Medicare Advantage special needs plans

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MEDPAC

SNP authority expiring

- Medicare Advantage special needs plans (SNPs) limit their enrollment to certain classes of beneficiaries
- Authority for exclusive enrollment expires at end of 2013
- Plans can continue as general MA plans

Outline of presentation

- Description of SNP program and current enrollment and availability
- Differences between SNP and general MA plans
- Quality of care in SNPs
- Chairman's draft recommendations

Framework for evaluating policy options

- How does the recommendation impact Medicare program spending?
- Will it improve beneficiary access to care?
- Will it improve the quality of care Medicare beneficiaries receive?
- Will the recommendation advance payment reform? Does it move away from fee-for-service and encourage a more integrated delivery system?

SNP types, enrollment and prevalence

SNP type	Beneficiary category	Enrollment, Sept. 2012	Plan Availability, 2013
D-SNPs	Medicare-Medicaid dual eligibles	1.26 million	Available to about ¾ of Medicare beneficiaries
C-SNPs	Beneficiaries with specific chronic or disabling conditions	223,000	Slightly over half of beneficiaries
I-SNPs	Institutionalized beneficiaries, or in community at institutional level of care	48,000	Slightly under half of beneficiaries

Differences between SNP and general MA plans

- SNPs can design benefit packages tailored to a specific population
- SNPs must meet additional structure and process requirements and additional reporting requirements
- Rules on enrollment differ

Differences between SNPs and general MA plans in enrollment rules

Enrollment opportunities outside of October-December open enrollment period (OEP)				
		Continuous enrollment based on status of beneficiary, for all plans		
	Can enroll any beneficiary	Can enroll duals and other low-income individuals any month	Can enroll institutionalized individuals any month	Can enroll beneficiaries with specified chronic conditions
General MA plans	If 5-star plan	X	X	
D-SNPs		X	X	
C-SNPs		If have condition	If have condition	One-time opportunity for each beneficiary with condition
I-SNPs		If institutionalized	X	

- Beneficiaries with end-stage renal disease (ESRD) may not enroll as new members of a general MA plan. Any SNP category can obtain a waiver to enroll ESRD beneficiaries.
- SNPs participate in the OEP but a beneficiary must have the SNP qualifying status to enroll.

Questions on enrollment and SNP sponsors

- Enrollment growth over last 12 months:
  - D-SNP enrollment growth (13 percent) similar to overall MA (15 percent)
  - C-SNPs higher (21 percent growth rate)
  - I-SNPs declined (39 percent—one entity changed status)
- Types of plan sponsors (for-profit/not):
  - For-profit dominant across all MA in number of enrollees (about 3/4 of all enrollment)
  - D-SNPs similar to overall MA
  - C-SNPs and I-SNPs have higher for-profit proportion

Do SNPs perform better than non-SNP MA plans on quality indicators?

- On average, CMS star ratings lower for SNPs
- Most process and intermediate outcome measures (HEDIS®) lower for SNPs than general MA averages
- Certain exceptions in each SNP category
- Concern that current measures and star system not appropriate for SNP plans, but new measures under development

Note: HEDIS is the Health Plan Employer Data and Information Set that MA plans report.

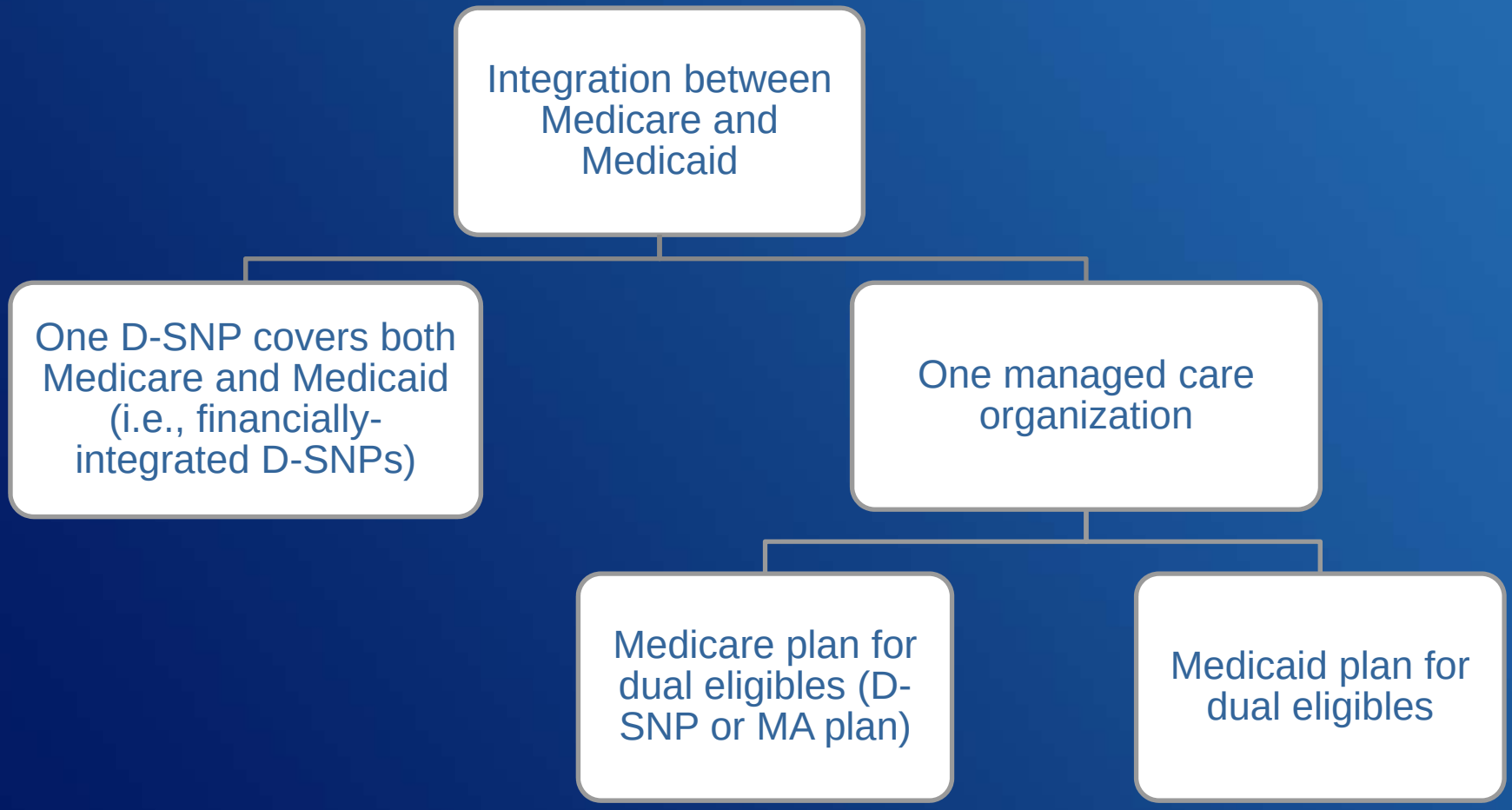
Summary of findings on I-SNPs

- Serve a defined population with specific needs and specific model of care
- Small enrollment, concentrated in urban areas
- Quality:
  - Perform well on hospital readmission rates and certain other measures
- Integration:
  - Can be viewed as promoting care integration for the target population

Summary of findings on C-SNPs

- Offer tailored care benefit packages and care models for target population
- Relatively small enrollment, but becoming more widely available
- Most frequently covered conditions not uncommon among beneficiaries (e.g., diabetes)
- Quality:
  - C-SNPs that are HMOs perform well on certain quality measures
- Integration:
  - Programs can be viewed as promoting care integration for the target population but should be a feature of all MA plans

Integration with Medicaid occurs under two types of D-SNPs



Majority of D-SNPs are likely not integrated

	Estimated number of D-SNPs	Estimated number of D-SNP enrollees	Percent of D-SNP enrollees
All D-SNPs	322	1.25 million	100%
Integrated D-SNPs	Approx. 60	Approx. 300,000	24%
Financially-integrated	Approx. 25	Approx. 65,000	5%
Companion Medicaid plan	Approx. 35	Approx. 235,000	19%
Non-integrated D-SNPs	Approx. 262	Approx. 950,000	76%

Note: data is preliminary and subject to change.
Source: MedPAC analysis of plan participation of Medicaid managed long-term care programs and SNP enrollment files from CMS.

Summary of main findings on D-SNPs

- Quality of care
  - Financially-integrated D-SNPs tend to perform well on star ratings
- Integration with Medicaid benefits
  - Few D-SNPs integrate most of all Medicaid benefits. An estimated 60 D-SNPs (the financially-integrated D-SNPs and those with a companion Medicaid plan) integrate most or all Medicaid benefits
  - The remaining D-SNPs may try to coordinate Medicaid benefits, but do not integrate them

Two administrative barriers to D-SNPs' integration with Medicaid

- Marketing requirements
  - D-SNPs cannot describe the Medicare and Medicaid benefits they cover in the same place on marketing materials
  - Precludes clear description of the advantages of the plan and can be confusing to beneficiaries
- Separate Medicare and Medicaid processes for appeals and grievances
  - Can be confusing and burdensome for beneficiaries and plans

Source: MedPAC June 2010 Report to Congress