ONLINE APPENDIXES 14

Medicare Advantage special needs plans

ONLINE APPENDIX 14-A

Additional data on Medicare Advantage special needs plans and information on quality

TABLE 14–A1

D–SNPs are widely available in 2013, but other SNP categories are not as widely available

	Availability (percent of population)	Enrollment (December 2012)	CCP types offering option	Areas where options are available
D–SNPs	82%	1,303,408	All	40 states, DC, PR
I–SNPs	46	49,714	HMOs, local PPOs	34 states, DC, PR
C–SNPs, by disease category*				
Any type of disease	55	232,530**	All	30 states, DC, PR
Diabetes	30	39,032	HMOs	24 states, DC, PR
CHF and diabetes	24	105,939	Regional PPOs, local PPOs, HMOs; for 7 percent of Medicare beneficiaries, only regional PPOs	18 states
Chronic lung disorders	37	15,501	HMOs	21 states
Cardiovascular disorders, CHF, and diabetes	27	61,108	HMOs	11 states, PR
ESRD requiring dialysis	7	2,527	Local PPOs, HMOs	CA, GA, NC, TN, TX
Chronic/disabling mental health conditions	8	2,889	HMO (one company)	AR, CA, PA, TN
Dementia	7	185	HMOs	FL, MN
HIV/AIDS	6	1,875	HMOs	Counties of Los Angeles (CA), Miami–Dade and Broward (FL); Bronx, Kings, and Queens (NY)
Cardiovascular disorders and CHF	8	3,131	HMOs	AZ, CA, FL
CHF alone	4	90	HMOs	TX
Cardiovascular disorders and diabetes	1	242	HMO (one company)	Miami–Dade and Broward counties (FL)

Note: D–SNP (dual-eligible special needs plan), SNP (special needs plan), CCP (coordinated care plan), I–SNP (institutional special needs plan), C–SNP (chronic or disabling condition special needs plan), PPO (preferred provider organization), CHF (congestive heart failure), ESRD (end-stage renal disease).
*Where more than one condition is listed, an enrollee must have at least one of the conditions to enroll in the C–SNP.
**The total figure is the CMS reported total and includes 11 enrollees in a plan or plans not specifically identified in the CMS report.

Source: MedPAC analysis of CMS Healthcare Effectiveness Data and Information Set® public use files.

TABLE 14–A2

Distribution of SNP enrollment by top 5 states or territories, December 2012

MA non-SNP plans		D–SNPs		C–SNPs		I–SNPs	
State or region	**Percent**	**State or region**	**Percent**	**State or region**	**Percent**	**State or region**	**Percent**
CA	14%	PR	19%	FL	24%	NY	20%
FL	9	CA	14	GA	13	CA	18
NY	7	FL	10	SC	13	OH	8
PA	7	NY	9	TX	13	MD	5
OH	6	PA	7	CA	9	FL	5
Total*	43	Total*	59	Total*	72	Total*	56

Note: SNP (special needs plan), MA (Medicare Advantage), D–SNP (dual-eligible special needs plan), C–SNP (chronic or disabling condition special needs plan), I–SNP (institutional special needs plan).
*Percent of total enrollment in top 5 states or territories for each category.

Source: MedPAC analysis of publicly released CMS enrollment and SNP data files (enrollment under 11 in plan or county suppressed in CMS files).

TABLE 14–A3

Rural beneficiaries will have more limited access to SNPs than beneficiaries residing in metropolitan areas in 2013

Classification of county	Overall Medicare population distribution	Percent of population with SNPs available by type		
		D–SNP	I–SNP	C–SNP
Metropolitan	79%	89%	57%	61%
Nonmetropolitan counties				
Micropolitan	12	61	9	38
Other rural counties	8	50	3	35

Note: SNP (special needs plan), D–SNP (dual-eligible special needs plans), C–SNP (chronic or disabling condition special needs plan), I–SNP (institutional special needs plan).

Source: MedPAC analysis of CMS landscape files.

TABLE 14–A4

Plans that exclusively or predominantly have SNP enrollees have lower average star ratings than non-SNP plans in each CCP category

	Number of contracts	SNP enrollment	Total enrollment	Average enrollment	Average star rating	Share of plans rated 4 stars or above
CCPs, all	524	1,513,631	12,642,977	24,128	3.44	28%
No SNP enrollees	273	—	5,925,712	21,706	3.64	39
Any SNP enrollees	251	1,513,631	6,717,265	26,762	3.20	16
Only SNP enrollees	80	316,946	316,946	3,962	3.22	19
HMO/PSO, all	361	1,333,036	8,751,306	24,242	3.43	29
No SNP enrollees	139	—	2,790,842	20,078	3.75	46
With SNP enrollees	222	1,333,036	5,960,464	26,849	3.19	17
Majority SNP enrollees	110	756,740	986,533	8,968	3.08	13
Local PPO, all	150	59,552	2,929,981	19,533	3.50	29
No SNP enrollees	127	—	2,521,359	19,853	3.53	32
With SNP enrollees	23	59,552	408,622	17,766	3.28	11
Majority SNP enrollees	13	40,875	45,369	3,490	3.23	9
Regional plans, all	13	121,043	961,690	73,976	3.23	9
No SNP enrollees	7	—	613,511	87,644	3.40	20
With SNP enrollees	6	121,043	348,179	58,030	3.08	0
Majority SNP enrollees	3	101,086	110,176	36,725	3.0	0

Note: SNP (special needs plan), CCP (coordinated care plan), PSO (provider-sponsored organization), PPO (preferred provider organization). CCP includes HMO, local PPO, and regional PPO. Enrollment and contract data are as of August 2012. Star ratings are 2013 ratings for the 2012 open enrollment period occurring October through December 2012. Averages and share of plans with 4 stars or higher ratings are computed based on plans with a star rating.

Source: MedPAC analysis of CMS enrollment and star rating files.

TABLE 14–A5

Among plans with SNP enrollment over 50 percent, highly rated plans are found in only a few states and have relatively small enrollment

Star ratings, 2013*	Number of contracts	States	Plan types and proportion of SNPs	SNP types	SNP enrollment, August 2012
4.5	2	MA, MN	HMOs *(both 100% SNP)*	Dual eligible	7,064
4	7	CA, MA, MN (3), OH, WI	6 HMOs, 1 local PPO *(all 100% SNP)*	6 dual eligible, 1 institutional	33,344
3.5	16	AZ, CA (3), CO, FL (2), MA, MA/RI, MN (2), OR (3), PA (2)	11 HMOs *(8 at 100% SNP; 2 > 85% SNP; 1 at 62%) SNP* 5 local PPOs *(all 100% SNP)*	8 dual eligible, 6 institutional, 1 dual and chronic, 1 dual and institutional	140,368
3	33	AR, AZ (5), CA (3), CO, CT (2), DC, DE, GA, MD, MO, NM, NY (5), OR (2), PA, PR (4), SC, TX, UT, WA	27 HMOs *(11 100% SNP; 7 at 75% to 90% SNP; 9 at 54% to 74% SNP)* 3 local PPOs *(all 100% SNP)* 3 regional PPOs *(85% or more SNP)*	20 dual eligible, 1 institutional, 2 chronic, 5 dual and chronic, 5 dual and institutional	521,559
2.5	24	AZ, CA, CO, FL, GA, IA, IL, IN, MD, MI, NJ, NM, NY, PA, PR, TN, TX, WA, WI	22 HMOs *(11 100% SNP; 2 at 89% to 95% SNP; 4 at 63% to 87% SNP; 3 at 50% to 60% SNP)* 2 local PPOs *(1 at 100% SNP and 1 at 63% SNP)*	21 dual eligible, 2 dual and chronic, 1 dual and institutional	148,608
Insufficient data to rate	35	Various	HMOs	All categories	30,258
New plans	3	GA, MI, PA	HMOs	Dual eligible	8,361

Note: SNP (special needs plan), CCP (coordinated care plan), PPO (preferred provider organization). CCP includes HMO, local PPO, and regional PPO. Enrollment and contract data are as of August 2012. Star ratings are for the 2012 open enrollment period for enrollments effective in 2013. Because star ratings are determined at the contract level, SNP enrollment can be a subset of the enrollment only under some contracts. Some contracts have 100 percent SNP enrollment; that is, the star rating applies to a contract that includes only SNP enrollees. Using the 50 percent or more enrollment criterion, the analysis of the distribution of star ratings in this table captures about 60 percent of the SNP enrollment. SNPs available only to residents of an assisted living facility sponsoring the SNP are excluded from this table.
*Maximum 5 stars.

Source: MedPAC analysis of CMS enrollment, service area, and star rating files.

Additional data and information on quality of special needs plans

We reported on the quality of care in special needs plans (SNPs) in our March and June 2012 reports (Medicare Payment Advisory Commission 2012a, Medicare Payment Advisory Commission 2012b). We noted that limited information was available on SNP quality indicators, primarily because of the way quality reporting occurs in Medicare Advantage (MA) for the majority of quality measures. For SNPs under a contract that includes non-SNP and SNP benefit packages, quality measures are reported at the aggregate contract level. SNP enrollees are thus combined with non-SNP enrollees in much of the data that we have on quality. Consequently, in our March and June reports we used a proxy method for evaluating SNP quality. We compared contracts that had only SNP enrollees, or a large proportion of SNP enrollees, with contracts with minimal or no SNP enrollment. We also examined the few measures that were available at the time that were reported at the SNP level (a small subset of the measures all plans report) as well as five measures that only SNP plans reported.

Since the Commission's release of the June report, CMS has posted more detailed information about the performance of SNPs on quality measures. In August 2012, CMS released the process and intermediate outcome results for all MA plans, which were the basis of the star ratings on Healthcare Effectiveness Data and Information Set® (HEDIS®) measures. At the same time, CMS released SNP-level data in a more complete format than had previously been released. The all-MA data enable us to update our findings on SNP versus non-SNP performance using our proxy method of plan comparisons. The SNP-specific data make us better able to examine SNP performance on the subset of measures MA plans report at the SNP benefit package level. The SNP-level data include SNP performance on the new measure, introduced last year, that tracks hospital readmission rates. We have also examined person-level data that plans report, which gives us a limited ability to compare classes of beneficiaries across plans (e.g., dual eligibles in dual-eligible SNPs (D–SNPs) compared with dual eligibles in general MA plans) for certain measures collected via administrative data such as claims and encounter data.

A number of studies have examined quality in SNPs. One study used the Health Outcomes Survey (HOS) to compare SNPs with other plan types. The three other studies that we discuss compare the performance of a specific SNP with the performance of fee-for-service (FFS) Medicare for like populations (and not a comparison of SNP performance with performance of non-SNPs in MA). The three studies differ in the scope of the FFS geographic areas used for comparison purposes: one matched to the plan's service area, another statewide, and another using national FFS data as the basis of comparison.

The study based on the HOS examined the quality of care among SNPs and Program of All-Inclusive Care for the Elderly providers (National Committee for Quality Assurance 2012). The study found wide variation across plans in their quality of care and noted the inability to measure many plans because in many cases SNPs were a segment of a larger reporting unit. The study's findings are consistent with our examination of the star system measures drawn from the HOS, for which we found wide variation in SNP performance, with plans at the extreme of being among the best plans and some being among the poorest performing plans (Medicare Payment Advisory Commission 2012b).

Another study compared utilization data on diabetics in a chronic condition SNP (C–SNP) with diabetics in FFS Medicare in the plan's service area (Cohen et al. 2012). The authors found that the C–SNP enrollees had lower rates of emergency department utilization, more primary care visits, and lower hospital admission and readmission rates than the comparison group in FFS (differences that narrowed after risk adjustment). In particular, the C–SNP readmission rates were 29 percent lower than the FFS comparison group. However, the C–SNP in this study has higher than expected readmission rates. This plan's observed-to-expected ratio is 1.26, which is among the highest observed-to-expected ratios among SNPs (see Table 13-8 in our March 2013 report for comparisons with other plan types). We should note that the authors use a different readmission measure. They use a 3-month readmission period while the HEDIS measure we report uses a 30-day readmission period.

Comparing the performance of an MA plan with FFS in a plan's service area, as Cohen and colleagues did, is consistent with the Commission's recommendation that plan-to-FFS comparisons be done by area, with a plan's performance being judged against the performance of FFS in the plan's geographic service area (Medicare Payment Advisory Commission 2010). The two other studies that were commissioned by SNPs (but not peer reviewed) compare SNP plan results with FFS results in a wider

geographic area. One study compared a health plan's D–SNP in California with all dual-eligible beneficiaries in FFS in California (Avalere Health 2012b). The study found that the dual-eligible beneficiaries enrolled in SCAN had 14 percent lower admission rates and 25 percent lower readmission rates. The HEDIS readmission results from CMS confirm that the SCAN D–SNPs perform well on readmissions (with an observed-to-expected ratio of 0.72). Ideally, the study would have compared results between SCAN enrollees and FFS beneficiaries in the same geographic area within California served by SCAN. The HEDIS readmission rates that CMS has posted show that even within SCAN, there is geographic variation in readmission rates among the counties the plan serves. In San Bernardino County, the SCAN D–SNP observed-to-expected readmission ratio is 0.99, while in neighboring Riverside County it is 0.65.

A study of a D–SNP plan in Arizona compared its performance with FFS results for dual eligibles nationwide (Avalere Health 2012a). The authors found that plan enrollees had higher risk-adjusted rates of access to preventive and ambulatory care, lower hospital discharge rates and lengths of stay, lower rates of emergency department visits, and lower hospital readmission rates compared with national FFS averages for dual-eligible beneficiaries. Looking at the HEDIS readmission rates for this plan, its observed-to-expected ratio (0.96) is about the same as the weighted average for all D–SNPs in Arizona (0.97) and for all D–SNPs nationally (also 0.97). However, the plan that is this D–SNP's most comparable peer in Arizona (a D–SNP with a similar number of admissions) has a lower observed-to-expected readmissions ratio of 0.89. ■

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