ONLINE APPENDIXES 3

Care coordination programs for dual-eligible beneficiaries

ONLINE APPENDIX 3-A

Additional analyses of special needs plans' quality of care

As part of the update on the Medicare Advantage (MA) program in the March 2012 report, we attempted to examine how special needs plans (SNPs) performed on the various metrics we have traditionally used to evaluate quality in MA (Medicare Payment Advisory Commission 2012). As we noted in the report, it is often necessary to use indirect or proxy means of evaluating SNPs as a category because only a few measures that plans report are at a level that allows a SNP-specific assessment of quality. Most reporting on quality in MA is done at the contract level, and SNPs are often components of larger contracts, which aggregate data on quality metrics for SNPs and other plans covered by the contract. However, because we had beneficiary-level data for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, we were able to group beneficiaries by their MA enrollment categories and could thus report on influenza vaccination rates, for example, across each SNP category and compare the rates with other groupings of MA enrollees.

After we completed our analysis of MA quality results to include in the March 2012 report, CMS released the 2011 report of a subset of measures described at the SNP benefit package level (rather than at the contract level). The publicly reported results include only a small number of measures given by all plan types at the contract level, but the reporting also includes several SNP-specific measures. We discuss the results below.

CMS recently provided us with the list of dual-eligible special needs plans (D–SNPs) that are fully integrated dual-eligible (FIDE) SNPs. CMS previously used a more restrictive definition of FIDE–SNPs in which plans had to cover all primary, acute, and long-term care services on a capitated basis. Our analysis of FIDE–SNPs included only the plans that met this definition in 2012. There were fewer than 20 of those plans, with a total enrollment of 23,000 beneficiaries as of February 2012, or about 2 percent of all dual-eligible beneficiaries enrolled in SNPs.[1] CMS revised the definition of a FIDE–SNP in the April 2012 call letter to include plans that are at risk for substantially all services and the risk for nursing facility services can be limited to six months (Centers for Medicare & Medicaid Services 2012). To the extent that comparisons are possible, FIDE–SNPs have better results on quality measures than other D–SNPs, as indicated below.

Factors to consider in SNP quality results

Representatives of SNP plans have explained why SNPs perform poorly on some measures and why some measures may not be appropriate for SNP populations. The plans argue, for example, that certain tests (particularly colorectal cancer screening) may not be appropriate for all individuals who would otherwise meet the Health Plan Employer Data and Information Set (HEDIS®) criteria because of the presence of multiple chronic conditions or other factors that make it inadvisable for an individual to have such a test. Screening measures, such as the rate of breast cancer screening and vaccination measures, are problematic in that they rely on educating patients, and cultural issues may cause some populations to avoid screenings or vaccinations. As for measures on which plans do well, part of the reason is that they undertake specific activities to address issues for which their enrollees are at particular risk—such as falls among the frail elderly.

Industry representatives also maintain that the appropriate way to determine whether SNPs provide better care to their enrollees is by comparing the results for subpopulations that SNPs serve across each of the three sectors in which special needs individuals can receive care: traditional fee-for-service (FFS) Medicare, MA plans not specializing in care to special needs enrollees, and SNPs. We were unable to make such a comparison directly but instead used CAHPS person-level data on influenza vaccinations (see Chapter 6 of our 2010 report for a discussion of the limitations of comparing SNPs with FFS) (Medicare Payment Advisory Commission 2010). Using these survey data, we found that, while SNP plans had lower influenza vaccination rates than non-SNP plans for dual-eligible beneficiaries, vaccination rates for dual-eligible beneficiaries were the same in each of the three sectors. That is, dual-eligible beneficiaries enrolled in SNPs had the same vaccination rates as dual-eligible beneficiaries in non-SNP plans and those enrolled in FFS.

For other measures for which we do not have person-level data, we can compare SNPs and non-SNPs only at the plan level, using a proxy method for determining whether a plan is primarily a SNP or primarily a non-SNP. We were able to examine a few measures reported at the SNP level, including some HEDIS measures and some SNP-specific measures reported only by SNP plans.

TABLE 3–A1

The small number of FIDE–SNPs reporting care for older adult measures show high average results for 2011

Plan type	Care for older adults measure				
	Medication review	Functional status assessment	Pain screening	Medication reconciliation postdischarge	Advance care planning
All D–SNPs, HMOs only					
Rate	62%	39%	36%	33%	23%
Number reporting	212	215	214	199	215
FIDE–SNPs, HMOs only					
Rate	84%	75%	70%	52%	64%
Number reporting	7	7	7	7	7
Non-D–SNPs, HMOs only					
Rate	76%	60%	55%	25%	46%
Number reporting	78	78	78	63	78

Note: FIDE–SNP (fully integrated dual-eligible special needs plan), D–SNP (dual-eligible special needs plan), HMO (health maintenance organization).

Source: MedPAC analysis of 2011 Healthcare Effectiveness Data and Information Set data from CMS.

HEDIS results

In the March 2012 report we noted that, using our proxy method of determining their performance, SNP plans performed worse than non-SNP plans on the measures that come from the primary source of quality indicators in MA–HEDIS (Medicare Payment Advisory Commission 2012). The proxy that we used to evaluate care in SNPs consisted of identifying contracts in which 75 percent or more of the enrollment was in SNPs and comparing those results with the results of contracts with 10 percent or lower SNP enrollment. Although we reported our findings on the HEDIS performance of all types of SNPs—not just D–SNPs—compared with non-SNP plans, the same finding holds for D–SNPs as a group. In comparing our proxy SNP category using only HMOs (consisting of 64 HMOs) with the non-SNP category (consisting of 164 HMOs), we found that, for the majority of the 45 HEDIS measures that we track, SNP plans show poorer performance than non-SNP plans and the differences are statistically significant. We find the same results if we examine only the primarily D–SNPs in our proxy category of SNPs (which includes 57 of the 64 primarily SNP HMOs).

For 11 of the 45 HEDIS measures that we track, there were no statistically significant differences between D–SNPs and non-SNPs. These measures included blood pressure control among diabetics, four of five measures for monitoring persistently used drugs, recording body mass index in the medical record, two measures of antidepression medication management, and the treatment of urinary incontinence, among others.

D–SNPs were better on five measures, four of which are HEDIS measures collected through the Health Outcomes Survey (HOS): two measures related to fall risks (discussing and managing fall risks), advising patients on physical activity, managing urinary incontinence, and bronchodilator pharmacotherapy management of exacerbation of chronic obstructive pulmonary disease (a non-HOS measure).

The 29 measures for which D–SNP performance was poorer than for non-SNPs, with differences that were statistically significant, included, among others, the intermediate outcomes of blood pressure control among enrollees with hypertension, blood glucose control among diabetics, and cholesterol control among diabetics and among those with cardiovascular conditions; breast cancer, colorectal cancer, and glaucoma screening; eye exams,

lipid profiles, blood glucose measurement, and monitoring nephropathy among diabetics; six measures of the use of drugs with potentially harmful interactions or the use of high-risk drugs; and osteoporosis management among women with fractures.

HEDIS results for SNP-reported measures

CMS has released a report on a small subset of measures that SNPs report at the benefit package level (rather than at the contract level). As we noted in the March 2012 report, our analysis of data for the years before 2011 showed that SNPs generally perform worse on such measures than non-SNPs, including for the one intermediate outcome measure that is part of the SNP-level reporting—control of blood pressure among members with hypertension. We found similar results in our analysis of SNP-level reporting for 2011. However, FIDE–SNPs perform very well on the SNP-level measures, to the extent that we can generalize from the small number of plans reporting. Eight FIDE–SNPs are HMOs that reported the blood pressure control measure for 2011, with rates ranging from 39 percent to 84 percent, with an average of 64 percent (compared with an average of 57 percent among HMO SNPs for dual-eligible beneficiaries that are not integrated plans). Four of the eight FIDE–SNPs have blood pressure control rates that place them above the 90th percentile of the rate for all reporting MA plans (which is 73 percent).

FIDE–SNPs also perform very well on the care of older adult measures that only SNPs report: medication review, functional status assessment, pain screening, medication reconciliation postdischarge, and advanced care planning (Table 3-A1). The FIDE–SNP average rates for these measures are well above the average for all D–SNPs and above the average for non-D–SNPs.

HOS results for SNPs

The third major source of information that we use to evaluate quality in MA comes from the HOS, which is used to determine whether a plan has performed well on measures of improvement in the physical and mental health of its Medicare enrollees. A sample of a plan's Medicare enrollees (or, for smaller plans, the entire enrolled population) is surveyed in a given year and then resurveyed two years later. A plan is deemed to have better or poorer outcomes if its results on the physical or mental health measures are better or worse than expected and differ significantly from the national average across all plans.

To examine the performance of SNPs in the HOS measures, we used the star ratings that CMS posts at Medicare.gov to determine the best and worst performing plans, using the proxy approach to identify contracts that primarily serve SNP enrollees. We found that SNPs are overrepresented among the poorer performing plans but do well on the mental health outcome results (Table 3-A2, p. 6). D–SNPs represent about 8 percent of plans with HOS star ratings (25 of 320) but make up about 15 percent of plans with better than expected physical health outcomes and one-third of those with better than expected mental health outcomes (three of nine plans). However, D–SNPs are one-quarter of plans (5 of 19 plans) with worse than expected physical health outcomes. Of the six plans that have worse outcomes in both physical and mental health, four (66 percent) are D–SNPs. For the four plans that have opposite results—either worse than expected mental health outcomes combined with better than expected physical health outcomes or physical and mental health reversed—in each case one of the two plans in the category is a D–SNP. ■

TABLE 3–A2

D–SNPs are over-represented in HOS outlier results, more so in poorer outcomes

Health plan category*	Total number with HOS star value	Results for improvement or decline in health status over two years				Plans that appear in multiple categories		
		Best in:		Poorest in:				
		Mental health	Physical health	Mental health	Physical health	Poorest in both mental and physical health	Best in physical health poorest in mental health	Best in mental health, poorest in physical health
Non-SNP	271	5	11	7	3	2	0	0
D–SNP	25	3	2	4	5	4	1	1
C–SNP	8	0	0	1	0	0	0	0
I–SNP	16	1	0	0	3	0	1	1
Total	**320**	**9**	**13**	**12**	**11**	**6**	**2**	**2**
Number of total that are:								
SNPs	49	4	2	5	8	4	2	2
D–SNPs	25	3	2	4	5	4	1	1
Percent of total that are:								
SNPs	15%	44%	15%	42%	73%	67%	100%	100%
D–SNPs	8	33	15	33	45	67	50	50

Note: SNP (special needs plan), D–SNP (dual-eligible special needs plan), C–SNP (chronic condition special needs plan), I–SNP (institutional special needs plan), HOS (Health Outcomes Survey).
*Determined by preponderance of enrollment in contract.

Source: MedPAC analysis of 2012 star ratings from CMS.

Endnotes

1 MedPAC estimates based on proprietary information from CMS.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. Announcement of calendar year (CY) 2013 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies and final call letter. April. Baltimore, MD: CMS.

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