ONLINE APPENDIXES

5

Coordinating the care of dual-eligible beneficiaries

ONLINE APPENDIX 5-A

Additional data

TABLE 5–A1

Combined Medicare and Medicaid spending for all-year full dual eligible beneficiaries, by chronic condition and use of nursing facility services, CY 2005

Chronic condition	No nursing home use (N = 3,697,718)		High users of nursing facility services (N = 179,100)		All dual eligible beneficiaries (N = 4,589,273)	
	Enrollees with condition as a percent of all-year full duals*	Spending per beneficiary	Enrollees with condition as a percent of all-year full duals*	Spending per beneficiary	Enrollees with condition as a percent of all-year full duals*	Spending per beneficiary
Acute myocardial infarction	1	$47,498	1	$100,870	1	$55,045
Alzheimer's disease	4	32,429	38	73,952	10	47,255
Alzheimer's disease and related disorders or senile dementia	10	31,833	75	75,225	22	46,578
Atrial fibrillation	5	31,106	11	78,922	6	43,471
Cataract	16	20,198	28	77,394	17	30,353
Chronic kidney disease	9	34,679	15	84,889	11	45,115
Chronic obstructive pulmonary disease	13	30,818	18	81,789	15	40,645
Colorectal cancer	1	36,003	1	81,469	1	44,400
Depression	18	27,739	35	77,864	21	38,829
Diabetes	30	23,416	37	79,008	32	32,188
Endometrial cancer	0	32,662	0	84,203	0	39,221
Female breast cancer	1	26,083	1	78,911	1	32,979
Glaucoma	9	19,401	10	77,726	9	26,748
Heart failure	20	30,102	43	78,915	26	40,632
Hip/pelvic fracture	0	48,848	1	99,614	1	62,228
Ischemic heart disease	31	25,162	47	79,277	34	34,568
Lung cancer	1	39,658	0	87,808	1	44,624
Osteoporosis	11	23,681	16	76,254	12	33,122
Prostate cancer	1	23,700	1	81,242	1	32,377
Rheumatoid arthritis/ osteoarthritis	23	22,888	30	75,061	25	31,864
Stroke/transient ischemic attack	4	35,641	18	79,126	7	50,141
All dual-eligible beneficiaries	100	19,171	100	75,469	100	26,185

Note: CY (calendar year). The analysis includes dual-eligible beneficiaries who were eligible for full Medicaid benefits who were enrolled during all 12 months of the year or who were enrolled January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Beneficiaries with multiple chronic conditions are reported in multiple categories. Chronic condition as indicated in CMS's Chronic Condition Warehouse. High users are defined as at or above the 80th percentile of nursing home spending among users of the service.
*The denominators used to calculate these percentages are at the top of each set of columns

Source: Mathematica Policy Research. 2010. Analysis prepared for MedPAC using CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

TABLE 5–A2

Combined Medicare and Medicaid spending for aged all-year full dual-eligible beneficiaries, by chronic condition and use of nursing facility services, CY 2005

	No nursing home use (N = 2,212,471)		High users of nursing facility services (N = 160,462)		All dual eligible beneficiaries (N = 3,017,620)	
Chronic condition	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee
Acute myocardial infarction	1	$46,759	1	$100,446	1	$54,919
Alzheimer's disease	6	31,422	41	73,753	15	46,939
Alzheimer's disease and related disorders or senile dementia	14	30,124	79	74,733	30	45,992
Atrial fibrillation	7	30,529	12	78,603	9	43,495
Cataract	22	17,661	29	76,841	22	29,105
Chronic kidney disease	11	33,407	15	84,049	14	45,194
Chronic obstructive pulmonary disease	16	30,213	18	81,041	18	41,693
Colorectal cancer	1	34,729	1	80,814	1	44,008
Depression	12	29,135	35	76,883	18	45,405
Diabetes	36	22,392	38	78,370	36	32,950
Endometrial cancer	0	31,881	0	82,608	0	39,166
Female breast cancer	2	24,471	1	78,307	2	32,733
Glaucoma	12	18,253	11	77,220	11	26,729
Heart failure	27	29,047	45	78,335	33	40,643
Hip/pelvic fracture	1	47,722	1	99,451	1	61,743
Ischemic heart disease	41	24,407	49	78,746	43	35,012
Lung cancer	1	38,643	0	86,677	1	44,024
Osteoporosis	15	21,230	16	75,628	16	32,098
Prostate cancer	2	23,245	2	81,038	2	32,318
Rheumatoid arthritis/ osteoarthritis	29	22,352	32	74,678	31	32,693
Stroke/transient ischemic attack	5	35,341	18	78,716	9	50,644
All aged dual-eligible beneficiaries	100	16,916	100	74,439	100	26,841

Note: CY (calendar year). The analysis includes dual-eligible beneficiaries who were eligible for full Medicaid benefits who were enrolled during all 12 months of the year or who were enrolled January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Beneficiaries with multiple chronic conditions are reported in multiple categories. Chronic condition as indicated in CMS's Chronic Condition Warehouse. High users are defined as at or above the 80th percentile of nursing home spending among users of the service.
*The denominators used to calculate these percentages are at the top of each set of columns

Source: Mathematica Policy Research. 2010. Analysis prepared for MedPAC using CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

TABLE 5–A3

Combined Medicare and Medicaid spending for under 65 and disabled all-year full dual-eligible beneficiaries, by chronic condition and use of nursing facility services, CY 2005

	No nursing home use (N = 1,485,247)		High users of nursing facility services (N = 18,638)		All dual-eligible beneficiaries (N = 1,571,653)	
Chronic condition	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee	Enrollees with condition as a percent of all-year full duals*	Total expenditure per enrollee
Acute myocardial infarction	0	$50,862	0	$111,338	0	$55,865
Alzheimer's disease	1	48,381	9	81,419	1	56,246
Alzheimer's disease and related disorders or senile dementia	3	43,990	42	83,143	5	53,707
Atrial fibrillation	1	36,329	3	90,737	1	43,158
Cataract	7	32,368	20	84,209	7	37,365
Chronic kidney disease	6	38,608	12	94,467	6	44,770
Chronic obstructive pulmonary disease	10	32,285	12	91,368	10	37,171
Colorectal cancer	0	43,384	0	103,583	0	47,289
Depression	27	26,852	39	85,544	28	30,853
Diabetes	22	25,855	32	85,505	23	29,883
Endometrial cancer	0	35,144	0	96,964	0	39,418
Female breast cancer	1	31,445	1	91,303	1	33,976
Glaucoma	4	23,945	6	85,982	4	26,834
Heart failure	9	34,596	22	89,063	11	40,563
Hip/pelvic fracture	0	57,760	0	103,707	0	68,312
Ischemic heart disease	16	28,016	24	88,532	17	32,379
Lung cancer	0	43,791	0	99,209	0	47,434
Osteoporosis	5	35,574	8	86,900	5	39,472
Prostate cancer	0	29,472	0	89,511	0	33,267
Rheumatoid arthritis/ osteoarthritis	13	24,726	12	84,021	13	28,093
Stroke/transient ischemic attack	2	36,783	14	83,675	3	47,056
All disabled dual-eligible beneficiaries	100	22,530	100	84,339	100	24,924

Note: CY (calendar year). The analysis includes dual-eligible beneficiaries who were eligible for full Medicaid benefits who were enrolled during all 12 months of the year or who were enrolled January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Beneficiaries with multiple chronic conditions are reported in multiple categories. Chronic condition as indicated in CMS's Chronic Condition Warehouse. High users are defined as at or above the 80th percentile of nursing home spending among users of the service.
*The denominators used to calculate these percentages are at the top of each set of columns

Source: Mathematica Policy Research. 2010. Analysis prepared for MedPAC using CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

TABLE 5–A4

Combined Medicare and Medicaid per capita service spending for dual eligible beneficiaries for the most frequent chronic clinical conditions

Service	Any chronic condition	Alzheimer's and related conditions	Chronic kidney disease	COPD	Depression	Diabetes	Heart failure	Ischemic heart disease	Rheumatoid arthritis/ osteoarthritis
Inpatient hospital	$5,126	$6,566	$12,798	$11,064	$7,222	$6,445	$9,299	$7,708	$5,839
Outpatient hospital	1,320	1,321	2,110	1,846	1,854	1,495	1,636	1,587	1,464
Physician & Part B	2,787	2,822	4,665	4,451	3,548	3,296	3,841	3,751	3,514
SNF	1,214	2,856	3,019	2,476	2,082	1,484	2,388	1,800	1,640
Nursing home	7,499	20,847	9,478	8,241	10,532	7,290	10,959	8,208	7,928
ICF–MR	537	301	279	1,100	439	215	246	141	124
Home health	968	1,125	363	1,564	1,078	1,379	380	1,418	1,493
Hospice	642	1,748	919	776	647	538	301	707	607
HCBS	2,947	3,059	2,846	2,345	3,111	2,846	2,950	2,774	2,836
Prescription drugs	3,998	3,888	4,587	4,841	5,422	4,665	4,246	4,251	4,232
Other	2,264	2,045	4,051	1,941	2,894	2,535	4,386	2,223	2,187
Total	29,302	46,578	45,115	40,645	38,829	32,188	40,632	34,568	31,864

Note: COPD (chronic obstructive pulmonary disease), SNF (skilled nursing facility), ICF–MR (intermedicare care facility for the mentally retarded), HCBS (home- and community-based services). The analysis includes dual eligible beneficiaries who were eligible for full Medicaid benefits who were enrolled during all 12 months of the year or who were enrolled January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Beneficiaries with multiple chronic conditions are reported in multiple categories.

Source: Mathematica Policy Research. 2010. Analysis prepared for MedPAC using CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

ONLINE APPENDIX 5-B

Background information on special needs plans

TABLE 5–B1

Enrollment by type of SNP in 2010

Type of SNP	Number of plans	Enrollment	Percent of all SNP enrollment
Chronic or disabling condition	153	221,052	17%
Dual eligible	335	957,420	75
Institutional	74	98,848	8
Total	562	1,277,320	100

Note: SNP (special needs plan).

Source: Centers for Medicare & Medicaid Services 2010b.

Special needs plans (SNPs) are Medicare Advantage (MA) plans that target enrollment to specific groups of beneficiaries. Dual-eligible SNPs target enrollment to beneficiaries who are eligible for both Medicare and Medicaid; chronic condition SNPs target enrollment to beneficiaries with 1 of 15 chronic conditions (see text box on key legislative changes and recommendations); and institutional SNPs enroll beneficiaries who reside in nursing facilities, intermediate care facilities, or inpatient psychiatric facilities or in the community but they have an institutional level of need. Dual-eligible beneficiaries can enroll in chronic care SNPs or institutional SNPs if they meet the eligibility criteria. About 11 percent of duals are enrolled in dual-eligible SNPs.

Between July 2006 and March 2010, the number of SNPs grew rapidly, from 276 to 562; beneficiary enrollment in these plans more than doubled during this period, to almost 1.3 million (Table 5-B1). Dual-eligible SNPs account for about 60 percent of SNPs and enroll almost three-quarters of the Medicare beneficiaries enrolled in SNPs.

Enrollment in individual SNPs is generally low, which can pose a problem if it is not sufficient for the plans to be financially viable, causing SNPs to exit the market. It can be a concern, particularly for the approximately 27 percent of beneficiaries enrolled in SNPs that are not part of larger MA contracts. If these SNPs leave the market, the beneficiaries they serve do not have the option of switching to another MA plan within the same company (Verdier 2008). In addition, SNPs with low enrollment may not have the resources to dedicate to establishing integrated care programs and providing integrated services, such as care coordination.

Between December 2009 and March 2010, the number of SNPs declined by 137—a decrease of 59 chronic or disabling condition SNPs, 69 dual-eligible SNPs, and 9 institutional SNPs. The decline in SNPs may reflect a decrease in the number of MA plans in general that is due to CMS's effort to decrease the number of low-enrollment plans (i.e., plans with fewer than 10 enrollees) and duplicative plans (Medicare Payment Advisory Commission 2010). Total SNP enrollment decreased over this time period by close to 118,000; the largest decline was in chronic or disabling condition SNPs, and dual-eligible SNPs were least affected. Dual-eligible SNP enrollment declined by almost 2 percent, institutional SNP enrollment declined by approximately 15 percent, and enrollment in chronic or disabling condition SNPs decreased by close to 40 percent (Centers for Medicare & Medicaid Services 2009b, Centers for Medicare & Medicaid Services 2010b).

Despite the large number of SNPs, most SNPs and most states are not currently contracting with one another to establish fully integrated managed care programs that offer institutional or community-based long-term care. Most SNPs, including dual-eligible SNPs, do not currently have contracts with states to offer Medicaid benefits. However, by 2013, all dual-eligible SNPs are required by law to have contracts in place with states (see text box on key legislative changes and recommendations). Most dual-eligible SNPs are in the early stages of establishing these contracts, and most contracts are beginning with limited Medicaid benefit offerings, such as Medicare cost-sharing and wraparound services, rather than offering long-term care services. ■

Key special needs plan legislative changes and recommendations

In 2007 and 2008, a number of legislative changes and Commission recommendations were made over concerns that special needs plans (SNPs) did not provide models of care tailored to the special needs populations they were intended to serve. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) placed a moratorium on the approval of new SNPs and the expansion of existing ones. However, as applications for new SNPs and expansions that were approved before December 2007 were allowed to enroll beneficiaries in 2008, the number of SNPs increased between 2007 and 2008, from 447 to 770. MMSEA did not address SNPs' structural elements, such as their model of care, performance measures, or contracting arrangements with states.

In 2008, the Commission made a number of recommendations that were intended to improve SNPs:

(1) **The Congress should require the Secretary to establish additional, tailored performance measures specifically for SNPs and evaluate their performance on those measures within three years;**

(2) **The Congress should direct the Secretary to require chronic condition SNPs to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems;**

(3) **The Congress should require dual-eligible SNPs within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits; and**

(4) **The Congress should require SNPs to enroll at least 95 percent of their members from their target population (Medicare Payment Advisory Commission 2008).**

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) converted the moratorium implemented by the MMSEA to a one-year freeze. This freeze permitted plans to begin submitting applications for new plans or expansions in 2009 for the 2010 SNP contract year. MIPPA also required the following changes:

- ***Contracts with state Medicaid agencies***—MIPPA required all new dual-eligible SNPs and expansions of existing SNPs to have a contract with the state Medicaid agency by 2010. MIPPA exempted existing SNPs that were not expanding their service area from this requirement; however, CMS clarified that existing dual-eligible SNPs not expanding their service area must submit a signed state Medicaid contract to CMS by 2011. As MIPPA did not require states to contract with SNPs, the plans could have difficulty establishing contracts with some states.

- ***SNP model of care***—MIPPA required all SNPs to implement an evidence-based model of care by contract year 2010. CMS had already specified elements of a model of care in a proposed rule that the agency intended to require of SNPs and interpreted MIPPA as adding to those elements. Elements of the model of care from both CMS and MIPPA include: care coordination, specialized provider network, comprehensive initial risk assessment and annual reassessments, appropriate provider networks, and performance measurement. CMS also issued guidance on how SNPs can develop their models of care, such as referring to evidence-based literature on the website of the Agency for Healthcare Research and Quality.

- ***Definition of a chronic or disabling condition***—MIPPA required CMS to convene an expert clinical panel to determine the specific conditions that could be considered severe or disabling chronic conditions and therefore could be targeted for enrollment in a chronic care condition SNP. The panel identified the following 15 conditions and only beneficiaries with

(continued next page)

Key special needs plan legislative changes and recommendations (cont.)

1 of these conditions are eligible for enrollment in a chronic care condition SNP beginning in 2010: (1) chronic alcohol and other drug dependence, (2) certain autoimmune disorders, (3) cancer (excluding precancer conditions), (4) certain cardiovascular disorders, (5) chronic heart failure, (6) dementia, (7) diabetes mellitus, (8) end-stage liver disease, (9) end-stage renal disease requiring dialysis, (10) certain hematologic disorders, (11) HIV/AIDS, (12) certain chronic lung disorders, (13) certain mental health disorders, (14) certain neurologic disorders, and (15) stroke.

- ***SNP quality improvement program requirements***—MIPPA added requirements for SNPs under the quality improvement program. Before MIPPA, SNPs were required to report Healthcare Effectiveness Data and Information Set measures and structure and process measures. In addition to reporting those measures, MIPPA also required SNPs to evaluate the impact of their models of care.

The Patient Protection and Affordable Care Act of 2010 (PPACA) made additional changes to SNPs, including the following:

- ***Extension of SNP authority***—PPACA extended SNP authority through December 31, 2013.
- ***Frailty adjustment for certain SNPs***—Beginning in 2011, fully integrated SNPs with state contracts for capitated Medicaid payments to cover Medicaid services, including long-term care and that serve a population similar in frailty to the Program of All-Inclusive Care for the Elderly (PACE) population, are eligible to receive the PACE frailty adjuster.
- ***Extension of deadline for state contracts for dual-eligible SNPs***—PPACA extended the deadline for state contracts for Medicaid services for existing dual-eligible SNPs that are not expanding their service areas from December 31, 2010, to December 31, 2012. Beginning in the 2013 contract year, these SNPs must have state contracts to provide Medicaid services.
- ***Requirement for National Committee for Quality Assurance approval***—By 2012, all SNPs are required to be approved by the National Committee for Quality Assurance.
- ***Risk-adjustment for chronic condition SNPs***—Beginning in 2011, a risk score reflective of the underlying risk profile and chronic condition status of similar individuals must be applied to chronic condition SNPs. In 2011, the Secretary is also required to evaluate whether the risk adjustment system accounts for higher costs associated with comorbidities, frailty, mental illness, and patient mix. ■

Source: Saucier et al. 2009, Centers for Medicare & Medicaid Services 2009a, Centers for Medicare & Medicaid Services 2010a.

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