNP Alliance is to improve policy and performance for high-risk beneficiaries and those with complex needs.

The Lewin Group has been engaged to prepare annual reports on the performance of the SNP Alliance plans. This year's report conveys quantitative findings from a national survey of SNP Alliance members using operational data from 2007, 2008 and 2009. Comparison statistics were also tabulated on the Medicare fee-for-service population by Ingenix Consulting using the CMS 5% Sample database. The Report's key findings are summarized below, and Table ES-1 summarizes some of the key data comparisons with fee-for-service.

- The SNP Alliance health plans continue to serve members with more complex needs than exist in the overall Medicare population or in "standard" Medicare Advantage plans. For example, all 20 SNP Alliance Plans reporting data had an average risk score above 1.00 in 2007, 2008 and 2009.
- These plans continue to demonstrate added value in specialized care coordination by achieving significant and sustained reductions in inpatient hospital usage rates.
- SNP Alliance health plans continue to provide evidence of the importance of a strong primary care model in serving high-risk beneficiaries.
- Legacy fully-integrated dual-eligible SNPs (FIDESNPs) provide solid evidence of the benefits associated with the integration of Medicaid and Medicare services as well as the benefits of a long-standing presence serving their enrollee populations.

**Table ES-1: Summary of Data Findings
(SNP Alliance data are for CY2009 - Medicare Fee-For-Service data are for CY2008)**

Population Group	Average Risk Score (mean)	Inpatient Days per 1,000 Persons per Year	Office Visits per 1,000 Persons per Year
SNP Alliance D-SNPs (non-FIDESNPs)	1.21	2,821	8,008
SNP Alliance FIDESNPs	1.47	2,788	7,847
Medicare Fee-For-Service Dual Eligibles	1.27	3,327	6,865
SNP Alliance I-SNPs	2.04	2,369	*
Institutionalized Fee-For-Service Beneficiaries	1.84	7,497	*
SNP Alliance C-SNPs	1.22	2,740	8,453
All Medicare Fee-For-Service Beneficiaries	1.00	2,063	7,260

*Office visit data was not reported for institutionalized beneficiaries given that this subgroup is ill-positioned to receive physician office-based services.

II. Background of The SNP Alliance & The Profile Report

// **The SNP Alliance is the only national organization exclusively dedicated to improving policy and practice for SNPs.** //

Congress created Special Needs Plans (SNPs), a new type of Medicare Advantage coordinated care plan, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The National Health Policy Group (NHPG) published the first SNP Alliance Profile and Advanced Practice Report in December 2008. The purpose was to answer three basic questions:

1. Are SNPs targeting a needy population?
2. Are SNPs doing anything special?
3. Are SNPs demonstrating added value?

This report builds on data findings contained in reports published in 2009 and 2010. Findings will be used to constructively shape public policy to optimize these coordinated care programs' success for all involved parties — including the beneficiaries eligible to enroll in SNPs and state and federal governments. Members of the SNP Alliance also use information contained in these reports to benchmark performance and refine care interventions to advance their quality and cost performance.

The NHPG founded and manages the SNP Alliance. The SNP Alliance is a national leadership group of 29 managed care organizations, providing SNP benefits and services to more than 650,000 special needs beneficiaries. A list of SNP Alliance members is provided in **Appendix A**.

The SNP Alliance is the only national organization exclusively dedicated to improving policy and practice for SNPs. Membership in the SNP Alliance is by invitation only, and members must commit to work together to improve policy and practice in serving high-risk beneficiaries. SNP Alliance members represent all three SNP types (chronic care, dual eligible, and institutional SNPs), a wide variety of organizational and ownership structures, and all regions of the United States. The overall purpose of the SNP Alliance is to improve policy and performance for high-risk beneficiaries.

The Lewin Group has been engaged by the NHPG to prepare annual updates of its initial report. The Lewin Group is a national health policy and human services consulting research firm with extensive managed care expertise. This year's report conveys quantitative findings from a national survey of SNP Alliance members using operational data from 2007, 2008 and 2009.

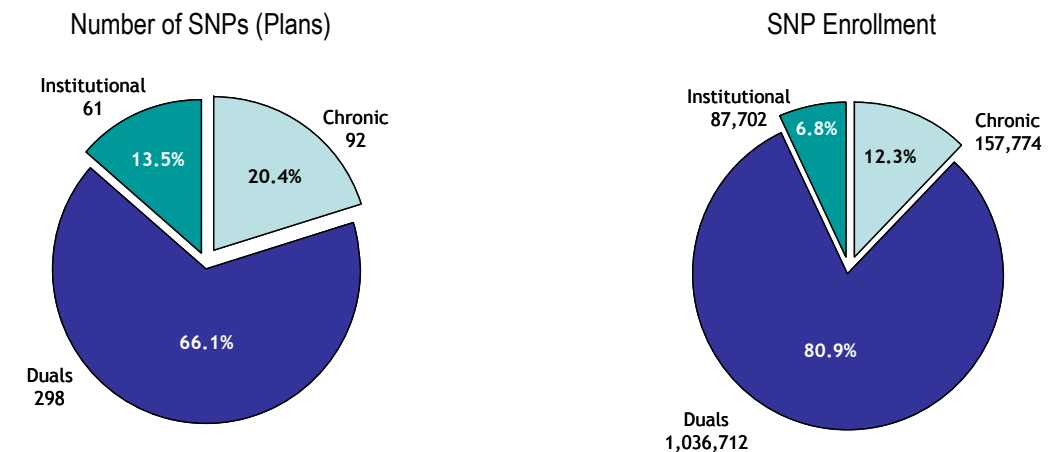
III. National Overview of Medicare Special Needs Plans (SNPs)

Enrollment Trends by Type of SNP

As of January 2011, 451 SNPs were under contract with the Centers for Medicare and Medicaid Services (CMS). Note that this figure represents the number of different "plans." A single company can operate several "different" SNPs depending on the number of different geographic areas served and the different population groups targeted. In reviewing the CMS website data, we estimate that 127 different organizations currently operate Medicare SNPs.

During January 2011, 1,282,188 persons were enrolled in SNPs. This enrollment represents 2.8% of the nationwide Medicare population. There are three categories of SNPs — those focused on enrolling and serving beneficiaries with specified chronic conditions (commonly known as C-SNPs), those focused on beneficiaries dually eligible for Medicare and Medicaid coverage (D-SNPs), and those focused on persons who are nursing home certifiable (known as institutional SNPs or I-SNPs). **Exhibit 1** shows the distribution of SNPs and SNP enrollment by plan type as of January 2011.

Exhibit 1. SNPs and Enrollment by Type of SNP, January 2011



Source: Derived from Special Needs Plan Comprehensive Report for January 2011. Each monthly report is published on the CMS website¹.

By any measure, the D-SNPs represent the majority of Medicare SNP activity. D-SNPs accounted for 66% of all Medicare SNPs and 81% of all SNP enrollment as of January 2011. With there being approximately 8.9 million dual eligibles nationwide, the D-SNP plans served 12% of the nation's dual eligibles as of January 2011. Given that a meaningful proportion of the C-SNP and I-SNP enrollees are also enrolled in Medicaid, dual eligibles represent approximately 90% of all SNP enrollees.

Footnote

¹ The website address is: www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp.

The progression of the Medicare SNP “industry” from December 2007 through January 2011 is presented in **Exhibit 2**, showing the number of SNPs and overall enrollment by type of SNP.

Exhibit 2. National Medicare SNP Overview: Number of Plans and Enrollment

Month and Year	Number of SNPs				Enrollment Level			
	C-SNP	D-SNP	I-SNP	Total	C-SNP	D-SNP	I-SNP	Total
Dec-07	73	320	84	477	192,610	760,561	145,583	1,098,754
Jan-08	241	440	89	770	188,732	771,142	142,859	1,102,733
Dec-08	241	436	85	762	283,406	911,950	127,776	1,323,132
Jan-09	209	406	83	698	267,881	907,493	125,549	1,300,923
Dec-09	212	404	83	699	308,631	972,547	114,010	1,395,188
Jan-10	153	334	74	561	235,180	930,871	101,368	1,267,419
Dec-10	153	335	74	562	227,271	1,036,319	95,137	1,358,727
Jan-11	92	298	61	451	157,774	1,036,712	87,702	1,282,188

Source: Special Needs Plan Comprehensive Reports. Each monthly report is published on CMS website.

Footnotes

² The reduction of 59 C-SNPs represents the net change between all market exits and any new market entrants between December 2009 and January 2010. This is why the phrase “market exit of at least 51 C-SNPs” is used.

Exhibit 2 demonstrates the uneven path the SNP industry has taken during the past few years. SNPs contract to serve the Medicare population on a calendar year basis. Several SNPs have exited the market at the beginning of each calendar year, as evidenced by the differences between the more recent December and ensuing January statistics. The number of SNPs decreased 8% from 762 to 698 between December '08 and January '09, decreased 20% from 699 to 561 between December '09 and January '10, and decreased further by 20% from 562 to 451 between December '10 and January '11.

Amidst this ongoing decline in the number of SNPs, Exhibit 2 also shows that total SNP enrollment has remained fairly stable in the vicinity of 1.3 million persons since late 2008. However, the three different SNP types have experienced markedly different enrollment trajectories as discussed below.

C-SNPs: The C-SNPs ironically experienced both the largest percentage growth and the largest percentage decline in enrollment since December 2007. From December 2007 to December 2009, C-SNP enrollment increased 60% reaching 308,631. However, the January 2011 enrollment of 157,774 is only 51% of that level. Roughly one-fourth of the December 2009 C-SNP members disenrolled in January 2010 in conjunction with the market exit of at least 59 C-SNPs.² A similar but larger-scale dynamic occurred at the end of 2010. Between December 2010 and January 2011, at least 61 C-SNPs exited the market resulting in a 31% reduction in nationwide C-SNP enrollment from 227,271 to 157,774.

This enrollment drop-off was largely driven by United HealthCare’s decision to discontinue all of its C-SNP business, as United held 34% of overall C-SNP members at the end of CY2010. Two issues are believed to have played a major role in the significant number of C-SNP market exits. First, it is reasonable to assume that SNPs will typically retain contracts with CMS that are profitable. Thus, it is highly likely that most entities curtailing their C-SNP business were not operating profitably and/or did not see a viable path to profitability in the foreseeable future.³ Second, CMS issued more specific regulations that required some SNPs that address multiple co-morbid conditions to establish separate SNPs for each condition. This increased the administrative cost for C-SNP operations and reduced the size of the target market for SNP benefits, thus reducing the financial viability of some SNPs in certain service areas.

D-SNPs: The D-SNPs have had the most favorable enrollment trajectory of the three SNP types. D-SNPs collectively experienced substantial and fairly steady enrollment growth from December 2007 – January 2011. Across this time frame, enrollment has increased 36% from 760,561 to 1,036,712. There have been more D-SNP market exits than new entrants during the past few years, however. The total number of D-SNPs declined from a peak of 440 in January 2008 to 298 in January 2011. While there have been enrollment declines every January in relation to the market exits, D-SNP enrollment increased by about 10,000 persons per month throughout CY2010 and declined by only 10,000 between December 2010 and January 2011 despite several market exits. The total D-SNP enrollment increase from January 2009 to January of 2011 was 14%.

I-SNPs: The I-SNPs have experienced a steady decline in both the number of SNPs and in enrollment throughout the past few years. Overall I-SNP enrollment has decreased from 145,583 in December 2007 to 87,702 in January 2011. Approximately two-thirds of this I-SNP enrollment decrease is related to SCAN Health Plan’s operations in southern California. SCAN has an agreement with CMS to freeze all new enrollment into its I-SNP as a condition of being able to retain the long-term care benefit previously offered to SCAN beneficiaries under its demonstration authority. However, if SCAN is disregarded, I-SNP enrollment would still have decreased during the December 2007 – January 2011 time frame. Market exits have also occurred among the I-SNPs – there were 84 I-SNPs in December 2007 versus 61 I-SNPs as of January 2011. I-SNP enrollment is declining throughout each calendar year (not only between December of one year and January of the next when SNP market exits take effect). This is largely explained by the freeze on new enrollments at SCAN. SCAN’s enrollment has decreased by nearly 8,000 persons from January – December 2010.

“ **During January 2011, 1,282,188 persons were enrolled in SNPs. This enrollment represents 2.8% of the nationwide Medicare population.** ”

Footnotes

³ Many SNPs are not-for-profit organizations. Thus, the term “operating profitably” is meant to denote a financially successful/viable operation rather than literal profits for these non-profit organizations.

// **Nationwide, D-SNP enrollment has remained on a steadily upward trajectory with dual eligibles representing approximately 90% of all SNP enrollees.** //

It also is likely that Federal marketing rules have contributed to the decline in I-SNP enrollment levels by restricting contact with, and education of, institutionalized beneficiaries and other persons who often are involved in decision making on behalf of these beneficiaries. While consumer protection rules are critical, persons with complex care needs often need more extensive and personal contact with plan personnel in order for them to adequately understand the coordinated care program. Caregivers are often a critical part of this decision making process. These dynamics make marketing to an institutional population more difficult under traditional Medicare Advantage marketing requirements.

Notwithstanding these challenges, apart from SCAN the I-SNPs increased their collective membership by roughly 2,000 persons (a 5% increase) during the course of CY2010. Thus, I-SNPs have collectively been able to attract new members beyond the rate at which they are losing members due to death or voluntary disenrollment (with the exception of SCAN, which is not allowed to enroll new I-SNP members). This is a considerable achievement given that the I-SNP population is disproportionately near the end of life and thus a substantial number of new enrollees are needed during the course of a year to simply maintain the health plan’s overall enrollment level.

Exhibit 3 summarizes the percentage changes in SNP enrollment that have occurred between January 2008 and January 2011. While nationwide D-SNP enrollment has remained on a steadily upwards trajectory, significant decreases have occurred in the C-SNPs and the I-SNPs. The C-SNPs and I-SNPs together comprised only 19% of all SNP membership as of January 2011 and 0.5% of all Medicare beneficiaries. Overall enrollment across these two SNP types as of January 2011 was only 58% of these SNP types’ peak enrollment levels. While several I-SNPs and C-SNPs continue to gain enrollment, further reductions in nationwide C-SNP and I-SNP enrollment seem likely to occur in the absence of policy changes that address the ability of these organizations to attract members and serve them in a financially viable manner.

Exhibit 3. National Medicare SNP Enrollment Trends

Type of SNP	January '08 - January '09	January '09 – January '10	January '10 - January '11	Total, January '08 - January '11
C-SNP	42%	-12%	-33%	-16%
D-SNP	18%	3%	11%	34%
I-SNP	-12%	-19%	-13%	-39%
Total	18%	-3%	1%	16%

Source: Tabulations using Special Needs Plan Comprehensive Reports

Geographic Distribution of SNP Enrollment

SNP enrollment is dispersed across 42 states plus the District of Columbia and Puerto Rico. However, SNP enrollment is disproportionately concentrated in the nation’s most populous states and Puerto Rico, as summarized in **Exhibit 4**. Almost two-thirds of nationwide SNP enrollees reside in California, Texas, New York, Florida, Pennsylvania or Puerto Rico.

A large proportion of the nation’s SNP enrollees (17%) reside in Puerto Rico, as the island’s modest Medicare FFS per capita costs relative to Medicare Advantage capitation payment rates has fostered particularly extensive market entry by MCOs and strong efforts to enroll the beneficiary population. Whereas nationwide, one in 36 Medicare beneficiaries were enrolled in a SNP as of January 2011, in Puerto Rico one of every three Medicare beneficiaries were enrolled in a SNP.

The nation’s five states with the largest overall population — California, Texas, New York, Florida, and Pennsylvania — are also the five largest states in terms of SNP enrollment. These five states collectively account for 36 percent of the total US population, as shown in the right-hand column of **Exhibit 4**, but hold 57% of nationwide SNP enrollment (excluding Puerto Rico enrollees), as shown in the middle column of **Exhibit 4**.

SNP enrollment is also heavily concentrated in urban areas: among the SNP Alliance plans reporting data for this report, 85% of C-SNP enrollees were reported to reside in Metropolitan Statistical Areas (MSAs), along with 94% of FIDESNP enrollees, 97% of other D-SNP enrollees, and 98% of I-SNP enrollees. For context, 80% of the total US population resides in an MSA.

Exhibit 4. Largest States’ Share of SNP Enrollment and Total USA Population

State/Territory	September 2010 SNP Enrollment	Percent of USA SNP Enrollment (excluding Puerto Rico)	Percent of Total USA Population (excluding Puerto Rico)
Puerto Rico	222,793		
California	215,758	19%	12%
Florida	131,689	12%	6%
New York	102,387	9%	6%
Texas	91,336	8%	8%
Pennsylvania	90,452	8%	4%
All Other	485,357	43%	64%
USA Total	1,339,772		
USA Total (excluding Puerto Rico)	1,116,979	100%	100%
Top 5 States Combined (excluding Puerto Rico)	631,622	57%	36%

The remainder of the report focuses on the enrollment and operational experience of the SNP Alliance health plans.

// **This Report represents the third year the SNP Alliance members have collected and published demographic, health care utilization, and cost data on SNPs and compared their findings with the fee-for-service setting.** //

IV. Data Collection Approach

Aside from the nationwide overview data presented in the previous section, most of the data used in this report were collected directly from the SNP Alliance member health plans. Working in conjunction with NHPG, The Lewin Group designed a survey instrument collecting SNP data across a three-year time frame encompassing calendar years 2007, 2008 and 2009. The data request primarily sought information the SNPs have already compiled, including:

- Enrollment and Average Risk Score from the December Monthly Membership Report (MMR)
- Average Number of HCCs from Model Output Report (MOR)
- Medicare Advantage Price Bid Submission

Member organizations were also asked to distinguish between enrollees “new to Medicare” and “all other” beneficiaries, since the risk score for enrollees new to Medicare is based on demographics alone, and health status adjustments are made only when an enrollee has claims experience in the Medicare program. Therefore, each plan distinguished between enrollees new to Medicare (Risk Adjustment Factor Type E) and all other enrollees.

Plans also submitted a range of demographic and health utilization statistics for their members for calendar years 2007 - 2009.

- Member Demographics
 - Enrollment by Age, Gender, and nursing home certifiable (NHC) status
 - Risk Score by Age, Gender, and NHC status
 - Hierarchical Condition Categories (HCCs) by Age, Gender, and NHC Status
 - Distinguished between enrollees “New to Medicare” and “All Other” Enrollees
 - Number of enrollees with 1+ claim with a Mental Health diagnosis
 - FIDESNP: ADLs

The following metrics were submitted as annualized utilization per 1,000 covered persons. Most of this information was readily available to plans from their Medicare Advantage Price Bid Submission(s):

- Healthcare Utilization & Cost
 - Inpatient Admissions & Days
 - Observation Days
 - Readmissions within 30 days
 - Total Physician Office Visits
 - Number of Prescriptions
 - Emergency Room Visits
 - Medicare & Medicaid PMPM costs
 - FIDESNP: nursing home & home care costs

Lewin obtained most of this information during August and September 2010 and consolidated the data into the report. Some additional data were obtained during December 2010 and January of 2011. All SNP Alliance members were invited and encouraged to provide data. All enrollment, risk score and other responses to the quantitative data request were included in this report — no information was excluded.

This report does not identify any individual SNP’s statistics by name. For example, while the report presents the range of average risk scores for all dual eligible SNPs, the names of the SNPs with the lowest and highest risk scores are not disclosed.



V. Overview of Survey Respondents and Their SNP Enrollment

Organizations Contributing Data

Information was provided to Lewin by 20 SNP Alliance organizations in direct response to the survey instrument. These 20 organizations, listed in Exhibit 5, represented 16% of the nation’s 127 unique SNP parent organizations and held 30% of nationwide SNP enrollment as of January 2011.

The majority of the SNP Alliance member organizations providing data for this report target dual eligible beneficiaries (17 of 20 or 85% percent) while chronic and institutional beneficiaries are targeted by 25% and 20% of these organizations, respectively. Three organizations operate plans that cover all three SNP Types.

For purposes of portraying the SNP Alliance plans in further detail — and due to the fact that most reporting SNP Alliance plans are D-SNPs — the reporting D-SNPs were divided into two groups: Legacy FIDESNPs and all other D-SNPs. The Legacy FIDESNPs (Fully Integrated Dual Eligible SNPs) represent nine organizations that operated D-SNPs under demonstration authority prior to the creation of the national SNP program. Nine Legacy FIDESNPs contributed data to this report, three each operating in the states of Massachusetts, Minnesota and Wisconsin. The Legacy FIDESNPs are shown in **Exhibit 5** and in all ensuing data tables. As their acronym implies, these health plans include the full spectrum of primary, acute and long-term care services provided under capitated Medicare and Medicaid funding using integrated methods of care and program administration.

All Legacy programs were involved in national integration demonstration programs prior to transitioning to SNP status. They have operated particularly highly integrated programs for dual eligibles for many years. It was deemed useful to separate these D-SNPs in this year's Profile Report to gain a sense of what the potential might be for advancing fully integrated programs through other states and SNP programs.

Exhibit 5. SNP Alliance Members Contributing Data to This Report

SNP Alliance Organization	State(s) Served	Legacy FIDESNP	Dual	Chronic	Institutional
Amerigroup	7 States		X		
Brand New Day (HMO California)	California			X	
Care Wisconsin	Wisconsin	X			
CareMore Health Plan	California		X	X	X
Commonwealth Care Alliance	Massachusetts	X			
Community Care	Wisconsin	X			
Community Health Partnership	Wisconsin	X			
Family Choice of New York	New York				X
Gateway Health Plan	Pennsylvania		X		
HealthPartners	Minnesota	X			
Highmark	Pennsylvania		X		
Independent Care Health Plan (iCare)	Wisconsin		X		
Medica Health Plans	Minnesota	X			
Passport Advantage	Kentucky		X		
SCAN Health Plan	AZ, CA		X	X	X
Senior Whole Health	MA, NY	X	X		
UCare Minnesota	Minnesota	X			
UnitedHealthcare (community of SNPs)	33 States	X	X	X	X
UPMC Health Plan	Pennsylvania		X		
XL Health	6 States			X	

The survey-responding health plans are widely dispersed geographically. These entities collectively operate SNPs in 41 states and the District of Columbia. Six states do not currently have operating SNPs: Alaska, Montana, North Dakota, New Hampshire, Vermont and Wyoming.

SNP Alliance Enrollment Overview

The 20 SNP Alliance member organizations that contributed data to the 2010 Profile Report collectively served 499,240 beneficiaries as of December 2009. The data used in this report constitutes 36% of nationwide SNP enrollment for that month. Exhibit 6 presents collective enrollment information by SNP Type from December 2007 through December 2009. As of December 2009, the 20 organizations held 62% of nationwide enrollment in chronic care SNPs, 26% of nationwide enrollment in dual eligible SNPs, and 41% of nationwide enrollment in institutional SNPs.⁴

Exhibit 6. Enrollment Across 20 SNP Alliance Organizations

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	112,771	188,533	190,407
Legacy FIDESNP	28,719	31,625	34,532
Other D-SNP	116,675	164,251	227,902
I-SNP	54,348	51,311	46,399
SNP Alliance Total	312,513	435,720	499,240

Among the 20 organizations the average enrollment as of December 2009 was 24,694 persons. However, this arithmetic mean is somewhat misleading given that overall SNP enrollment across the 20 organizations is heavily concentrated in a few plans. The largest SNP organization in each category provides specialty care services to approximately 53% - 62% of these plans' collective December 2009 enrollment. Thus, the mean and median enrollment figures shown in Exhibit 7 present a much different picture of the 20 SNPs' average enrollment levels. The overall median enrollment level was 7,318. Also, the median enrollment varies by SNP type; plans serving dual eligible beneficiaries had the smallest median enrollment (3,449); chronic care SNPs had the largest (10,932).

These averages represent a "roll-up" to the organization level of the different SNPs each organization operates in its markets. Thus, as shown in the nationwide SNP data presented earlier shows that mean enrollment at the SNP level is fewer than 3,000 persons as of January 2011, and median enrollment levels are considerably lower. A large organization may operate dozens of health plans in a number of states but for the purposes of the profile report that organization is providing a single, collective enrollment level for each point in time shown. Therefore, large organizations with many plans or plan benefit packages within and/or across several contracts skew the enrollment averages upward substantially from what would be shown at the plan level.

Footnotes

⁴ The I-SNP percentage excludes from the SNP Alliance totals persons who are technically enrolled in an I-SNP but who are not nursing home certifiable. The overall percentage of SNP enrollees (across all SNP Types) captured by the SNP Alliance data in this report also excludes from the numerator and denominator approximately 72,000 I-SNP enrollees who are not nursing home certifiable. Congress eliminated the "disproportionate" SNP category that allowed SNPs to enroll a certain percentage of beneficiaries who did not meet the SNP enrollment criteria; however, I-SNPs are no longer permitted to enroll beneficiaries who are not eligible for institutional care.

// **SNP Alliance plans continue to achieve significant and sustained reductions in inpatient hospital usage rates and demonstrate the importance of a strong primary care model in serving high-risk beneficiaries.**

Similar dynamics exist with the risk score and other figures presented later in this report — all statistics in this section have been tabulated only at the overall organization or MAO level for each of the 20 SNPs. If organizations operate multiple types of SNPs (e.g., one or more dual eligible SNP and one or more chronic care SNP), separate statistics were provided by that organization for each SNP type.

Exhibit 7. Average Enrollment Across 20 SNP Alliance Organizations

SNP Type	Dec 2007	Dec 2008	Dec 2009
Mean Enrollment			
C-SNP	22,554	37,707	38,081
Legacy FIDESNP	3,191	3,514	3,837
Other D-SNP	10,607	9,662	13,406
I-SNP	13,587	12,828	11,600
Median Enrollment			
C-SNP	4,040	7,965	10,932
Legacy FIDESNP	2,600	2,670	2,730
Other D-SNP	2,021	872	1,367
I-SNP	12,754	11,677	10,512

These enrollment distributions warrant careful consideration when interpreting risk score and other statistical information in the remainder of this report. While the “enrollment weighted mean” provides an accurate and valid average, this statistic is heavily influenced by the largest survey-respondents. Therefore, median values and ranges are also typically included. These additional statistics depict the spectrum of SNP Alliance organizations in a manner that is not skewed by the largest companies. Note also that when ranges are provided, the outlier figures are often attributable to low enrollment levels. The smallest enrollment in a reporting plan for the December 2009 statistics, for example, is 487 beneficiaries for the chronic care SNPs, 281 for the dual eligible SNPs, and 650 for the institutional SNPs.

Demographic Mix of SNP Alliance Enrollees

The demographic mix of the SNP Alliance enrollees by age, gender, new enrollee and, where available, institutional and nursing home certifiable status, is summarized in **Exhibit 8**. While the majority of the enrollees are elderly, a meaningful proportion are disabled persons under age 65 (particularly for dual eligible SNPs, where approximately 40% of enrollees are below age 65). The gender composition of all SNP Alliance enrollees is 62% female and 38% male. Outside of the I-SNP setting (where all enrollees are institutionalized or are nursing home certifiable), 31% of FIDESNP SNP Alliance enrollees are institutionalized or nursing home certifiable.

Exhibit 8 also indicates that 6.5% of SNP Alliance enrollees are newly eligible for Medicare. Historically, CMS has used demographic factors, without regard for health status, to determine a SNP’s monthly payment for members in their first year of enrollment. This caused plans focusing on certain populations to be significantly underpaid, relative to fee-for-service, for a certain segment of their population — since the presence of one or more chronic conditions is necessary for enrollment to occur. The Affordable Care Act (ACA) corrected for this disparity for C-SNPs in 2011 and beyond by requiring CMS to modify its payment methods for enrollees new to Medicare, even though the formula used is not condition-specific. However, the ACA did not account for this disparity in payment for some D-SNPs, even though the data from SNP Alliance members shows that 4-7% of D-SNP enrollees are new to Medicare. While this may not be a problem for D-SNPs serving a relatively normal distribution of dual eligible beneficiaries, it is a significant problem for D-SNPs where a high percentage of new enrollees have complex care needs at the time of enrollment, and particularly for plans that exclusively target duals that are nursing home certifiable.

Exhibit 8. Demographic Mix of SNP Alliance Enrollees, December 2009

SNP Type	% Aged (65+)	% Female	% Nursing Home Certifiable	% New to Medicare
C-SNP	81.0%	57.2%	N/A	9.6%
Legacy FIDESNPs	97.0%	71.1%	30.6%	4.1%
Other D-SNPs	54.8%	62.8%	N/A	6.6%
I-SNPs	92.8%	76.4%	100.0%	0.6%

VI. Risk Score Assessment

Enrollment-Weighted Mean Risk Scores

Medicare Special Needs Plans (SNPs) serve diverse populations both within and across SNP types. All SNPs serve complex, high-need subgroups that require individually tailored support and interventions. A risk score assessment is included in the Profile Report to attempt to quantify the degree to which the SNPs serve particularly high-need, high-cost Medicare subgroups. The average risk score across the Medicare population is normalized at 1.00; risk scores below 1.00 are generally reflective of “healthier-than-average” Medicare beneficiaries whereas risk scores above 1.00 are associated with persons with greater-than average health care needs.

The top rows of **Exhibit 9** present the average aggregate risk scores across the 20 SNP Alliance health plans that responded to the survey. These scores represent an enrollment-weighted mean for each year and SNP type.⁵ As of December 2009, the average risk score (derived across nearly 500,000 enrollees) was 1.32, meaning the expected per capita costs of these persons would be 32% above the average per capita cost for the entire Medicare beneficiary population. This December 2009 figure is slightly below the averages in the prior two years (1.36 in December 2007 and 1.33 in December 2008). The decrease is primarily attributable to the changing mix of the SNP Alliance enrollment by SNP type, as the I-SNPs (where risk scores are highest) comprise a lower share of overall membership with each passing year. Only modest changes in average risk scores occurred between 2007 and 2009 within any of the three SNP types.

Exhibit 9 also presents average risk score data in the Medicare fee-for-service setting for various population subgroups.⁶ This information shows that dual eligible SNP Alliance plans (with an average risk score of 1.26) are serving persons whose needs are parallel to the broader U.S. population of dual eligibles (where the most recent available average risk score is 1.27). The December 2009 average risk score for the institutional SNP Alliance plans is 2.04, which is 11% above the most recent average for all institutionalized beneficiaries in traditional Medicare (1.84). Another point of comparison is the “standard” Medicare Advantage setting (non-SNPs); where the average risk score has been estimated to be approximately 0.97 as of 2006.⁷

Within the D-SNPs, the Legacy FIDESNPs are serving a particularly high-need population as evidenced by their December 2009 enrollees’ average risk score of 1.62. The other SNP Alliance D-SNPs’ average risk score was 1.21.

The average risk score across the C-SNP enrollees was 1.22 as of December 2009. While the different C-SNPs focus on a wide variety of chronic conditions (e.g., diabetes, HIV, mental illness, cardiovascular illness, respiratory illness, etc.) and thus will have markedly different risk scores, their enrollees’ collective health status is more than 20% costlier than the average for the overall Medicare population. Average risk scores in the fee-for-service setting are 1.40 for beneficiaries with diabetes and 1.84 for persons with congestive heart failure.

Exhibit 9. Weighted Average Risk Score, SNP Alliance Health Plan Enrollees

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	1.21	1.18	1.22
All D-SNPs			
Legacy FIDESNP *	1.41	1.42	1.47
Other D-SNPs	1.22	1.25	1.21
I-SNP **	1.81	1.98	2.04
Medicare Fee-For-Service Comparison Statistics (CMS 5% Sample Benchmarks)			
Total Medicare Population	1.00	1.00	
Chronic: Diabetes	1.39	1.40	
Chronic: Congestive Heart Failure	1.82	1.84	
Dual Eligibles	1.26	1.27	
Institutional	1.82	1.84	

* Legacy FIDESNPs receive a frailty factor add-on to their risk score which is not shown in the above figures. The frailty factor averaged 0.20 in 2007, 0.17 in 2008 and 0.11 in 2009.

** SNP Alliance risk scores for I-SNPs are limited to those enrollees who are nursing home certifiable. Due to conversion of Social HMO demonstration program enrollees, some I-SNPs also have enrollees who are not nursing home certifiable.

We offer two cautions in assessing the risk score figures in Exhibit 9. First, while the statistics in Exhibit 9 clearly show that the SNP Alliance plans are focusing on persons whose health status is considerably worse than the overall Medicare population’s average, it is not appropriate to assume that a higher average risk score is inherently “better” than a lower one. For example, C-SNPs that specialize in care for adults under age 65 with disabilities tend to have lower risk scores than those serving older persons, not because their care needs are less complicated but because age is a significant factor in determining a person’s overall risk score. Perhaps more importantly, while the highest risk scores would be associated with serving persons near the end of life who are beset with a multitude of conditions at an advanced disease stage, it is valuable for a coordinated care program to engage with persons at much earlier stages to delay/prevent disease progression. Thus, a SNP focusing on, for example, earlier stage diabetics should not be presumed to be fulfilling a less valuable role than a SNP focusing on later-stage diabetics who have a higher risk score.

Footnotes

⁵ As an example, if one SNP had 3,000 enrollees with an average risk score of 1.50 and another SNP had 500 enrollees with an average risk score of 1.20, the enrollment-weighted mean across these two SNPs would be 1.425.

⁶ The fee-for-service figures were tabulated using CMS’ Medicare 5% Sample data base and assigning risk scores based on the algorithms used by CMS for the 2009 contract year. Persons new to Medicare were assigned risk scores based entirely on their demographic characteristics.

⁷ The 0.97 figure was derived for a previous SNP Alliance Profile Report. While that estimate has not been updated, it is not likely that the broader Medicare Advantage population’s average risk scores are fluctuating considerably year-to-year.

Second, because the SNPs' capitation payments are substantially affected by their enrollees' risk scores, and because fee-for-service providers' payments are not affected by their patients' risk scores, it is reasonable to assume that some of the differences between the FFS and SNP risk scores are caused by factors other than health status differences. Some of the observed differences are potentially attributable to SNPs' efforts to more thoroughly capture their enrollees' ailments in the claims their network providers are submitting.

This impact is likely smaller than five percentage points, however. In establishing CY2010 Medicare Advantage payment rates, for example, CMS made a 3.41% coding intensity adjustment to account for expected average differences in coding practice between the FFS and capitated settings. Moreover, the risk score information presented throughout this section strongly suggests that all the SNP Alliance plans are targeting and serving beneficiary subgroups with risk scores exceeding the average occurring in FFS and among standard Medicare Advantage plans. In some cases, plans are serving persons with significantly higher risk scores than for a comparable group of persons in fee-for-service.

Median Risk Scores and Ranges of Average Risk Scores

As described earlier, the average risk scores of the SNP Alliance Sample (as derived through an enrollment-weighted mean) are heavily influenced by the largest reporting plans in each SNP category. Exhibits 10 and 11 present the median and range risk score values for the SNP Alliance plans. The medians further demonstrate that most of the SNP Alliance plans are serving Medicare subgroups with particularly significant health needs.

Exhibit 10. Median Risk Score

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	1.26	1.20	1.19
All D-SNPs	1.31	1.34	1.39
Legacy FIDESNP	1.46	1.52	1.54
Other D-SNPs	1.22	1.25	1.22
I-SNPs	1.92	2.09	2.20

Exhibit 11. Range of Risk Scores

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNPs	1.05 – 1.33	1.03 – 1.43	1.06 - 1.52
All D-SNPs	1.07 – 2.22	1.11 – 2.25	1.11 – 2.21
Legacy FIDESNP	1.35 – 2.22	1.38 – 2.25	1.39 – 2.21
Other D-SNPs	1.07 – 1.68	1.11 – 1.46	1.11 – 1.50
I-SNPs	1.61 – 2.10	1.72 – 2.22	1.68 - 2.40

The ranges shown in Exhibit 11 demonstrate the wide variety of members served by the 20 SNP Alliance plans responding to the survey. The variation is most dramatic among the D-SNPs, where the SNP with the highest risk score has roughly twice the risk score of the lowest SNP in each data year.

One constant theme demonstrated by the risk score ranges in Exhibit 11 is the high-need nature of the SNP Alliance plans' enrollee populations — each of the 20 SNPs has an average risk score above 1.00 for each SNP category it operates. The overall range in average risk scores across all 20 organizations as of December 2009 extends from 1.06 – 2.40.

Risk Scores for Selected Enrollee Subgroups

Risk scores were tabulated for selected demographic subgroups as shown in Exhibit 12. Statistics were collected for persons above and below age 65, for enrollees who are (and are not) nursing home certifiable, and for enrollees who are (and are not) new to the Medicare program.

Age: Interestingly, average risk scores for enrollees below age 65 are often higher than for persons in the 65+ age cohort. This occurs across the C-SNPs, FIDESNPs and I-SNPs. However, the older enrollees have a higher average risk score in the D-SNPs that are not FIDESNPs (1.34 for the 65+ age group versus 1.05 for the <65 members). These D-SNPs hold the vast majority of overall SNP Alliance enrollment and also serve large numbers of <65 members (45% of their members are under age 65, as shown earlier in Exhibit 8).

Exhibit 12. Average Risk Scores by Selected Demographic Subgroup, December 2009

	C-SNP	FIDESNP	Other D-SNP	I-SNP
Age 65+	1.22	1.62	1.34	2.29
Age <65	1.24	1.83	1.05	2.60
Nursing Home Certifiable	N/A	1.88	N/A	2.04
Non-Nursing Home Certifiable	N/A	1.49	N/A	N/A
New to Medicare	0.67	1.16	0.97	1.07
Not New to Medicare	1.25	1.64	1.23	2.32

// **As of December 2009, the overall range in average risk scores across all organizations participating in the study was 1.06 – 2.40.** //



Institutional Status: As would be expected, average risk scores are considerably higher for nursing home certifiable enrollees than for non-nursing home certifiable members.⁸ Nursing home certifiable enrollees are 46% higher than other enrollees in the C-SNPs, 26% higher in the FIDESNPs, and 69% higher in the other D-SNPs.

New Medicare Eligibles: CMS determines risk-adjustment factors for every new Medicare enrollee throughout the first twelve months based only on demographic indicators, since health care claims information is not immediately available. During this twelve month time frame, the risk scores for this subgroup do not factor in any health status information.

The average risk score figures in **Exhibit 12** for SNP Alliance members who are new to Medicare are below 1.00 for the C-SNP and D-SNP categories. Given that the SNP Alliance plans are

targeting high-need persons (and given the evidence in the previous tables demonstrating that a high-need enrollment mix has in fact occurred), the average risk score for SNP Alliance enrollees who are new to Medicare is far below the risk score for the remaining SNP Alliance population. This differential is quantified in **Exhibit 12**, showing that the new enrollee risk score is sometimes less than half that of the remaining SNP Alliance membership. Payment adequacy issues related to the “new to Medicare” subgroups were described earlier in relation to the figures in **Exhibit 8**.

Risk Score Distribution

While the different SNP Alliance plans often have considerably different overall average risk scores, due to the populations being targeted and enrolled, there is also substantial variation within each SNP with regard to the health status of its members. **Exhibit 13** presents the distribution of risk scores across the SNP Alliance membership as of December 2009 by SNP type, and also shows the distribution for the overall Medicare FFS population and for dual eligibles in the FFS setting.⁹ In the FFS setting, approximately two-thirds of all Medicare beneficiaries and half of dual eligibles have risk scores below 1.00. The percentage of SNP Alliance enrollees with risk scores below 1.00 is considerably smaller for each SNP type.

For C-SNPs, 85% of enrollees have risk scores below 1.50, divided fairly evenly between those with risk scores below 1.00 and between 1.00 and 1.50. Regarding dual eligibles, 43% of the Legacy FIDESNPs’ members have risk scores above 1.50, versus 13% for other D-SNPs and 27% of FFS dual eligibles. Most I-SNP members’ (74%) risk scores exceed 2.00, whereas “only” 34% of institutionalized beneficiaries in the FFS setting have risk scores above 2.00.

Exhibit 13. Percentage Distribution of SNP Alliance Enrollees by Risk Score, December 2009

Risk Score Range	FFS – All Medicare Beneficiaries	FFS – All Dual Eligible Beneficiaries	C-SNPs	Legacy FIDESNP	Other D-SNPs	I-SNPs
Less than 1.00	65.7%	49.4%	39.6%	25.2%	29.7%	1.4%
Between 1.00 - 1.49	16.3%	23.5%	45.0%	32.1%	56.8%	2.4%
Between 1.50 - 1.99	7.4%	10.6%	6.6%	18.2%	8.8%	22.6%
2.00 and Above	10.7%	16.5%	8.6%	24.7%	4.3%	73.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

VII. Health Care Conditions Assessment

Hierarchical Condition Categories

Another means of depicting the health needs of the SNP Alliance health plans’ enrollees involves tabulating the Hierarchical Condition Categories (HCCs). Each HCC represents an unrelated clinical condition that contributes to the calculation of the risk score assigned to each Medicare beneficiary.¹⁰ **Exhibits 14, 15 and 16** present the weighted average mean, median, and range of HCCs for the SNP Alliance plans, respectively. **Exhibit 14** also conveys the national average of HCCs in the fee-for-service Medicare population.

Footnotes

Footnotes

⁸ I-SNPs have no enrollees that are not nursing home certifiable. This is the requisite condition for I-SNP enrollment.

⁹ The FFS risk score distributions were tabulated by Ingenix Consulting using CMS 5% Sample data files.

¹⁰ For example, a person with two different diabetes HCCs (and no other identified conditions) would be categorized as having only a single HCC in these tables.



Exhibit 14. HCCs Per Enrollee (enrollment weighted mean)

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	2.59	2.36	2.37
D-SNP			
Legacy FIDESNP	2.37	2.18	2.32
Other D-SNP	1.81	1.91	1.78
I-SNP	3.09	3.67	3.88
Medicare Fee-For-Service Comparison Statistics (CMS 5% Sample Benchmarks)			
	CY2007	CY2008	
Total Medicare Population	1.46	1.49	
Chronic: Diabetes	2.62	2.65	
Chronic: Congestive Heart Failure	3.35	3.30	
Dual Eligibles	1.89	1.92	
Institutional	3.14	3.14	

Exhibit 14 shows that the overall Medicare population averages roughly 1.5 HCCs per beneficiary. With an overall average number of HCCs above 2.2, the SNP Alliance membership is beset, on average, with considerably more co-morbidities than the Medicare population. As of December 2009, the average number of HCCs per enrollee is 2.37 for the C-SNPs, 2.32 for the Legacy FIDESNPs, 1.78 for other D-SNPs, and 3.88 for the I-SNPs. The relatively low figure for the “other D-SNPs” is likely attributable to the fact that 45% of these plans’ members are under age 65. Enrollees in these D-SNPs are thus less likely to have accumulated the health conditions that are highly correlated with advanced age. The average number of HCCs for these D-SNPs across the 2007-2009 time frame is closely aligned with the average HCCs of FFS dual eligibles.

The average number of HCCs decreased slightly (3.7%) from December 2007 to December 2009 across all reporting health plans, driven by an 8.5% decrease in the average number of HCCs per enrollee in the chronic care SNP category and a 2.6% decrease in the dual eligible category. The average number of HCCs per enrollee in the institutional SNPs increased sharply (by 30.6%) from 2007 - 2009. This increase could at least partly be attributable to the I-SNP enrollment dynamics described earlier - the high proportion of persons reaching end-of-life coverage months coupled with only a modest influx of new (presumably healthier) enrollees.

Exhibits 15 and 16 present the median and range of HCC values for the SNP Alliance health plans. The median SNP Alliance plan’s membership averaged 2.14 HCCs as of December 2009, somewhat below the weighted mean average of 2.21 but still well above the most recently tabulated overall Medicare population average (1.49 HCCs). With the exception of one dual eligible SNP, every SNP Alliance plan’s reported average number of HCCs exceeded the national average number of HCCs (1.49) for the overall Medicare population. The high end of the ranges in Exhibit 16 shows that several SNP Alliance plans are serving members that have an exceptionally high number of co-morbidities.

Exhibit 15. Median Number of HCCs Per Enrollee

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	2.02	1.97	2.30
D-SNP (all)	2.03	2.07	2.12
Legacy FIDESNP	2.47	2.52	2.61
Other D-SNP	1.71	1.81	1.95
I-SNP	3.45	4.21	4.55

Exhibit 16. Range of Average Number of HCCs per Enrollee

SNP Type	Dec 2007	Dec 2008	Dec 2009
C-SNP	1.41 – 3.34	1.38 – 4.23	1.56 – 4.02
D-SNP (all)	1.28 – 4.05	1.48 – 4.59	1.61 – 4.23
Legacy FIDESNP	2.01 – 4.05	1.60 – 3.95	2.10 – 4.23
D-SNP	1.28 – 2.51	1.48 – 4.59	1.61 – 2.31
I-SNP	2.28 – 3.77	2.73 – 4.80	2.71 – 5.60

The average number of HCCs was also tabulated for three demographic subgroups within each SNP type: (1) persons <65 and persons age 65+; (2) persons who were and were not nursing home certifiable; and (3) persons who were and were not new to Medicare. These findings are presented in **Exhibit 17**. The elderly members of the C-SNPs and “Other D-SNPs” had more HCCs, on average, than the <65 enrollees in these two SNP types. The opposite was the case for the FIDESNPs and I-SNPs (with the younger enrollees having more HCCs), although there were very small numbers of <65 enrollees in these two SNP types.

Among the FIDESNPs, nursing home certifiable members had more HCCs than enrollees who were not nursing home certifiable. Similarly, enrollees who had been covered by Medicare for more than a year had more HCCs than enrollees who were “new to Medicare.”

//
Every SNP Alliance plan’s reported average number of HCCs exceeded the national average number of HCCs (1.49) for the overall Medicare population, with the high end of the ranges having an exceptionally high number of co-morbidities.
//

Exhibit 17. Average Number of HCCs by Selected Demographic Subgroup, December 2009

	C-SNP	FIDESNP	Other D-SNP	I-SNP
Age 65+	2.01	2.48	1.88	4.71
Age <65	1.45	3.75	1.67	5.14
Nursing Home Certifiable	N/A	2.89	N/A	3.88
Non-Nursing Home Certifiable	N/A	2.27	N/A	N/A
New to Medicare	N/A	1.97	1.58	N/A
Not New to Medicare	2.57	2.51	1.86	4.73

Mental Health Conditions

The SNP Alliance plans provided data on the proportion of their members who had one or more claims/encounters with a behavioral health diagnosis during the year. This information is presented in Exhibit 18 for CY2009. Comparison statistics for the Medicare fee-for-service population are shown in Exhibit 19 for the most recent available year, CY2008.

While many behavioral health conditions go undiagnosed during the course of a year, the statistics in Exhibit 18 demonstrate that mental conditions play a major role in the lives of the SNP Alliance enrollee population. More than half of the I-SNP and Legacy FIDESNP enrollees had at least one mental health diagnosis during 2009. These prevalence rates were 10% for C-SNP enrollees (which was similar to the proportion of all Medicare FFS beneficiaries with a mental health diagnosis) and 27% for “Other D-SNP” enrollees (which was above the prevalence rate of 23% for FFS dual eligibles). The prevalence among I-SNP enrollees (58%) was above the corresponding rate of 53% for institutionalized FFS Medicare beneficiaries.

While one C-SNP focuses exclusively on beneficiaries with significant mental health conditions, many SNP Alliance plans have extensive experience serving a large cadre of persons with behavioral health conditions. These SNPs need to be adept at addressing a wide array of physical and behavioral health conditions and co-morbidity combinations, both at the individual enrollee level and across their entire enrollment base.

Exhibit 18. Mental Health Condition Prevalence Among SNP Alliance Enrollees

SNP Type	Percentage of 2009 Enrollees with 1+ Mental Health Diagnosis
C-SNPs*	10%
D-SNPs (all)	30%
Legacy FIDESNPs	52%
All Other D-SNPs	27%
I-SNPs	58%

* One C-SNP serves only persons with behavioral health conditions. However, this SNP’s enrollment is fewer than 2,000 persons and it does not profoundly impact the above average.

Exhibit 19. Diagnosed Mental Health Conditions in Medicare Fee-For-Service Setting, 2008

Beneficiary Subgroup	Percentage of 2008 FFS Beneficiaries with 1+ Mental Health Diagnosis
All Medicare	10%
Dual Eligibles	23%
Institutionalized Persons	53%

In the I-SNP enrollee population, 44% of the CY2009 enrollees had Alzheimer’s or another form of dementia. This represents 77% of the population with some mental condition (although those individuals may also have other mental health conditions). During 2009, Alzheimer’s and other dementia were diagnosed in 18% of Legacy FIDESNP enrollees, and in 2% of the C-SNP and Other D-SNP members.

// **Mental conditions play a major role in the lives of the SNP Alliance enrollee population. More than half of the I-SNP and Legacy FIDESNP enrollees had at least one mental health diagnosis during 2009.** //

// **Fifty-two percent of Legacy FIDESNP enrollees and 30% of all other D-SNP enrollees had at least one mental health diagnosis, compared with 23% among dual eligible beneficiaries in fee-for-service Medicare.** //

VIII. Health Care Utilization

The SNP Alliance health plans provided health care utilization statistics for the following services (all per 1,000 enrollees per year, unless noted otherwise):

- Inpatient Days, Admissions and Average Length of Stay
- Distribution of Persons by Number of Inpatient Admissions
- Observation Days
- Emergency Room Visits
- Distribution of Persons by Number of Emergency Room Visits
- Physician Office & Home Visits
- Home Health Visits
- Number of Prescriptions

Inpatient Utilization

Inpatient hospital usage provides an important “window” for reviewing and assessing the SNP Alliance Plans’ performance. Inpatient hospital usage provides an inexact but useful means of quantifying the degree to which the enrolled population is experiencing health crises. Exhibit 20 presents inpatient usage, expressed as days of inpatient care per 1,000 persons per year, for each SNP type from 2007-2009 and for various Medicare fee-for-service comparison populations for 2007 and 2008. These figures are discussed below by SNP type.

C-SNP: The C-SNP members averaged 2.7 inpatient days per person during 2009. Because the different C-SNPs target a wide variety of conditions, it was not possible to establish a valid FFS comparison group within the scope of this report. Usage statistics were tabulated for some of the subgroups C-SNPs have targeted: FFS beneficiaries with diabetes averaged 3.7 inpatient days per person and FFS beneficiaries with congestive heart failure averaged 8.1 inpatient days. Some findings in this report suggest that C-SNPs have achieved reductions in inpatient usage, but as noted above, a solid FFS comparison population has not been established for the C-SNP enrollees. The C-SNPs’ inpatient usage trend has been favorable – inpatient days per 1,000 decreased 20% for C-SNP enrollees from 2007-2009. This reduction occurred during a time period when C-SNP enrollees’ average risk score did not change. Thus the reduced inpatient usage does not appear to be explained by enrollee health status differences. The data suggest that the C-SNPs are becoming increasingly proficient at reducing hospital usage as they mature.

FIDESNP: The Legacy FIDESNPs averaged 2.5 – 3.1 inpatient days per person per year from 2007 through 2009. This is well below the average inpatient usage of FFS dual eligibles (3.3 days per person per year) despite the fact that the average risk score among FIDESNP members (1.62 in 2009) is 28% higher than the average for all dual eligibles (1.27). In addition, the FIDESNPs’ 2009 inpatient usage closely paralleled the average in the C-SNPs and other D-SNPs (all three SNP types had between 2,740 and 2,821 day/1,000) – again despite the FIDESNPs having a much higher average risk score. Thus, a strong case can be made that the Legacy FIDESNPs have achieved exceptionally low inpatient usage.

Exhibit 20. Average Inpatient Days per 1,000 Enrollees by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	3,428	2,941	2,740
D-SNP			
Legacy FIDESNP	3,056	2,564	2,788
Other D-SNP	3,077	3,222	2,821
I-SNP	2,111	2,439	2,369
Medicare Fee-For-Service Comparison Statistics (CMS 5% Sample Benchmarks)			
	CY2006	CY2008	
Total Medicare Population	2,093	2,063	
Chronic: Diabetes	3,874	3,744	
Chronic: Congestive Heart Failure	8,268	8,103	
Dual Eligibles	3,387	3,327	
Institutional	7,344	7,497	

D-SNP (non-FIDESNP): Excluding the FIDESNPs, D-SNPs averaged 2,821 days/1,000, which is 15% below the most recent available average for the FFS dual eligibles (3,327). The average risk score for these D-SNPs (1.21) was slightly above the FFS average for non-institutionalized dual eligibles (1.17). These D-SNPs’ 2009 usage was also considerably lower than in the previous years — their average of 2,821 days/1,000 in 2009 was 8% below the 2007 level and 12% below 2008.

I-SNP: The I-SNPs’ inpatient usage has been extraordinarily low in contrast to the Medicare FFS norms for institutionalized persons. Institutionalized Medicare beneficiaries have used inpatient care at the rate of 7.0 – 7.5 days per person per year in the FFS setting. The I-SNP members averaged between 2.0 and 2.5 inpatient days per beneficiary per year throughout the 2007-2009 time frame. This comparison is not “apples to apples” given that I-SNP members are nursing home certifiable and thus only a portion of these enrollees are institutionalized. However, the I-SNP members’ average risk score — 2.04 during 2009 -- has been above the risk score for institutionalized FFS beneficiaries (as shown earlier in **Exhibit 9**). From this information, it appears that the I-SNPs have achieved a substantial (quite possibly more than 50 percent) reduction in inpatient usage versus what their enrollees would have utilized in the FFS setting.

All SNP Alliance plan types have seemingly achieved inpatient usage reductions relative to available FFS comparison populations. The inpatient days/1,000 of the FIDESNPs and the I-SNPs suggest that rather enormous reductions in inpatient usage have occurred across their membership. The yearly trends observed in Exhibit 20 also suggest that the SNP Alliance Plans are lowering their inpatient days/1,000, particularly among the C-SNPs and other D-SNPs.

Improved Impacts Over Time: Taking all the above usage information into account, there seems to be a correlation between a SNP’s maturity (years in business) and the level of inpatient usage reductions being achieved. The SNPs that have had the longest-standing relationships with their enrollees (the Legacy FIDESNPs and I-SNPs) have achieved the largest-scale inpatient usage reductions — probably several dozen percentage points. The remaining SNP Alliance plans (C-SNPs and other D-SNPs) have achieved smaller-scale reductions (but reductions nonetheless) in inpatient usage, although inpatient usage rates in these plans appears to be dropping rapidly as these plans mature. These SNP Alliance plans tend to be younger and may also be on a path to achieving large-scale inpatient usage reductions given the opportunity to serve their members across a wide span of years.

The SNPs’ average inpatient admission rates are presented in **Exhibit 21** and average length-of-stay (ALOS) statistics are shown in **Exhibit 22**. Comparison FFS data were not available for these statistics. Because ALOS is fairly consistent across the SNP types (averaging 5.4 at the lowest during 2009 for Other D-SNPs and 6.5 at the highest for I-SNPs), the admissions/1,000 statistics demonstrate similar trends to the days/1,000 figures described above. The admission rates for all the SNP categories except I-SNPs decreased between 2008 and 2009.

Exhibit 21. Average Inpatient Admissions per 1,000 Enrollees by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	537	473	451
D-SNP			
FIDESNP	577	531	473
Other D-SNP	483	565	519
I-SNP	330	359	366

Exhibit 22. Average Inpatient Length of Stay by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	6.4	6.2	6.1
D-SNP			
Legacy FIDESNP	5.3	4.8	5.9
Other D-SNP	6.4	5.7	5.4
I-SNP	6.4	6.8	6.5

The distribution of the number of admissions occurring in the SNP and FFS settings is presented in **Exhibits 23 and 24**. These figures show that more SNP Alliance enrollees go through the year without any inpatient admissions than occurs in the Medicare FFS setting. Whereas 73% of dual eligibles in FFS had no admissions during the year, 75% of FIDESNP members and 79% of Other D-SNP members had no admissions.

I-SNPs have a more pronounced differential - less than half (47%) of institutionalized FFS beneficiaries did not use inpatient services during the most recent available year (2008), whereas 83% of I-SNP members had no inpatient admissions during 2009. The large I-SNP differential could be attributable to specific incentives related to care for institutionalized beneficiaries between the FFS and I-SNP settings. In the FFS setting, a nursing home’s mounting costs are shifted to the hospital when inpatient admission transfers occur, whereas SNPs experience a net cost increase in these situations (if hospitalizations occur) which they strive to avoid.

Exhibit 23. Distribution of SNP Enrollees by Number of Inpatient Admissions, 2009

Admissions	C-SNP	Legacy FIDESNP	Other D-SNP	I-SNP
0	78%	75%	79%	83%
1	14%	16%	13%	14%
2	5%	5%	4%	2%
3+	3%	4%	4%	1%
Total	100%	100%	100%	100%

Exhibit 24. Distribution of FFS Beneficiaries by Number of Inpatient Admissions, 2008

Admissions	Total Medicare	Dual Eligibles	Institutionalized Persons	Persons with Diabetes	Persons with CHF
0	79%	73%	47%	44%	70%
1	13%	16%	24%	27%	17%
2	5%	6%	13%	14%	7%
3+	3%	6%	16%	14%	6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

// **This Report confirms the SNP Alliance plans' favorable impacts on inpatient usage – both in keeping enrollees out of the hospital and in limiting the degree to which enrollees require multiple hospitalizations.** //

At the high end of the inpatient distribution tables in **Exhibits 23 and 24**, it appears that the SNPs are also reducing the degree to which persons are hospitalized many times during the year. For example, 6% of FFS dual eligibles had 3 or more admissions during 2008. The corresponding figures for the D-SNPs are 4% for Legacy FIDESNPs and 4% for Other D-SNPs. While 16% of institutionalized FFS beneficiaries had three or more admissions, only 1% of I-SNP enrollees had 3+ admissions during 2009. For C-SNPs, 3% of enrollees had 3+ admissions, which is similar to the overall Medicare FFS population despite the C-SNPs serving a considerably less healthy population, on average, based on risk score differentials. This distributional data provides further confirmation of the SNP Alliance plans' favorable impacts on inpatient usage – both in keeping enrollees out of the hospital altogether during a given year and in limiting the degree to which enrollees experience multiple crises requiring hospitalization.

Another hospitalization management statistic involves the degree to which observation days are occurring in the SNP setting, as summarized in Exhibit 25. Observation days are coded as such when the patient is watched for several hours but is not formally admitted. While the SNPs clearly utilize observation days as a means of avoiding full admissions, this is not occurring frequently. Observation days would add about 1% to the total inpatient hospital activity for C-SNPs, 3% for FIDESNPs, 1% for Other D-SNPs, and well below 1% for I-SNPs. Thus, the inpatient usage reductions described earlier cannot be attributed to a mere re-categorization towards “observation days.”

Exhibit 25. Observation Days per 1,000 Enrollees Per Year by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	40	26	27
D-SNP			
Legacy FIDESNP	37	46	76
Other D-SNP	27	20	23
I-SNP	18	3	3

Physician Visits

Physician office visits per 1,000 enrollees per year were tabulated by the SNPs and for various Medicare subgroups, as shown in **Exhibit 26**. The data is encouraging, indicating that the SNPs are providing strong access to “front-line” office-based services that grow with each passing year. Office visit usage among the C-SNPs' members increased from 6.1 visits per enrollee during 2007 to 8.5 visits in 2009. Office visit usage in the overall Medicare population averaged 7.3 visits per beneficiary per year during 2008. Among the D-SNPs (both the FIDESNPs and the other D-SNPs), office visit usage also increased each year from less than 7 visits per person per year in 2007 to approximately 8 visits per person per year in 2009. FFS dual eligibles averaged 6.9 office visits per person during 2008.

Taking the SNP enrollees' high and increasing office visit usage into consideration jointly with these enrollees' low and decreasing inpatient usage, a highly favorable picture appears to be emerging regarding the SNPs' care coordination model. Usage of low-cost, “front-end” services is relatively high, and this investment may be causing at least some of the observed reductions in inpatient usage.

Exhibit 26. Physician Visits per 1,000 Enrollees by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	6,083	8,381	8,453
D-SNP			
Legacy FIDESNP	6,293	7,407	7,847
Other D-SNP	6,841	7,479	8,008
Medicare Fee-For-Service Comparison Statistics (CMS 5% Sample Benchmarks)			
Total Medicare Population		7,260	
Chronic: Diabetes		9,850	
Chronic: Congestive Heart Failure		12,006	
Dual Eligibles		6,865	

Note: Office visit data was not presented for I-SNPs given that institutionalized persons are ill-positioned to access office-based services.

Emergency Room Utilization

Emergency room visits per 1,000 enrollees per year were tabulated by the SNPs and for various Medicare subgroups, as shown in **Exhibit 27**.

Exhibit 27. Average Emergency Room Visits per 1,000 Enrollees, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	752	624	637
D-SNP			
Legacy FIDESNP	593	917	914
Other D-SNP	799	919	958
I-SNP	210	236	252
Medicare Fee-For-Service Comparison Statistics (CMS 5% Sample Benchmarks)			
		CY2008	
Total Medicare Population		418	
Chronic: Diabetes		572	
Chronic: Congestive Heart Failure		799	
Dual Eligibles		844	
Institutional		714	

The ER data in **Exhibit 27** suggest that the usage is far lower in the I-SNP setting than for institutionalized FFS beneficiaries. The data are less conclusive for the C-SNPs and D-SNPs. As described earlier, a demographic match for the C-SNPs' enrollees has not been made available. The D-SNPs' ER usage is above the FFS average for dual eligibles, but the risk score information suggests that the SNPs are serving a relatively high-need subgroup of duals (particularly the Legacy FIDESNPs).

The distribution of persons by their number of annual emergency room visits was also tabulated, as shown in **Exhibit 28** for the SNP Alliance plans and in **Exhibit 29** for the Medicare FFS population. These data comparisons offer similar findings to those in **Exhibit 27** - that ER usage seems to clearly be lower in the I-SNP setting than for comparable FFS subgroups but that the impact is less clear/conclusive for the C-SNPs and D-SNPs. The proportion of C-SNP enrollees receiving more than five ER visits per year, while quite small, is similar to the proportions seen in the FFS setting.

High-volume ER users among the SNP population may present an opportunity for additional, targeted care coordination efforts.

Exhibit 28. Distribution of SNP Enrollees by Number of Emergency Room Visits, 2009

ER Visits	C-SNP	Legacy FIDESNP	Other D-SNP	I-SNP
0	71%	67%	65%	85%
1	17%	18%	18%	12%
2 - 4	10%	12%	13%	3%
5+	2%	3%	4%	0%
Total	100%	100%	100%	100%

Exhibit 29. Distribution of FFS Beneficiaries by Number of Emergency Room Visits, 2008

ER Visits	Total Medicare	Dual Eligibles	Institutionalized Persons	Persons with Diabetes	Persons with CHF
0	76%	64%	62%	71%	62%
1	16%	20%	22%	18%	23%
2 - 4	7%	13%	14%	9%	13%
5+	1%	3%	2%	2%	2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Prescription Drugs

Prescriptions per 1,000 enrollees per year were tabulated and reported by the SNPs as shown in **Exhibit 31**. During 2009, the C-SNP members obtained an average of 43 prescriptions, compared with 52 for FIDESNP enrollees, 50 for other D-SNPs, and 91 for I-SNPs. Prescription usage rates have been fairly stable in all SNP types between 2007 and 2009.

Exhibit 31. Prescriptions per 1,000 Enrollees by SNP Type, 2007 - 2009

SNP Type	CY2007	CY2008	CY2009
C-SNP	41,904	39,844	42,768
D-SNP			
FIDESNP		53,839	52,448
Other D-SNP	45,296	46,214	49,624
I-SNP	88,204	90,074	90,864

No fee-for-service benchmark information has been tabulated for prescription usage that can be contrasted with the above SNP Alliance statistics. One study conducted by the PRIME Institute for Families USA estimated that the overall senior population averaged 38.5 prescriptions per person during 2010.

Appendix A: SNP Alliance Members as of January 2011

- AIDS Healthcare Foundation - Los Angeles, CA
- Amerigroup - Virginia Beach, VA
- ArchCare Advantage - New York, NY
- BlueCross BlueShield of MN - St. Paul, MN
- Brand New Day - Signal Hill, CA
- CalOptima - Orange County, CA
- CareMore Health Plan - Downey, CA
- Care Wisconsin - Madison, WI
- Commonwealth Care Alliance - Boston, MA
- Community Care, Inc. - Milwaukee, WI
- Community Health Partnership - Eau Claire, WI
- Elderplan - Brooklyn, NY
- Family Choice of New York - Buffalo, NY
- Gateway Health Plan, Pittsburgh, PA
- HealthPartners, Minneapolis, MN
- HealthSpring - Franklin, TN
- Highmark - Pittsburgh, PA
- Independent Care Health Plan (iCare) - Milwaukee, WI
- Kaiser Permanente - Oakland, CA
- Medica Health Plans - Minneapolis, MN
- Molina Health Care - Sacramento, CA
- On Lok Lifeways - San Francisco, CA
- Passport Advantage - Louisville, KY
- SCAN Health Plan - Long Beach, CA
- Senior Whole Health - Cambridge, MA
- UCare Minnesota - St. Paul, MN
- UnitedHealthcare - Minneapolis, MN
- UPMC (University of Pittsburgh Medical Center) Health Plan - Pittsburgh, PA
- XL Health - Baltimore, MD

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