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Evaluation of Medicare Advantage Special Needs Plans

Summary Report

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EXECUTIVE SUMMARY

Section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for the first time permitted Medicare Advantage (MA) plans to target beneficiaries in certain categories: beneficiaries residing in nursing homes, those dually eligible for Medicare and Medicaid, and those with severe or disabling chronic conditions. The Act termed such plans "specialized MA plans for special needs individuals" but they are commonly referred to as Special Needs Plans (SNPs). Previous to this legislation, MA plans were required to enroll any interested beneficiary residing in their service area. SNPs are intended to provide specialized models of care to serve their targeted groups.

In addition to defining the three target populations, Section 231 granted the Secretary of Health and Human Services (HHS) the authority to define the severe or disabling conditions that could be served by SNPs and to approve SNPs that served disproportionate percentages of special needs individuals as well as SNPs that served such populations exclusively. The Centers for Medicare & Medicaid Services (CMS) subsequently introduced a number of important policy decisions through rule making and subregulatory guidance. These decisions:

- Expanded the definition of "Institutional" - In the preamble to the final rules for SNPs, CMS stated that it would consider as institutionalized "those individuals living in the community but requiring a level-of-care equivalent to that of those individuals in ... long term care facilities."[1] (This report refers to them as institutional equivalent (IE) SNPs.)
- Defined a disproportionate percentage SNP - as one that enrolls a greater proportion of the target group than occurs nationally in the Medicare population.
- Permitted passive enrollment of dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) on a one-time basis in January, 2006 - 46 dual eligible SNPs approved for 2006 were owned by managed care organizations (MCOs) with existing Medicaid managed care contracts. These "dually contracted" MCOs were allowed to enroll dually eligible members of their Medicaid plans into their dual eligible SNPs effective January 1, 2006. Members were notified in advance and allowed to "opt out" if they objected.
- Defined dual eligible subsets - In the call letter of April, 2007, CMS added two new sub-types of dual eligible SNPs to the two types originally approved (all dual eligibles and full benefit dual eligibles only): "Zero Cost Sharing" dual eligibles[2] and plans that target subsets of dual eligibles that coincide with existing or proposed subsets in Medicaid

[1] Federal Register Vol. 70, No. 18 pp 4588-4741

[2] Zero cost sharing dual eligibles are Qualified Medicare Beneficiaries (QMBs) who are also enrolled in Medicaid. These individuals are entitled to Medicare Part A, have income of 100 percent of the Federal poverty level or less, and resources that do not exceed twice the limit for SSI eligibility. Most elderly and disabled Medicaid enrollees are eligible for the QMB program, although not all apply for it. Medicaid covers their Medicare Part B premiums as well as Part C (Medicare Advantage) premiums, cost sharing, and deductibles.

managed care contracts. The intention was to facilitate the development of SNPs with fully integrated Medicare and Medicaid managed care contracts. For this SNP sub-type, CMS requires an applicant MCO to provide written documentation that the State supports the proposed sub-setting methodology.

Section 231 also requires the Secretary to submit a report to Congress by December 31, 2007 that assesses the impact of specialized MA plans on the cost and quality of care provided to special needs individuals. CMS contracted with Mathematica Policy Research, Inc. to evaluate SNPs and to assist in the development of its report to Congress. This report fulfills that mandate. During the period when this report was being prepared, two laws affecting SNPs were enacted, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This report does not examine these changes to the SNP program. The study examined the program as it was in effect prior to the enactment of this legislation.

The evaluation sought to answer the following basic questions about aspects of SNP operations and outcomes:

- How have plans proliferated, and how has enrollment grown since 2004?
- What are the basic features of SNPs operating in 2006?
- What specific steps did SNPs take in 2006 to improve care for their special-needs target populations?
- To what extent did States develop relationships with SNPs to better coordinate Medicaid and Medicare services?
- How did 2006 SNP members compare with other Medicare beneficiaries who were eligible to enroll but did not?
- How did the bids of SNPs compare to those of other similar MA plans?
- Do SNPs appear to have the potential to improve care quality for their target populations?
- What are the effects of SNPs on Medicare costs?

The evaluation relied on both primary and secondary data. It administered a mail survey of SNPs to provide an overview of all plans operating in 2006, including their provider networks, relations with Medicaid, and member interventions. To describe plan features and operations in detail, it conducted site visits with selected plans and parent organizations that operated multiple plans. To gain the member perspective on plan operations, it also conducted focus groups with members of many of the visited plans. Interviews with State Medicaid officials gauged State government reaction to SNPs and in particular to dual-eligible SNPs.

The evaluation also assessed plan growth, compared plan members with eligible nonmembers, and assessed differences in bids. Data from the Health Plan Management System Payment Files were used to describe SNP enrollment and disenrollment between January 2005

and March 2007. These data were merged with beneficiary data to estimate the number of dual-eligible beneficiaries who were passively enrolled into SNPs in 2006. The evaluation used the 2005 Medicare Beneficiary Database, the Minimum Data Set for nursing home residents, and Hierarchical Condition Category (HCC) risk-group data to identify Medicare beneficiaries in individual SNP market areas who appeared eligible to enroll in SNPs but did not enroll (that is, eligible nonenrollees), in order to compare them to SNP members. The MA bid data for SNPs were compared with those of non-SNP MA plans in overlapping market areas for 2006 and 2007 as a means of determining whether the bid-to-benchmark ratios for SNPs differed, on average, from those associated with other similar MA plans.

The Growth of SNPs

The number of SNPs has increased rapidly since 2004, the year following passage of the MMA, when there were 11 SNPs were in operation. By 2006, the first year in which all three types of SNPs were offered, there were 276 plans and by 2007, 491 (see Table E.1). CMS received over 400 applications for new SNPs or expansions of existing SNPs in 2008. About two thirds of all SNPs are dual-eligible SNPs.

TABLE E.1

PLAN AND ENROLLMENT GROWTH, 2004-2007

	All SNPs		Dual Eligible		Institutional		Chronic Condition	
	Plans	Ever Enrolled	Plans	Ever Enrolled	Plans	Ever Enrolled	Plans	Ever Enrolled
2004	11	12,774	11	12,774	0	0	0	0
2005	137	129,220	108	103,896	29	25,329	0	0
2006	276	747,430	226	626,605	37	49,200	13	87,502
2007	491	887,583	323	654,458	84	146,259	84	90,467

Source: MPR analysis of Medicare Health Plan Management System (HPMS) and HMO Payment Files.

Note: Institutional SNPs include institutional and institutional-equivalent plans. Because some beneficiaries enrolled in more than one type of plan during a year, enrollment by type of plan will not sum to "All SNP" total; 2007 enrollment is as of March 2007.

As of December 2007, the number of SNPs had decreased to 477 due to the withdrawal of some plans. Overall SNP enrollment, however, had increased by nearly 25 percent to 1,098, 754. See http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP.

SNP enrollment rose dramatically in January 2006 due to passive enrollment (a one time event), which was responsible for 212,000 new SNP enrollees. Plan redesignations (that is, the conversion of an existing plan, such as a demonstration program, into a SNP) and plan transfers (from a non-SNP plan to a dual eligible SNP plan within the same MCO) also contributed substantially to the January 2006 increase but are also not likely to be repeated in the future. Institutional SNP enrollment increased sharply in January 2007, primarily because of the conversion of a large demonstration plan (the SCAN Social/ HMO) with roughly 90,000 members to an institutional-equivalent SNP. As of March 2007, total SNP enrollment had reached nearly 860,000 (Table E.2); dual-eligible SNPs accounted for 74 percent of total SNP enrollment and 66 percent of all SNPs.

Enrollment in chronic-care and institutional SNPs tended to be concentrated in plans operated by particular large parent organizations. The chronic-care SNP offered by Medicare y Mucho Mas of Puerto Rico accounted for over 70 percent of all enrollment in chronic-care SNPs in 2007. In that same year, SNPs offered by two organizations – SCAN and United Healthcare – accounted for over 80 percent of enrollment in institutional SNPs. By contrast, the largest dual-eligible SNP in 2007 was operated by the Kaiser Foundation; it accounted for just nine percent of enrollment in dual-eligible plans.

Disenrollment rates for SNPs, initially quite high (at 19 percent in 2005), have declined over time and now more closely resemble those of other MA plans (at 14 percent in 2006). The extent of disenrollment among those enrolled passively or through plan redesignations, and among beneficiaries inadvertently enrolling in free-standing Part D drug plans (triggering disenrollment from SNPs) could not be examined completely in time for inclusion in this study.

TABLE E.2

SELECTED PLAN FEATURES, 2007
(Percentage)

	All SNPs		Dual Eligible		Institutional		Chronic Condition	
	Plans	Enrollees	Plans	Enrollees	Plans	Enrollees	Plans	Enrollees
Medicaid contract	10.0	29.1	13.6	39.0	4.8	1.4	1.2	0.8
Disproportionate percentage	19.6	26.6	20.7	18.5	10.7	76.5	23.8	5.5
For-profit	83.3	65.2	82.0	70.3	82.1	21.9	89.3	98.6
Stand-alone	24.4	26.2	18.6	26.8	20.2	28.4	51.2	18.0
Total number	**491**	**856,571**	**323**	**632,372**	**84**	**139,845**	**84**	**84,354**

Source: CMS HMO Payment Files and Health Plan Management System (HPMS) files, 2007.

Notes: Enrollees are categorized in the type of SNP in which they were enrolled during March 2007. Includes plans active in 2007. "Stand-Alone" organization is defined as a plan that does not have other non-SNPs under the same contract number, or under different contract numbers for the organization. Table does not include people who had SNP payment records for March 2007 but were identified by enrollment files as having died prior to March.

Just under 40 percent of 2007 dual-eligible SNP members were enrolled in plans with Medicaid contracts; those plans made up 14 percent of all dual-eligible SNPs. For institutional and chronic condition SNPs, the proportion of plans with Medicaid contracts is under 5 percent. Enrollment in disproportionate-percentage SNPs varies from less than 6 percent of chronic condition SNP enrollees to over 76 percent of enrollees in institutional SNPs, although the latter percentage was heavily skewed by SCAN, an institutional equivalent, disproportionate percentage plan that accounted for 65 percent of all institutional SNP enrollees.

The number of SNPs has increased rapidly, from 11 in 2004 to 491 in 2007. With over 400 applications to CMS from organizations wishing to expand existing SNPs or offer new SNPs for 2008, it is clear that health plans do see a potential for increased enrollment. Nevertheless, the number of SNP plans with minimal enrollment may be worth further study and further monitoring.

Selected SNP Features in 2006

According to plan responses to the evaluation's mail survey, in 2006 most did not have a contract with Medicaid, consistent with the 2007 administrative data just presented. Among the plans that reported a contract, the majority included a capitated payment for Medicaid services. The service included in such a contract most often was coverage of medications excluded from the Medicare Part D benefit, followed by nursing home services and home- and community-based waiver program services. A significant proportion of plans that did not have Medicaid contracts in 2006 reported that they would seek them in the future (see Table E.3). However, more than half the responding plans (not shown) noted conflicting Medicare and Medicaid regulations as a disadvantage or barrier to Medicaid contracting.

All SNP mail survey respondents reported offering care coordination and almost all offered disease management.[3] Roughly 42 percent of plans reported identifying the need for the plan's special services *at enrollment* using screening tools administered by the plan's clinical staff; 49 percent used screens administered by nonclinical staff and 52 percent used screens administered by the enrollees themselves. The most common way of identifying the need for services *following enrollment* was through clinical reassessments; relatively few plans noted using automated reviews of electronic patient records for this purpose.

TABLE E.3

MEDICAID CONTRACTS, 2006
(Percentage unless otherwise noted)

	All SNPs	Dual Eligible	Institutional	Chronic Condition
Has Medicaid contract	32.2	37.0	19.2	12.5
Receives capitation (among those with Medicaid contract)	91.3	90.0	100.0	100.0
Capitation covers the following (among those with capitation):				
Drugs excluded by Part D	88.1	86.1	100.0	100.0
Nursing home services	76.2	72.2	100.0	100.0
HCB waiver services	59.5	52.8	100.0	100.0
Other services	66.7	63.9	80.0	100.0
Plans to seek Medicaid contract in future (if no contract in 2006)	69.8	73.5	71.4	28.6
Number of survey respondents	**142**	**108**	**26**	**8**

[3] For the purposes of the evaluation, c*are coordination* was defined as an array of services for people who have multiple medical or behavioral health conditions or who are medically complex. It often involves assigning a person to a single staff member or team (1) to monitor the person's clinical care and support services, (2) to assist with transitions between care settings, and (3) to help the person access needed health and support services. *Disease management* was defined as services that (1) teach people how to adhere to treatment plans, (2) monitor clinical status and adherence to treatment recommendations, and (3) monitor provider adherence to evidence-based practice guidelines. Disease management is typically targeted to people with specific chronic diseases, such as heart failure or diabetes. Such diseases often have complex treatment regimens, and maintaining adherence requires the sustained efforts of patients and physicians.

Source: Evaluation mail survey conducted between March and May 2007

Note: HCB = home and community based; "Other services" includes behavioral health care and other services that supplement Medicare

Plans reported the majority of institutional and chronic condition SNP enrollees (79 and 88 percent, respectively) received disease management in 2006, as compared with just 32 percent of dual-eligible SNP enrollees. Roughly similar percentages of institutional and chronic condition plan enrollees received care coordination, while 43 percent of dual-eligible plan enrollees did so. Other special services provided by SNPs included transportation to medical appointments, pain management services, and wound care. Relatively few plans offered special services for enrollees with dementia.

SNP Interventions in 2006

The evaluator conducted site visits to 10 individual SNPs and 4 parent organizations that operated multiple but similar plans. The evaluation also conducted focus groups of enrollees at the 10 individual plans to gauge their satisfaction with the enrollment process and plan services. While not a random sample of all plans operating in 2006, they represented a geographically diverse group serving the three SNP target populations and having substantial membership. Site visits focused on three broad areas to determine what made plans "special": level of integration with Medicaid, adaptation of services to individual needs, and provision of special services.

Integration with Medicaid. An arrangement with state Medicaid programs that renders SNPs in some way responsible for the cost or coordination of Medicaid services for their enrollees could benefit all plans that serve dual-eligible beneficiaries, but especially the dual-eligible SNPs. For example, a capitated contract for all Medicaid services would eliminate incentives to make care decisions based on payer and might give plans more leverage over providers, thus improving enrollee access to Medicaid-covered services.

Few visited plans had capitated contracts with Medicaid programs that included all (or almost all) Medicaid-covered services. Only two plans did; both were in Arizona, a state with a long history of managed long-term care. A third plan, whose sponsor was the County Organized Health System administering Medicaid for its SNP's service area, had a Medicaid contract that included most services but excluded institutional and some types of community based long-term care. Three other plans had capitated contracts for wraparound services only.

Nevertheless, staff from several plans with Medicaid contracts noted the importance of having information about services received in both the Medicare and the Medicaid programs and of having the ability to intervene effectively, when the need arose, with both Medicare and Medicaid providers. In addition, concentrating enrollees with special needs into a single plan seemed to cause staff to focus on the depth of those needs more than when such enrollees were a minority in regular plans.

Adaptation to Individual Needs. All the visited SNPs adapted their services to at least some degree in recognition of the fact that, collectively, beneficiaries in all three target groups are more likely to have limited literacy, poor English proficiency, needs for basic services (such as food and housing), complex medical problems, cognitive limitations, or behavioral health

problems. Having trained staff and clear procedures to address these problems allows enrollees and their health care providers to focus on improving health. Most commonly the visited plans employed social workers or behavioral health professionals to assist nurses with enrollees who had complex psychosocial problems or mental health disorders. Further, most plans either had staff who were bilingual or had their written materials translated into the languages commonly spoken by their enrollees. It was not possible to say whether these efforts went beyond those typical of regular MA plans.

Provision of Special Services. All the visited plans offered care coordination and disease management; most offered it only to enrollees determined to be "high risk." Staff at some plans estimated that 5 to 10 percent of enrollees received care coordination at any given time. Among plans that viewed disease management as a discrete intervention (rather than an educational component of care coordination), staff reported that between 15 and 35 percent of enrollees used the service. However, all enrollees of the two visited chronic-condition SNPs were considered to need disease management, at least for their target conditions.

It is unclear whether many of the visited plans could improve enrollee health substantially, as they were operating at the time of the visits. The literature suggests that success requires having highly trained staff and actively involved providers, as well as a structured intervention that can be adapted to individual patient needs (see for example, Chen et al. 2000). Recent evaluations of CMS's fee-for-service care coordination demonstrations suggest that in-person contact with enrollees may also contribute to success (Brown et al. 2007).

- All the visited plans had some of the features recommended by the literature. They had nurses providing these services, and most required that they be registered nurses or have some experience in community nursing. Further, all the plans conducted comprehensive assessments and from them derived care plans.
- Most of the visited plans lacked many of the recommended features, however. Few of these plans integrated physicians into the delivery of their special services, and few took a structured approach to enrollee education but relied instead on nurse-judgment-driven approaches. Few had the ability to contact enrollees in person, and few had software systems that supported special service delivery or could generate quality-monitoring reports. Among these plans, staff reported that care coordination and disease management were very similar to services already provided in their sponsors' Medicare or Medicaid managed care plans.
- On the other hand, several visited plans might have greater potential to improve enrollee health. These plans based their special SNP services on previous experience either operating demonstration programs or as commercial chronic disease management providers. All had relatively structured self-care education and regular monitoring by nurses and other professionals with a frequency at least at a pre-set minimum. Some of these plans had the ability to contact enrollees in person. All had also developed sophisticated software to guide staff in consistently providing care coordination and disease management services, to warehouse data on enrollees using those services, and to produce monitoring reports from those data upon which to make decisions on refining intervention features as necessary.

Finally, most focus group participants from most plans were satisfied overall with the services. However, for only two plans (one dual-eligible plan and one chronic-care plan) did most members believe their care was better under the SNP than previously. Members of the dual-eligible plan particularly liked the SNP because it lacked the stigma they had felt as members of a Medicaid plan (even though it was operated by the same sponsor as the SNP). They also liked the plan's pharmacy benefit and disease management services. Members of the chronic condition plan liked the calls from nurses.

In summary, the year 2006, the first year of operations for most of the visited plans, presented SNP staff with complications related to the start of the Medicare Part D benefit and the competitive bidding process, and to CMS's new enrollment database, MARX. During 2006, some of the visited plans were focused on resolving various enrollment problems, and others were just starting to realize they needed to refine their special services by making them more structured (for example, by adopting forms and protocols rather than relying primarily on individual nurse judgment) or more intense (for example, by being longer-term rather than episodic, or by giving staff smaller enrollee caseloads). It is thus too early to tell whether the SNPs will ultimately improve beneficiary health beyond what might be expected in a regular MA plan.

Medicaid Staff Views on SNPs

In early 2007, evaluation staff interviewed Medicaid staff in 14 States about their interest in contracting with SNPs. In some States, Medicaid directors saw SNPs as an opportunity to integrate Medicare and Medicaid services and thereby improve the quality and cost-effectiveness of care or to reduce the incentives for cost shifting between the programs. In general, however, States with such views are those that already have Medicaid managed care programs that include long-term care services, or plan to develop such programs in the near future. In States that used managed care contracts only for acute care services, Medicaid directors tended to view contracting with SNPs as of limited value because enrollees in SNPs are Medicare eligible and their acute care needs are thus covered by Medicare. The directors reported that they saw few advantages to contracting with SNPs because of the limited scope of the Medicaid services that would be covered.

Medicaid directors and their staffs cited several factors that may account for States' lack of interest in managed long-term care. First, providers, advocacy groups, and even unions have, at times, opposed managed care, (or, at least, managed care for long-term care services) and have attempted to prevent its introduction. Second, it can be costly, in terms of time and resources, for States to develop capitated rates and negotiate contracts with managed care organizations. In States with relatively small Medicaid populations, it may not be cost effective to do so. Finally, States may not be convinced that integrating Medicare and Medicaid services for their dual eligible populations would produce sufficient benefits to the State to justify the resources needed to accomplish this goal.

SNP Enrollees Compared with Eligible Nonenrollees

SNP enrollees were consistently healthier than the eligible but not enrolled population, based on 2006 risk scores.[4] This was the case even when comparisons were restricted to those strictly eligible for plans' target groups.[5] It was not possible to determine whether this difference was due to plan marketing practices or to a tendency on the part of less healthy individuals to avoid managed care. Because the HCC system pays plans more accurately than did the former system, which adjusted capitation payments only on the basis of demographic characteristics, the apparent difference in health status should not result in over or underpayment. It is too early at this point to determine whether or not enrollees are more likely to disenroll from SNPs when their health declines. As data become available, CMS will be able to compare disenrollment rates of beneficiaries by level of health risk as measured by HCC scores.

SNP Bids

The ratio of SNP bids to their benchmark amount are about the same, on average, as the ratio of bid-to-benchmark amount for MA plans that resemble SNPs and whose market areas overlap with those of SNPs. Since required benefit packages, payment rates, and risk adjustment for SNPs are identical to those of other MA plans, this result is to be expected. With only two years of bids available for analysis and the somewhat uncertain relationship between bids and actual financial performance, it is clearly too early to reach any conclusions about whether SNP bids will ultimately be higher or lower than those at non-SNP plans.

Conclusions

Despite limitations imposed by data availability, the material contained in this report provides important information about the variety of new models of care that SNPs are developing, the populations they are serving along with some preliminary indications of what they are accomplishing. Note that the study includes the time period prior to further legislative changes made to the SNP program as were enacted by MMSEA and MIPPA.

The opportunity that SNPs provide for specializing in care of particular groups of Medicare beneficiaries has proven to be attractive to industry. Organizations wishing to offer new SNPs or expand existing SNPs submitted over 400 applications to CMS for 2008. If all applications were approved, there would be 815 SNPs in 2008—nearly triple the number

[4] The comparisons between SNP enrollees and eligible non-enrollees have some limitations, particularly for chronic condition and institutional equivalent plans. First, diagnoses drawn from Hierarchical Condition Category (HCC) data may not always replicate the specific groups targeted by chronic condition SNPs. Second, the HCC data themselves were not available to the evaluation for beneficiaries entering SNPs in 2006. Thus, our approach will fail to identify beneficiaries who were first diagnosed with a target condition in 2006. Third, it was not possible to identify beneficiaries in traditional Medicare who were nursing-home certifiable using CMS administrative data. This precluded construction of a comparison group for institutional-equivalent SNPs.

[5] As noted, SNPs are not required to limit enrollment exclusively to their target group. Disproportionate percentage SNPs can include a substantial percentage of non-target group members.

operating in 2006. The number of chronic-condition SNPs has grown especially rapidly, from 13 in 2006 to 84 in 2007, with 264 applications for new and existing plans submitted for 2008. Despite this rapid growth in the number of SNPs, a substantial proportion—about 30 percent in 2007—had fewer than 50 enrollees, suggesting that some plans are unlikely to be sustainable over a longer term.

While SNP enrollment grew rapidly from 2005 to 2007, their ultimate appeal to Medicare beneficiaries is not yet clear. Enrollment in dual-eligible SNPs grew substantially in 2006 due in part to the one-time passive enrollment policy implemented by CMS and the redesignation of some MA contractors to SNP status. Growth continued more slowly between 2006 and 2007. Enrollment in institutional SNPs increased more rapidly during that time period, but this was due, in large part, to the conversion of a large demonstration plan to SNP institutional-equivalent status. While passive enrollment and plan redesignation accounted for a substantial share of SNP enrollment, at least 45 percent of beneficiaries ever enrolled in a SNP between 2004 and 2006 (353,000 out of 774,000) made an active choice to do so, either by leaving fee-for-service Medicare to enroll in a SNP or by leaving an MA plan to enroll in a SNP operated by a different parent organization. Rates of disenrollment from SNPs have declined over time and resemble rates of disenrollment from other MA plans.

Still it is impossible to tell what the long-term enrollment in SNPs is likely to be. If about half of those who enrolled in SNPs made an active decision to do so, then about half did not. Some events that contributed significantly to enrollment trends in 2006 and 2007, such as passive enrollment and the conversion of demonstration plans to SNP status, were one-time occurrences, while others, such as plan redesignations and transfers within MCO's will play a diminishing role in the future. As current enrollees leave SNPs due to death, loss of eligibility, or disenrollment, total enrollment in SNPs will be maintained only if an equal number are attracted to actively enroll in SNPs. This in turn will require that SNPs convince prospective enrollees of the value of the special services and interventions they offer.

Integration of Medicare and Medicaid services through SNPs may require several years to achieve in many States. With the exception of demonstration SNPs, few dual-eligible SNPs have entered into risk-based contracts with States for coverage of full Medicaid services. In some States with experience and current interest in promoting managed Medicaid long-term care, the barriers to Medicare/Medicaid integration may consist primarily of conflicts between State and Federal policy or other procedural problems. But in a majority of States, Medicaid officials appear to feel that other competing issues are more pressing at this point than developing and contracting for integrated approaches to Medicaid long-term care. Some State officials and staff noted that there were suspicions of large for-profit managed care organizations in their States, and concerns that managed care would be disruptive to providers in their State. Managed care organizations, for their part, indicated some reluctance to engage in long-term negotiations and discussions with Medicaid agencies that do not appear to be receptive, and also expressed concerns about shifting State requirements and priorities.

Staff members from several of the plans visited for the evaluation pointed out that joint contracting provides information that permits more effective coordination of care and helps them intervene more effectively when the need arises. Perhaps for this reason, 70 percent of health plans responding to the survey of SNPs in this study indicated an interest in pursuing Medicaid contract arrangements. In the States without a defined interest in SNPs, the process of

contracting with SNPs to provide full Medicaid coverage might require several years of ongoing contact between a SNP, CMS, and a State Medicaid agency, as it did in Massachusetts, Minnesota, and Wisconsin.

In 2007, 18 States had entered into Medicaid contracts with one or more SNPs. Of these, eight included some form of long-term care benefit. Because incentives to contract with SNPs appear limited for States that do not include long-term care services in their Medicaid managed-care contracts, we will need to improve our understanding of State attitudes and decision-making regarding managed long-term care. Without better information on this issue, it will be difficult to understand or anticipate the prospects for growth in the number of dually contracted SNPs.

It is too early to tell whether SNPs improve care and thus outcomes for their members. As noted above, SNPs are so new that quality measures derived from CAHPS, HEDIS, and HOS are not yet available. That said, visits to SNPs turned up promising indications. SNP staff at most of the visited sites displayed a strong sense of mission and a keen desire to do whatever is necessary to address member's health problems and concerns. In survey responses, all SNPs reported providing care-coordination and disease-management services. However, these terms can be used to describe a wide range of practices with varying degrees of intensity. It was beyond the scope of the evaluation to examine individual plan practices in a way that would allow a detailed analysis of the manner in which plans were implementing these programs.

At the same time, some evidence indicates that SNP enrollees may have somewhat lower care needs than comparable beneficiaries who did not enroll in SNPs. Whether this pattern stems primarily from a reluctance of beneficiaries with the most severe health problems to enroll in managed care plans or whether this is a result of specific SNP marketing strategies is difficult to ascertain. In any case, the introduction of HCC risk adjusted payments has substantially reduced the likelihood that plans enjoying favorable selection will be overpaid. HCC risk adjustment, takes diagnostic information into account and consequently does a much better job of matching payments to medical complexity and cost than the previous payment system that relied only on demographic information to predict expenditures.

There is no evidence at this point that Medicare payments to SNPs differ from payments to other MA plans. Because SNPs are paid in the same way as all MA plans, they will impose the same costs on the Medicare program unless (1) their enrollees are more or less likely, on average, to transition to higher-paying HCCs than are similar beneficiaries enrolled in MA plans, or (2) their bids are systematically lower than those of other MA plans. Assessment of SNP and MA bids indicated that the ratios of plan bids to local benchmarks were nearly identical for SNPs and MA plans with overlapping market areas. There is no reason at this point to suggest that result will change in future years. A potential avenue for cost reduction through SNPs is the prospect that improved care might retard the progression of chronic illness, benefiting SNP enrollees and lowering cost to Medicare by slowing the growth of capitation payments. It is still too early to examine this possibility because HCC scores reflecting beneficiary health conditions in 2006 were not available in time for this analysis.

I. BACKGROUND AND OVERVIEW OF THE EVALUATION

A. LEGISLATIVE AND POLICY BACKGROUND

1. Legislative Mandate

Section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for the first time permitted Medicare Advantage (MA) plans to target beneficiaries in certain categories: institutionalized beneficiaries, those enrolled in both Medicare and Medicaid (dual eligibles), and those with severe or disabling chronic conditions[6]. The Act termed such plans "specialized MA plans for special needs individuals" but they are commonly referred to as Special Needs Plans (SNPs). SNPs are intended to provide specialized models of care to serve their targeted groups.

In addition to defining the three special needs populations noted above, Section 231 contained the following provisions:

- authorized the Secretary of Health and Human Services (HHS) to define the severe or disabling chronic conditions that could be served by SNPs
- authorized "disproportionate percentage SNPs" that would not be required to limit enrollment exclusively to beneficiaries with special needs
- required CMS to submit to Congress, no later than December 31, 2007, a report on the impact of SNPs on the cost and quality of services provided to enrollees
- included a "sunset" provision that terminated, as of December 31, 2008, the authority for SNPs to limit enrollment to special needs groups

The major effect of the law was to allow MA plans, for the first time (aside from certain demonstrations), to restrict enrollment to specific sub-groups of Medicare beneficiaries with special needs. Aside from this change in enrollment policy, the law does not exempt SNPs from any of the requirements for existing MA plans nor does it provide for any special payment arrangements. SNPs participate in competitive bidding and must meet the same standards for provider networks, member rights, solvency and marketing and enrollment practices as any other MA plan. CMS also requires all SNPs to offer a Part D plan. Section 231 does not define the kinds of special programs or services to be provided by SNPs nor does the associated conference report. The conference report does suggest that SNPs could offer "targeted geriatric approaches and innovations in chronic illness care" and cites the Evercare and the Wisconsin Partnership Program demonstrations as examples of "specialized Medicare Advantage plans ..... that exclusively serve special needs beneficiaries." While it included dual eligible beneficiaries as a special needs group, the legislation did not require dual eligible SNPs to enter into contracts with Medicaid programs. SNPs represent a significant new Medicare Advantage (MA) option that is available under program—not demonstration—authority for millions of Medicare beneficiaries.

[6] The full text of Section 231 is in Appendix I; the Conference Agreement is in Appendix II.

The projected growth in the number of Medicare beneficiaries for the next five to ten years underlines the need for the development of new and more effective treatment options for people with severe and chronic illnesses.

This chapter describes the evolution and implementation of SNP policies by CMS. It then gives a brief history of numerous demonstrations that pioneered the development of special programs for special needs groups. (In many ways, these programs can be legitimately viewed as early prototypes for SNPs and, as already noted, two of them were explicitly cited in the MMA conference report as examples of existing programs serving special needs populations.) The chapter concludes with a brief overview of the evaluation design. With a due date of December 31, 2007, a full evaluation of the impact of SNP plans on the quality and cost of care provided to special needs populations was not feasible since the data required for such an evaluation were not available in time for inclusion in this report. Most of the information gathered for the report is descriptive in nature and is intended to provide early indications and impressions. The descriptive information is supplemented by analyses of the data that were available, at the time the study was conducted, from CMS enrollment and payment files and from bids submitted by SNPs and comparison plans.

2. Evolution of CMS Policies

Perhaps the most important policy change that enabled the implementation of SNPs was the introduction of the Hierarchical Condition Category (HCC) risk adjusted payment model in 2004. The implementation of this new payment model was unrelated to the introduction of SNPs, but without the resulting increased accuracy of payments, it would not have been possible for SNPs to target special populations. The previous payment system, based only on demographic factors, underpaid plans that disproportionately enrolled more medically complex beneficiaries. The HCC model, which uses diagnostic as well as demographic information, generates more accurate payments for both frail and healthy beneficiaries and thus makes it possible for plans to target the former without the adverse financial impact that would have resulted under the previous payment system.

Additional policy changes pertaining directly to SNPs are summarized in Table I.1. Note that the content of this report does not pertain to the legislative changes to the SNP program as were enacted in the MMSEA and MIPPA. These changes, however, are included in the table.

TABLE I.1

POLICY CHANGES CENTRAL TO THE EVOLUTION OF SNPS

CMS call letter issued June 22, 2004

- Invited interested plans to submit applications for SNPs serving dual-eligible and institutionalized beneficiaries for contract year 2005.
- Did *not* solicit applications for chronic-condition SNPs, but promised guidance about these types of plans through later rulemaking.

CMS Medicare Advantage Program regulation: Preamble to Final Rule January 28, 2005 (*Federal Register*, vol. 70, no. 18)[a]

- Stated that for contract year 2006, CMS would consider proposals for chronic-condition SNPs on a case-by-case basis; "[b]ecause this is a new 'untested' type of MA plan, we are not setting forth in regulation a detailed definition of severe and disabling chronic condition that might limit plan flexibility." (p. 4596)
- Stated that "those individuals living in the community but requiring a level of care equivalent to that of individuals in . . . long-term care facilities" would be considered institutionalized. (p. 4596)
- defined a disproportionate percentage SNP as "one that enrolls a greater proportion of the target group of special needs individuals than occurs nationally in the Medicare population based on data acceptable to CMS." (p. 4595)

CMS call letter issued April 15, 2005

- CMS announced that, subject to prior CMS approval, Managed Care Organizations (MCOs) with Medicaid managed care contracts would be allowed to passively enroll members of their Medicaid plan into their Medicare dual eligible SNP. To passively enroll dual eligibles, plans were required to submit proposals to CMS stipulating that they would not charge premiums for Medicare Part A and Part B services and would retain qualified Medicaid providers in their networks. Plans were also required to send a CMS-approved letter to members, notifying them that they would be enrolled in the SNP on January 1, 2006 unless they notified the plan that they did not wish to be so enrolled.

CMS call letter issued April 19, 2007, announced new subsets for dual-eligible plans

- Prior to 2008, CMS allowed SNPs to limit enrollment to all dual eligibles or just to dual eligibles with full Medicaid benefits. For contract year 2008, four dual-eligible SNP subsets would be permitted: (1) All dual eligibles (those with comprehensive Medicaid benefits as well as those with more limited cost sharing such as QMBs, SLMBs, and QIs); (2) Full dual eligibles (those with comprehensive Medicaid benefits); (3) Zero Cost Sharing dual eligibles (QMB-only or QMB with comprehensive Medicaid benefits) and (4) Medicaid subsets - subsets of dual eligibles that coincide with existing or proposed subsets in Medicaid managed care contracts. For this SNP sub-type, CMS requires an applicant MCO to provide written documentation that the State approves the proposed sub-setting methodology.

Increased Specification of Models of Care

- The application for contract year 2008 required SNPs to provide a much more detailed description of their models of care. The model of care must be specific enough to clearly identify what process and outcome measures could be used by a SNP to determine if the structures and processes of care were having the intended effect on the target population. Protocols must be specific enough to define the circumstances or conditions under which specific actions should be taken. The model of care must describe the types of clinicians who would be involved, the types of clinical expertise that would be required, how clinical care would be organized and delivered, and the special benefits and services that would be provided to meet the special needs of members.
- The 2008 application also added the requirement that an institutional SNP must have written contracts with every nursing facility in which it operates. The contracts must describe in detail the nature of the relationship between the SNP and the nursing facility, delineating the responsibilities of each party and describing how they will coordinate patient care activities.

Quality Measurement Initiatives

- CMS collaborated with the National Committee for Quality Assurance (NCQA) and the Geriatric Measurement Advisory Panel (GMAP) to select evaluation measures that were SNP-specific. The proposed measures were posted for public comment by NCQA on December 12, 2007. In 2008, NCQA will begin a three-year strategy to collect and analyze these evaluation measures. In the first year, NCQA will collect 13 HEDIS measures and 13 structure/process measures (existing NCQA accreditation measures) from every SNP at the plan level. HOS and CAHPS will collect 2008 survey data at the contract level for SNPs. In year two, NCQA will expand the number of HEDIS and structure/process measures to include measures that focus on the care for older adults. Benchmark measures will be tested as well and CAHPS and HOS will be collected by each SNP. If the SNP legislation is extended beyond its projected December 31, 2009 sunset, NCQA may expand the HEDIS measures to include access/availability of care, service utilization, and cost of care in year three.

Extension of SNP Authority

- On December 29, 2007, the President signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 [42 U.S.C. 1395w-21(b)(1) and (2) of the Social Security Act]. Section 108 of the statute extended the SNP enrollment authority to December 31, 2009. The statute precludes the designation of MA plans as SNPs after January 1, 2008. In addition, the statute restricts SNP enrollment to existing SNP service areas which were open for enrollment on January 1, 2008.

- On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (PL 110-275) was enacted. Section 164, for which CMS is developing guidance, include the following changes to SNPs:

  - Extending the SNP program through December 31, 2010.
  - For CY 2010, a new moratorium precludes CMS from approving other plans as SNPs.
  - New requirements were added for institutional, dual eligible and disabling or chronic condition SNPs. In 2010, all new enrollees must meet the definition and requirements as "institutionalized" or "institutional equivalent"; as "dual eligible"; or must meet the definition and requirements for the "chronic condition."

Table I.1 *(continued)*

- All new and existing SNPs must meet care management requirements in 2010.
- SNPs shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the model of care for each SNP type in 2010.
- All new dual-eligible SNPs must have a State contract that provides or arranges for benefits under Title XIX in 2010. During 2010, existing 2009 dual-eligible SNPs without Medicaid contracts will not be allowed to expand their service area.
- States are not required to enter into a contract with the MA organization.

CMS was tasked to convene a panel of clinical advisors to determine the chronic conditions that meet the definition of severe or disabling chronic condition. It will also provide staff and resources that can address coordination of the State and Federal programs with respect to dual-eligible SNPs for State inquiries.

[a]Subsequent instructions and guidance were provided to potential MA applicants through the annual MA application process, through materials disseminated via CMS's Health Plan Management System, and through conferences with health plans and interested outside organizations. In the application cycles for contract years 2005 through 2008, CMS provided much of its guidance through annual "call letters" and advance notices of change in payment policies.

[b]QMB - Qualified Medicare Beneficiary; SLMB - Specified Low-Income Medicare Beneficiaries; QI - Qualified Individuals.

B. FINDINGS FROM CMS DEMONSTRATIONS SERVING SPECIAL POPULATIONS

Underpinning the creation of SNPs is the idea that concentrating certain groups into a managed care arrangement leads to benefits, including better health outcomes, more efficient care delivery, and reduced acute-care use. The specific mechanisms that bring about these benefits may vary across types of SNP. For each of these interventions, however, there are evaluations of CMS demonstration projects that provide relevant findings. Results of these evaluations are discussed in the following three sections.

1. Dual-Eligible Demonstrations

Dual eligibles require more health care services, on average, than do other Medicare beneficiaries. They are more likely to have chronic illnesses, are more likely to be disabled, and are more likely to be hospitalized. The wide variety of health problems and the frequency with which these problems may be accompanied by non-medical issues such as inadequate caregiver support, substandard housing, and language barriers make it difficult to design effective interventions, particularly if the interventions are limited to Medicare-covered services. Even joint provision of Medicare and Medicaid services under managed care contracts may be of limited value unless the Medicaid services include long-term care services such as nursing-home care, personal care, and other community supportive services.

CMS has supported three demonstration programs that provide Medicare and Medicaid services to dual eligibles under joint capitation arrangements—two in Minnesota and one in Massachusetts[7]. The Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) provide acute and community based[8] long-term care services to elderly and

[7] While the Wisconsin Partnership Program demonstration is usually included in the category of dual eligible demonstrations, we discuss it in the section on nursing home demonstrations because it limits enrollment to beneficiaries requiring a nursing home level of care. WPP plans were originally approved as institutional SNPs although they were recently reclassified as dual eligible SNPs with institutional equivalent subsets.

[8] Plans are at risk for the first 180 days of nursing home care only.

disabled dual eligibles in the State. MSHO began operation in 1997, MnDHO in 1999. All members in both programs are assigned a coordinator at the time of their enrollment. The coordinator ensures that each member has an ongoing source of primary care and manages primary, acute, and long-term care services across all settings. To facilitate early intervention and management of chronic conditions and manage access to community-based services, all members are assessed within 30 days of enrollment.

An evaluation of the two Minnesota programs was performed by Kane and Homyak (2003). For many of the outcome measures examined, there was no significant difference between MHSO or MnDHO and a fee-for-service comparison group. They did find, however, that preventable emergency-department admissions were significantly reduced among MSHO and MnDHO members and that hospital length of stay was reduced.

The Massachusetts Senior Care Options (SCO) Dual Eligible Demonstration began operation in 2004. SCO plans deliver care through a geriatric model, financed by the pooling of Medicare and Medicaid revenues at the plan level. Like plans in the Wisconsin Partnership Program demonstration (WPP), SCO plans use care teams rather than a single coordinator to develop care plans and manage member care across settings. Unlike the Wisconsin and Minnesota demonstrations, SCO plans provide care only to aged dual eligibles. The SCO program has not been subject to an evaluation of its cost effectiveness and quality as were the Wisconsin and Minnesota demonstrations, but it incorporates many of their features. All three demonstrations are described in detail in a recent report by Leutz et al (2007).

2. Nursing Home Demonstrations

Institutional SNPs may serve two distinct categories of beneficiary: long-term nursing-home residents and community residents who are certified by their State as requiring a nursing-home level of care. A common complaint about nursing homes is that operators have little incentive to provide skilled monitoring and preventive care for residents. Therefore even minor medical problems can lead to emergency-room visits and perhaps inpatient admissions. An institutional SNP that is at risk for acute care services can place its own nurses or nurse practitioners in nursing homes to help prevent exacerbations of mild conditions and thereby reduce the rate of hospitalizations.

The Evercare demonstration, which served nursing home residents exclusively, was an early prototype for institutional SNPs. Evercare plans placed nurse practitioners in nursing homes to monitor residents and to communicate directly with hospital staff if residents required hospitalization. An evaluation found dramatic reductions in use of acute care by Evercare members, with no adverse effects on care quality, relative to comparison groups of nursing home residents not receiving the intervention (Kane and Keckhafer 2002).

Institutional SNPs may also target beneficiaries who live in the community but are certified by their State as requiring a nursing-home level of care (we refer to these as institutional equivalent SNPs). Two demonstrations have targeted such beneficiaries with interventions that fully integrate Medicare and Medicaid services: (1) the Program for All-Inclusive Care of the

Elderly (PACE), and (2) the Wisconsin Partnership Program (WPP)[9]. Both provide integrated medical, restorative, and long-term care funded by pooled Medicare and Medicaid capitation payments. Both use interdisciplinary care teams of physicians, nurses, and social workers to oversee patient care, though PACE teams also have additional disciplines such as therapists, home care coordinators and dieticians. The two programs differ primarily in their locus of care. Most PACE care is provided at centers that typically house both a day program and a health clinic with primary care physicians, nurses, and rehabilitative staff present. In contrast to PACE, the WPP plans provide most healthcare services through contracted providers and, with certain exceptions[10], do not operate day programs or primary care centers. A WPP nurse practitioner serves as team leader and is responsible for maintaining communication with each member's primary care physician and obtaining his or her input into the treatment planning process.

An early evaluation of PACE found the program to be associated with reduced likelihood of hospital admission and reduced number of nursing home days relative to a comparison group of beneficiaries who expressed interest in PACE but did not enroll (Chatterji et al. 1998). However, a later evaluation found that the combined Medicare and Medicaid capitation payments were somewhat higher than they would have been in the absence of PACE (again comparing PACE participants to those interested in the program but not participating) (White et al. 2000). However, evaluation data permitted cost projections only for a single year following PACE enrollment.

An evaluation of the WPP (Kane and Homyak 2004) found relatively modest differences among the WPP program and three comparison groups: (1) participants in the State's Medicaid home- and community-based waiver program who resided in a WPP county; (2) participants in the waiver program who did not reside in a WPP county; and (3) participants in PACE who resided in a WPP county. WPP participants had somewhat fewer preventable hospital admissions than the second comparison group and fewer emergency-room visits than either the first or second comparison groups. There was also a modest trend suggesting lower mortality for WPP enrollees with disabilities compared to similar non-enrolled beneficiaries in the two waiver participant comparison groups. PACE participants had slightly lower rates of hospitalization but did not differ from WPP participants in the overall number of hospital days per member year. The evaluation was limited to the first three years of the demonstration. Two of the plans were evolved from Centers for Independent Living and had no prior experience as healthcare providers or as MCOs so that only a minority of the enrollees in these plans were exposed to fully developed programs for more than a year. In contrast, both the PACE and waiver programs had been in operation for many years at the time of the study.

[9] PACE, which began as a Medicare demonstration in 1990, became a permanent part of the Medicare program under the BBA and thus had no need to seek approval as a SNP. The WPP plans have operated under demonstration authority, which will end December, 31, 2007. However, they, along with other demonstration programs, are transitioning from demonstration to regular program status as SNPs. (This is discussed more fully in Section C.)

[10] The exceptions are two organizations, one that operates its WPP plan side-by-side with its PACE plan, and a second that was previously a PACE plan. The former provides access to PACE facilities and services for some of its WPP members and the latter continues to provide day program services for some of its WPP members in space previously used for this purpose by its PACE program.

The Social Health Maintenance Organization (S/HMO) demonstration plans - ElderPlan and Senior Care Action Network (SCAN) - also served institutional-equivalent beneficiaries, although they comprised a relatively small portion of their total membership. S/HMO plans received a supplement to the regular Medicare capitation payment to provide care coordination and expanded community long-term care services. The plans were at risk for acute care benefits but not for institutional care. Evaluations of the S/HMO plans by Newcomer et al. (1995) and Wooldridge et al. (2001) found no consistent evidence, as of 2000, that they improved beneficiary outcomes. The S/HMOs have continued to evolve since these evaluations were completed, however. In 2005, ElderPlan initiated a virtual team-based approach to support its members, using proprietary software to aid prevention of adverse events. Both SCAN and ElderPlan were rated among U.S. News's Best Health Plans of 2006.

3. Chronic-Condition Demonstrations

Chronic-condition SNPs are meant to provide the type of disease management interventions that have recently become popular in commercial managed care plans and some Medicaid programs. Plans that enroll a sufficient number of members with a specified illness or condition can thereby invest in targeted interventions designed to provide a point of contact for members in order to provide information about worrisome symptoms, educate members about their illness, attempt to change some behaviors, such as smoking, diet, and exercise, and improve their ability to manage certain aspects of their condition. Moreover, by relying on explicit disease-management protocols for treating chronic conditions, together with systematic monitoring and contact with members, plans can provide care using established evidence-based clinical practices. If plans succeed in these efforts and if the progression of chronic illness is sufficiently sensitive to altered behavior and management, then disease management, and by extension, chronic condition SNPs, may improve health outcomes and reduce acute-care needs by beneficiaries with chronic conditions.

Numerous studies have arrived at conflicting assessments about the promise and effects of disease management. A recent random-assignment-based evaluation of a CMS demonstration of 15 coordinated care programs for fee-for-service Medicare beneficiaries with chronic illness found that only one appeared to reduce the probability of hospitalization during the first year after enrollment (Brown et al. 2007). None was associated with substantially improved patient adherence to treatment recommendations or with reduced Medicare spending. Program participants, however, were highly satisfied with the care they received, and physicians tended to rate the programs highly. Outcomes of these demonstrations over three years will be available in a separate Report to Congress. CMS has also funded a random-assignment-based evaluation of disease management programs supplemented with a prescription drug benefit for fee-for-service Medicare beneficiaries (which predates implementation of Medicare Part D). Results of that evaluation can be found in Peikes et al. (2007).

C. CONVERSION OF DEMONSTRATION PLANS TO SNPS

Over the same period that it was developing SNP policies, CMS was working with demonstration programs to help them to transition from demonstration to regular program status as SNPs. These demonstrations had targeted subsets of beneficiaries with special needs and had substantial experience in developing specialized services for their populations. Waivers for

many of the demonstrations were set to expire at the end of 2007 and the SNP legislation was critical in allowing these plans to continue operating without demonstration waivers.

The following demonstrations have become SNPs and are currently operating under regular MA program authority or will be doing so by January 1, 2008:

- The Evercare demonstration - The Evercare demonstration plans, serving institutionalized beneficiaries, were designated as institutional SNPs effective January 1, 2005, and have operated without demonstration waivers since that time.
- Capitated Disease Management Demonstration - Two of the sites approved for the capitated disease management demonstration were approved as chronic condition SNPs for contract year 2006. These sites were thus able to implement their programs even though the demonstration itself was cancelled.
- Social/Health Maintenance Organizations (S/HMOs) - The ElderPlan S/HMO became an institutional-equivalent SNP effective January 1, 2006; one of the SCAN S/HMOs became a chronic condition SNP effective January 1, 2006 and another became an institutional-equivalent SNP effective January 1, 2007.
- Medicaid/Medicare Integration Demonstrations - Participating plans in Massachusetts and Minnesota were approved as dual-eligible SNPs and the Wisconsin plans were approved as institutional SNPs, all effective January 1, 2006. As of 2008, the Wisconsin plans will be re-classified as dual eligible SNPs with Medicaid subsets. With the exception of a frailty adjustment provided under a Medicare 402/222 payment waiver,[11] all of the Medicaid/Medicare integration demonstration plans are operating under the same regulations as other MA SNPs. The frailty adjustment will be phased out by the end of 2010.
- End-stage Renal disease (ESRD) demonstration - This demonstration began enrolling participants in 2006. Two of the participating plans were also approved as chronic condition SNPs effective January 1, 2006. This will allow them to continue serving ESRD beneficiaries when the demonstration ends.

Many of these demonstration plans had managed care contracts with both Medicare and Medicaid. They relied, in varying degrees, on demonstration waivers to reconcile conflicting requirements arising from the different legislative and regulatory authorities governing Medicare and Medicaid (for example, regarding quality improvement, enrollment, marketing, grievances, and program monitoring). As the demonstration programs became SNPs, they had to find ways to reconcile the conflicting requirements without demonstration waivers. Similar challenges were faced by MCOs that sought to align new dual-eligible SNPs with existing Medicaid plans. To assist all of these plans, CMS formed a workgroup that identified areas in which Medicare and Medicaid regulations appeared to conflict and issued a series of working papers[12] to provide

[11] Section 402 of the Social Security Amendments of 1967 (PL 90-248) and Section 222 of the Social Security Amendments of 1972 (PL 92-318).

[12] See http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#

guidance to States, health plans, and CMS regional offices on how to accommodate Medicare and Medicaid requirements in ways that facilitated the integration of the two programs at the plan level. A second goal of this work group was to eliminate or minimize duplicative oversight and monitoring activities, an effort that is ongoing.

D. OVERVIEW OF THE EVALUATION DESIGN

The SNP evaluation sought to answer basic questions about plan features and member interventions, trends in the growth of plans, relationships between plans and State Medicaid programs, the types of beneficiaries who enrolled in the plans, and the relationship of SNP bids to bids of other MA plans.

The evaluation drew on multiple data sources to address these questions (Table I.3). It administered a mail survey of SNPs to provide an overview of all plans operating in 2006, including their provider networks, relations with Medicaid, and member interventions. So that it could describe plan features and operations in detail, it conducted site visits with selected plans and parent organizations that operated multiple plans. To gain the member perspective on plan operations, it also conducted focus groups with members of many of the visited plans. Interviews with State Medicaid officials gauged State government reaction to SNPs and in particular to dual-eligible SNPs. One focus of these interviews was the willingness of States to contract with SNPs for the provision of Medicaid services to dual-eligible SNP members.

TABLE I.2

SNP EVALUATION RESEARCH QUESTIONS AND DATA SOURCES, WITH CHAPTER CONTAINING FINDINGS

Research Question	Data Source	Report Chapter
How have plans proliferated, and how has enrollment grown since 2004?	CMS 2006-2007 MA payment files CMS Health Plan Management System (HPMS) CMS Medicare Beneficiary Database (MBD) CMS 2008 SNP Application File	II
What are the basic features of SNPs operating in 2006?	MPR SNP mail survey CMS 2006 SNP Application File	III
What specific steps did SNPs take in 2006 to improve care for their special-needs target populations?	MPR site visits to selected plans MPR focus groups with members of selected plans	IV
To what extent did States develop relationships with SNPs to better coordinate Medicaid and Medicare services?	MPR site visits with selected State Medicaid and Medicare regional office staff	V
How did 2006 SNP members compare with other Medicare beneficiaries who were eligible to enroll but did not?	CMS Enrollment Database (EDB) CMS MBD CMS 2006 Budget Neutrality file for HCCs CMS MA payment files CMS Minimum Dataset (MDS) CMS CCW Beneficiary 2005 Summary file	VI
How did the bids of SNPs compare to those of other MA plans?	CMS 2006 and 2007 plan bid data files	VII
Do SNPs appear to have the potential to improve care quality for their target populations? What are the effects of SNPs on Medicare costs?	Synthesis of quantitative and qualitative evaluation findings	VIII

Note: CCW = Chronic Condition Warehouse.

The evaluation also used a variety of administrative databases to examine plan growth, to compare plan members with eligible nonmembers, and to assess differences in bids. Data from the Health Plan Management System Payment Files were used to describe SNP enrollment and disenrollment between January 2005 and March 2007. These data were merged to another CMS database to estimate the number of dual-eligible beneficiaries who were passively enrolled into SNPs in 2006. The evaluation used the 2005 Medicare Beneficiary Database, the Minimum Data Set for nursing home residents, and HCC risk-group data to identify Medicare beneficiaries in individual SNP market areas who appeared eligible to enroll in SNPs but did not enroll (that is, eligible non-enrollees), in order to compare them to SNP members. The MA bid data for SNPs were compared with those of similar non-SNP MA plans in the same market area for 2006 and 2007 as a means of determining whether there were systematic differences between the two types of plans.

Some analyses that might ordinarily be conducted as part of an evaluation were precluded in this case by time and data limitations. A typical approach to evaluation of beneficiary outcomes associated with SNP enrollment might compare the trajectory of utilization and health status for beneficiaries enrolled in SNPs with those of selected comparison group beneficiaries who were similar in terms of demographic characteristics and prior health status and utilization. That strategy is not available here for two reasons. First, SNPs were approved as regular MA plans, not as demonstration projects. SNPs therefore report only those data that are required of all other MA plans, including the Health Plan Employer Data and Information Set (HEDIS) and the Medicare Health Outcomes Survey (HOS). No beneficiary-level claims or encounter data are available that would permit comparison with non-enrollees. Second, the time frame for the evaluation requires analyses to be completed before other data such as the 2006 HEDIS and HOS surveys or HCC risk scores reflecting 2006 diagnoses become available. Later analyses of SNP outcomes could employ these data to compare the risk status, utilization, and personal assessments of SNP enrollees with those of similar beneficiaries in fee-for-service Medicare or non-SNP MA plans.

The assessment of the impact of SNPs on Medicare costs and the quality of care will rely primarily on comparisons of SNPs with other MA plans. While such comparisons are useful, they should be considered in the context of broader changes that were occurring as a result of the MMA. The quantitative analyses reported in this evaluation focus primarily on SNP operations in 2006, the same year in which two major changes were introduced to the MA program - the Medicare Part D drug benefit and competitive bidding. As a result, SNPs - a substantial number of which were in their first year of operation - were implementing two major new Medicare initiatives at the same time that they were implementing their special needs programs. In addition, MA plans were also midway through the process of implementing risk adjustment, a major change in payment methods mandated by the Balanced Budget Act (BBA) of 1997. This required MA plans to transition from a relatively simple system of payment based on demographic factors to the HCC payment model, a much more complex system based on the diagnoses of individual plan members. The transition began in 2004 and most MA plans completed the transition and were receiving fully risk-adjusted payments as of January, 2007. Demonstration plans that became SNPs were granted an additional year to complete the transition.

E. ORGANIZATION OF THE REPORT

The remainder of this report is organized as follows. Chapter II describes the growth of Medicare SNPs and SNP enrollment from 2004 to 2007. Chapter III briefly describes results of a mail survey of SNPs in operation in 2006, highlighting their means of assessment and provision of special services. Chapter IV describes the operation of SNPs as observed during site visits to 11 SNPs and focus groups with members of 9 of those same organizations. Chapter V assesses the perspective of State Medicaid agencies about SNPs and the prospects for joint Medicare-Medicaid contracting with SNPs. Chapter VI contains an analysis of the characteristics and health risk of SNP enrollees compared with those of samples of eligible non-enrollees. Chapter VII compares the bids of SNPs for plan years 2006 and 2007 with those of other non-SNP MA plans. Chapter VIII presents conclusions.

II. THE EVOLUTION OF SNPS: 2004 - 2008

This chapter examines the characteristics of SNPs and their enrollees from 2004, when the first SNPs were approved, through 2008. It draws on data from the Health Plan Management System (HPMS), the Medicare Enrollment Database (EDB), MA Payment files, and data provided by CMS identifying plans approved to passively enroll dual-eligible beneficiaries in 2006. The first section below describes the growth in the number of SNPs from 2004 through 2008 and in their enrollment through March 2007. The second section examines the characteristics of SNP plans with accompanying enrollment numbers to provide perspective on the relative number of beneficiaries enrolled in plans of various types.

A. THE GROWTH OF SNP PLANS

1. Terminology

For purposes of clarity, we will begin this section by defining the terms that will be used in discussing managed care organizations. The terms "managed care plan" or "plan" are often used interchangeably with the term "managed care organization", but the term "plan" has a specific meaning in CMS administrative terminology and it is therefore important to be precise in how we use these and related terms.

For administrative purposes CMS defines a plan as a distinct combination of services (benefits), premiums, and cost sharing arrangements offered in a specified service area as part of a contract between CMS and a Managed Care Organization[13] (MCO). "Plan" is shorthand for "plan benefit package" (PBP). Contracts may be regional - covering CMS defined areas of one or more States - or local - limited to a single State or portions of a State. An MCO may have one or more contracts with CMS in different States or regions as well as contracts with State Medicaid agencies. A SNP is a plan as defined above; an MCO may offer one or more SNPs, along with one or more regular plans under the same or different contracts.

Medicare MCOs are part of the Medicare Advantage (MA) Program (often referred to as Medicare Part C), which includes several types of coordinated care plans[14] as well as medical savings accounts, and private fee-for service plans. SNPs are a type of coordinated care plan, defined in 42CFR422.4 as a plan that has (1) a network of contracted providers approved by CMS, (2) mechanisms to control utilization, and (3) financial arrangements with providers that offer incentives to furnish high quality and cost-effective care. Coordinated care plans include local and regional preferred provider organizations (PPOs), health maintenance organizations

[13] CMS actually uses the term Medicare Advantage Organization (MAO) to refer to the contracting entity. We decided to use MCO to refer to the contracting entities responsible for SNPs because MAO includes Medical Savings Accounts and Private Fee-for-Service Plans, which cannot be SNP sponsors.

[14] The reader will note that the use of the term "plan" in the Medicare regulations sometimes differs from its usage in this report)

(HMOs), and provider sponsored organizations (PSOs), but not private fee for service (PFFS) plans.

2. An Overview of SNP Growth

SNPs vary widely in terms of both enrollment and service areas making it impossible to describe SNP growth accurately using plan numbers alone. One MCO, for example, has two dual-eligible SNPs - one covering all of northern California and the other covering all of southern California. Their combined enrollment exceeds 50,000 members. In contrast, another MCO in a different State offers 28 dual eligible SNPs with service areas that correspond to individual counties and overall enrollment of fewer than 10,000 members. Aside from the fact that they have different service areas, the 28 SNPs appear to be identical except for relatively minor variations in premiums and cost sharing requirements. As these examples indicate, plan numbers alone are not a reliable measure of SNP growth. They should be used only in conjunction with enrollment numbers as a means of describing SNP growth.

Table II.1 presents the number of plans and the number of beneficiaries ever enrolled from 2004 through March, 2007. It also includes the number of plans that may be available in 2008 based on applications submitted in 2007. The sharp growth in the number of plans over the period is evident. The total number of plans doubled between 2005 and 2006, and increased by another 78 percent between 2006 and 2007. Over 880,000 Medicare beneficiaries were enrolled in a SNP at some point in the first three months of 2007. A substantial majority of SNP members are enrolled in dual-eligible SNPs. The number of beneficiaries enrolled in dual-eligible and chronic condition SNPs grew slowly between 2006 and 2007. The rapid increase in enrollment in institutional equivalent SNPs between 2006 and 2007 was accounted for almost entirely by the conversion of the Senior Care Action Network (SCAN) S/HMO demonstration plan, with about 90,000 enrollees, to SNP status on January 1, 2007.

Figure II.1 shows that there were sharp spikes in SNP enrollment each January, followed by more gradual growth for dual-eligible SNPs and limited growth for institutional SNPs and chronic condition SNPs during the remainder of each year. The underlying reasons for the growth patterns in Figure II.1 will be discussed next.

TABLE II.1

PLANS AND ENROLLEES, BY SNP TYPE: 2005-2008

	Institutional SNPs: Institutional		Institutional SNPs: Institutional Equivalent		Dual-Eligible SNPs		Chronic condition SNPs		Total	
	Number of Plans	Ever Enrolled	Number of Plans	Ever Enrolled	Number of Plans	Ever Enrolled	Number of Plans	Ever Enrolled	Number of Plans	Ever Enrolled
2004[a]	0	0	0	0	11	12,774	0	0	11	12,774
2005	29	25,329	0	0	108	103,896	0	-	137	129,220
2006	32	27,489	5	21,711	226	626,605	13	87,502	276	747,430
2007[b]	70	33,633	14	112,626	323	654,458	84	90,467	491	887,583
2008 Applications[c]	75	n.a.	15	n.a.	461	n.a.	264	n.a.	815	n.a.
% Increase (2005-2006)	7%	9%	n.a.	n.a.	109%	503%	n.a.	n.a.	101%	478%
% Increase (2006-2007)	119%	22%	133%	419%	43%	4%	546%	3%	78%	19%
% Increase (2007-2008)	7%	n.a.	14%	n.a.	43%	n.a.	214%	n.a.	66%	n.a.

Sources: MPR analysis of Medicare Health Plan Management System (HPMS) and HMO Payment Files.

Notes: 2005 SNP enrollee counts are missing approximately 1,280 enrollees in two plans (H4454 009 and 010). Table does not include people who only had SNP payment records in months after a date of death on CMS enrollment files.

Institutional SNPs include institutional and institutional-equivalent plans. Because some beneficiaries enrolled in more than one type of plan during a year, enrollment by type of plan will not sum to "All SNP" total; 2007 enrollment is as of March 2007.

The number "Ever Enrolled" indicates the number of beneficiaries enrolled in a SNP for at least one month during the designated year.

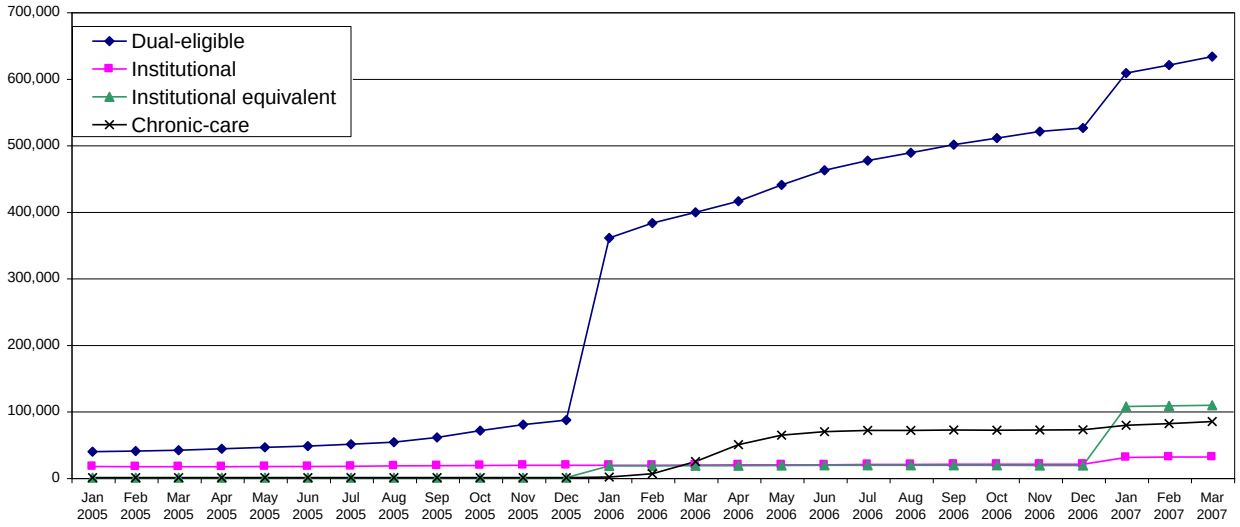
[a] 2004 enrollment is as of December 2004.

[b] 2007 enrollment is through March 2007.

[c] Of the 815 applications submitted, 97 were still pending approval based on information provided by CMS in June, 2007. Of the pending approvals, 3 were for I SNPs, 71 for Dual-Eligible SNPs and 23 for CDC SNPs.

FIGURE II.1

2005-2007 SNP ENROLLMENT, BY SNP TYPE



Source: CMS HMO Payment files.

3. The Impact of Enrollment Policies on SNP Growth

Most of the spikes in enrollment that occurred in January of each year (Figure II.1) are attributable to CMS policy decisions concerning enrollment. The policy decisions having the greatest impact on enrollment trends were those pertaining to election periods and passive enrollment. Intra-MCO transfers (from a non-SNP plan into a SNP within the same MCO) were initiated either by the MCOs or by beneficiaries and did not result from a CMS policy decision.

a. Election Periods and Enrollment Procedures

Enrollment in an MA plan is a two-step process in which a beneficiary first chooses (elects) to join or change a plan and then implements that election by enrolling or disenrolling.[15]

Election Periods – All Medicare Advantage eligible beneficiaries may elect to enroll in or disenroll from an MA plan during the annual election period (AEP) that runs from November 15 through December 31 each year. An individual is eligible to elect an MA plan when s/he meets certain conditions, such as entitlement to Medicare Part A and enrollment in Part B, permanently resides in the service area of the MA plan, is not medically determined to have ESRD, etc.). Medicare Advantage also provides an initial coverage election period (ICEP) that is available to

[15] Election and enrollment rules are complex and the present discussion summarizes only those that are most relevant to SNPs. A complete presentation of these rules can be found in Chapter 2 of the Managed Care Manual (http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/Chapter2UpdateMAEnrollmentDisenrollment.pdf).

beneficiaries when they first become entitled to both Medicare Part A and B. There are also numerous special election periods (SEPs) available to beneficiaries in specific circumstances.

Finally, during the Open Enrollment Period (OEP) an MA eligible beneficiary may make one MA OEP election from January 1 through March 31 each year, which will be discussed in more detail in the next section.

1. **Dual Eligibles** – Individuals who are entitled to Medicare Part A and Part B and receiving any type of assistance from the Title XIX (Medicaid) program have an SEP that begins the month the individual becomes dually-eligible and exists as long as he or she receives Medicaid benefits. An SEP is also available to individuals who lose their Medicaid eligibility. (Neither SEP is limited to dual eligibles seeking to enroll in or disenroll from SNPs, but apply to all MA plans.)

2. **Individuals Who Lose Special Needs Status** – CMS provides an SEP for those enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. This SEP begins the month the individual's special needs status changes and ends the earlier of when the beneficiary makes an election or three months after the expiration of the period of deemed continued eligibility.

3. **Individuals with Chronic Conditions** – CMS provides an SEP (for MA and Part D) to allow individuals with severe or disabling chronic conditions to enroll in a Chronic Condition SNP. The SEP begins when the individual is diagnosed with the qualifying condition and ends once he or she enrolls in a SNP. Once the SEP ends, that individual may make changes only during regular MA election and open enrollment periods.

Enrollment Procedures – Elections made during an AEP become effective on January 1 of the following year. Elections made during ICEPs and SEPs generally become effective on the first day of the month following the month in which the election is made.

As indicated earlier, elections can also be made during open enrollment periods, although MA organizations are not required to open their MA plans for enrollment during an OEP. The following are the open enrollment policies most relevant to SNPs (although they are not necessarily limited to SNPs):

1. **2006 Open Enrollment**[16] - any MA eligible individual was allowed to make one MA OEP election from January 1 through June 30, 2006.

2. **Open Enrollment for 2007 and subsequent years** – the OEP is from January 1, through March 31.

[16] Part D enrollment rules differ slightly from the MA rules. When Part D coverage was introduced in 2006, the initial election period ran from November 15, 2005 through May 15, 2006. The AEP is often referred to as "Open Enrollment" which can be confusing and is technically not correct. The open enrollment period established by the MMA is limited in scope and intended only to allow beneficiaries an opportunity to change Part D plans but not to pick up or drop Part D coverage.

3. **Open Enrollment for Institutionalized individuals (OEPI)** – any institutionalized individual (including community resident individuals who qualify for an Institutional Equivalent SNP) may elect to enroll in or disenroll from a plan at any time during the year and can make an unlimited number of elections during the year.

While open enrollment periods in 2006 and subsequent years have allowed beneficiaries to enroll in MA plans after January 1, most enrollment decisions continue to be made during the annual election period from November 15 to December 31, becoming effective on January 1 of the following year. Accordingly, a major portion of MA enrollment continues to become effective in January. However, the greater flexibility of SNP-eligible beneficiaries to enroll and disenroll throughout the year, and the ability of SNPs to use more targeted marketing strategies has resulted in a comparatively robust growth in SNP enrollment throughout the year.

b. Determinants of SNP Enrollment Patterns

The trends in SNP enrollment shown in Figure II.1 reflect the combined effects of a number of factors that are described in detail below. One of these factors was passive enrollment, a one-time occurrence that contributed substantially to the large spike in enrollment that can be seen in January, 2006. Two other factors - intra-MCO transfers and plan redesignations - had significant impacts in 2006 and 2007, but are unlikely to play a significant role in future enrollment gains. A final factor, and one that contributes substantially to the steady increases in enrollment that can be seen from February through December, is the ability of beneficiaries to enroll in SNPs in any month of the year.[17]

Passive Enrollment. Passive enrollment (described in Section B.1) took place in 2006 on a one-time basis. We identified beneficiaries who were passively enrolled into SNPs by means of an indicator variable in the Medicare Beneficiary Database (MBD) used by Medicare to prevent SNP plan members from being auto-enrolled in a Part D plan other than the one provided by their plan.[18] We defined a beneficiary to be passively enrolled if (1) the MBD contained a Part D opt-out reason code of "SNP" and (2) he or she was enrolled, between November, 2005 and March 2006, into a SNP approved by CMS for passive enrollment. (A small number of beneficiaries with the SNP flag were enrolled prior to

[17] Institutionalized beneficiaries and dual eligible beneficiaries were already allowed to enroll and disenroll in MA plans in any month even before the development of SNPs. Beneficiaries with qualifying chronic conditions may enroll for the first time in a chronic condition SNP in any month. Once enrolled for the first time, however, they become subject to the same enrollment limitations as other, non-dual eligible and non-institutionalized beneficiaries.

[18] On January 1, 2006, dual eligible beneficiaries already enrolled in MA plans were to be automatically enrolled in their MA plan's prescription drug plan. Dual eligibles not enrolled in an MA plan could chose to enroll in an MA plan that offered prescription drug coverage or they could remain in traditional Medicare and enroll in a free-standing PDP. If they failed to do one or the other, they were to be automatically enrolled in a free-standing PDP. A mechanism was needed to ensure that beneficiaries, who were selected for passive enrollment into a SNP and who did not opt out, were not auto-enrolled into a free-standing PDP. This was accomplished by giving the MBD indicator a value of "SNP".

January 1 or later in February or March. However 95 percent of passive enrollments occurred in January, 2006).

Redesignation. MCOs were permitted to convert an existing plan into a SNP provided that the SNP offered the same, or more generous, benefits and allowed members who did not meet the SNP enrollment criteria to remain in the plan. We identified a plan as a redesignated SNP if it was identified as a non-SNP plan in one year and as a SNP in the next. Beneficiaries who were enrolled in the new SNP were assigned a flag for redesignation.

Intra-MCO Transfers. Some SNP enrollees, particularly those entering dual eligible SNPs, transferred[19] from another plan operated by the same MCO. These transfers were identified in the payment files as beneficiaries who were enrolled in a non-SNP MA plan in one month and enrolled in the SNP plan in the same MCO the following month.

Otherwise Enrolled. SNP enrollees who were not assigned to one of the above three categories were considered to be otherwise enrolled. Most enrollees in this category simply enrolled in a SNP from traditional Medicare, from another MA plan, or they enrolled in the SNP upon enrolling in Medicare. For ease of exposition, we refer to these enrollees as having actively enrolled.[20]

4. Enrollment and Disenrollment Trends by SNP Type

Tables II.2, II.3, and II.4 each show patterns of enrollment and disenrollment between 2004 and March, 2007. Table II.2 presents a year-by-year sequence, showing number enrolled at the start of the year, number who enrolled, disenrolled, and died during the year, and the number enrolled at the end of the year. Tables II.3 and II.4 show enrollment and disenrollment in 2005/2006 combined and for early 2007 by mode of entry into a SNP.[21] Note that Tables II.2 and II.3 differ in their approach to counting SNP enrollees. Table II.2 counts each enrolled beneficiary, even if he or she enrolled in two different types of SNP during a year. Tables II.3 and II.4 assign each beneficiary to the SNP type in which he or she was *first* enrolled during a year.[22]

[19] Plans must obtain beneficiary consent to such transfers.

[20] Beneficiaries may be erroneously assigned to the "otherwise enrolled" category if administrative data elements are missing. For example, if the Part D opt-out flag was not set to "SNP" for some enrollees, they would inappropriately be categorized as "otherwise enrolled." The "otherwise enrolled" category may therefore overstate the number of beneficiaries who actively enrolled in a SNP.

[21] 2005 and 2006 are combined since our definition of passive enrollment spans the two years. This time period is also the one used for later analysis of enrollee characteristics.

[22] Tables II.3 and II.4 do not distinguish institutional from institutional-equivalent SNPs in the way that Tables II.1 and II.2 do.

The discussion that follows treats the results from both tables by type of SNP. Note that the reported disenrollment rates may overstate the long-term probability of disenrolling from a SNP. Information collected during site visits suggests that many cases of disenrollment occurred because SNP members mistakenly believed they needed to enroll in a Part D prescription drug plan. Enrolling in such a plan, however, automatically disenrolled them from the SNP, a situation they might discover only when they visited a provider who told them they were no longer enrolled. In most cases, it was possible for the plan to correct the problem and re-enroll the beneficiary. (We count disenrollment as any break in enrollment from a plan.)

a. Institutional SNPs

By the end of 2006, enrollment in institutional-equivalent SNPs was nearly equal to that of regular institutional SNPs. During 2007, enrollment in institutional-equivalent SNPs grew much more rapidly, due primarily to the conversion of SCAN Health Plan to this form of SNP. By March, 2007, there were more than three times as many enrollees in institutional-equivalent SNPs as in regular institutional SNPs (Table II.2).[23] Among those first enrolled into institutional SNPs from 2005 to 2006, 30 percent were enrolled at the beginning of 2005 (Table II.3). Roughly 40 percent actively enrolled and 27 percent were in plans redesignated as SNPs. Note that over 100,000 enrollees entered institutional SNPs via redesignation of plans between January 2005 and March 2007, while only about 5,500 beneficiaries entered dual-eligible or chronic condition SNPs in this manner. Enrollees in institutional SNPs that were redesignated from other MA plans were actually somewhat less likely to disenroll than those who actively enrolled.

b. Dual-Eligible SNPs

Though dual-eligible SNPs exhibit higher disenrollment rates than either institutional or chronic condition SNPs, they also show substantial spikes in enrollment at the beginning of each year followed by steady growth through out the remainder of the year[24] (Table II.2). Nearly 48 percent of beneficiaries who first enrolled in a dual-eligible SNP in 2005 or 2006 actively

[23] Of the 109,000 beneficiaries enrolled in institutional-equivalent SNPs in March, 2007, more than 95 percent were enrolled in Elderplan and SCAN. Both are disproportionate percentage SNPs and the target population of community-resident, nursing home certifiable beneficiaries comprises 26% of their combined enrollment as of February, 2007 (data provided by CMS Office of Research, Development, and Information). The remaining 74% of the plans' enrollees are not required to be nursing home certifiable. (CMS policy, described in Table I.1, is that disproportionate percentage plans are not required to limit enrollment exclusively to their target group but must enroll "a greater proportion of the target group of special needs individuals than occurs nationally in the Medicare population based on data acceptable to CM."

[24] Disenrollment rates from dual-eligible SNPs range from 18 to 21 percent in 2005 and 2006, and are substantially higher than the rates for MA plans overall, which average 6 percent according to the current Medicare Personal Plan Finder. At least some of this increase probably results from the freedom of dual eligibles to disenroll in any month and to passive enrollment and plan redesignations. These enrollment methods were unique to SNPs and could have resulted in increased rates of disenrollment. Further study will be needed to fully understand the higher SNP disenrollment rates in SNPs.

enrolled (Table II.3). The 42 plans approved for passive enrollment enrolled 212,525 members in this fashion, amounting to 27 percent of total SNP enrollment for 2006.

One third were passively enrolled and 13 percent transferred from other plans offered by the same organization. Those who actively enrolled were just as likely to disenroll from a SNP as those who were passively enrolled in 2006. In each case, the fraction of the group that later disenrolled was about 26 percent. The 26 percent disenrollment rate in Table II.4 does not include those beneficiaries who were informed by their plans (as required by CMS) that they would be passively enrolled and exercised their option to reject it. These beneficiaries were never enrolled into a SNP and so never appear in Tables II.3 or II.4.

c. Chronic-condition SNPs

Chronic-condition SNPs became available to Medicare beneficiaries in January 2006. Fewer than 800 beneficiaries enrolled in SNPs during the regular MA enrollment period (Table II.2). More than 86,000 enrolled during the CY 2006. Most of these were transferred by a single organization, Puerto Rico's Medicare y Mucho Mas, from its other MA plans into its SNPs.[25] As Table II.3 shows, two thirds of beneficiaries entering chronic-condition SNPs in 2006 were transferred from other plans offered by the same organization. Rates of disenrollment were about the same for those who were transferred and those who actively entered a chronic-condition SNP.

[25] MMM has both a dual-eligible and chronic-care SNP, and transferred people to both plans from their regular MA plan.

TABLE II.2

SNP ENROLLMENT AND DISENROLLMENT, 2004 - 2007

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic-Disease SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2004										
Enrollment as of December 31	0	0	0	0	12,774	-	0	0	12,774	-
2005										
Enrolled in January	16,726	-	-	-	39,100	-	-	-	55,826	-
New Enrollment, February-December	8,603	-	-	-	64,796	-	-	-	73,394	-
Disenrollment (not due to death)[a]	1,411	6	-	-	15,558	15	-	-	16,964	19
Died[a]	5,301	21	-	-	1,989	2	-	-	7,290	6
Enrollment as of December 31	18,617	-	-	-	86,349	-	-	-	104,966	-
2006										
Still Enrolled on January 1	17,495	-		-	78,390	-		-	96,085	-
Newly Enrolled in January	976	-	17,577	-	281,560	-	794	-	300,707	-
New Enrollment, February-December	9,018	-	4,134	-	266,655	-	86,708	-	350,638	-
Disenrollment (not due to death)[a]	1,648	6	2,376	11	80,450	13	13,707	9	82,572	14
Died[a]	5,708	21	957	4	21,021	3	1,870	2	29,288	4
Enrollment as of December 31	20,133	-	18,378	-	525,134	-	71,925	-	635,570	-
2007 (through March)										
Still Enrolled on January 1	18,896	-	17,624	-	505,203	-	66,708	-	610,657	-
Newly Enrolled in January	11,485	-	89,283	-	102,506	-	12,089	-	213,137	-
New Enrollment, February-March	3,282	-	5,719	-	46,749	-	11,670	-	63,789	-
Disenrollment (not due to death)[a]	1,629	5	3,633	3	17,974	3	5,705	4	25,318	3
Died[a]	1,018	3	164	0	4,112	1	408	0	5,694	1
Enrollment as of March 31	31,016	-	108,829	-	632,372	-	84,354	-	856,571	-

Source: CMS HMO Payment files and Health Plan Management System (HPMS) files.

Notes: SNP enrollees can be counted in more than one type of SNP (more than one column) if they switch between SNP types. SNP enrollment by type of SNP as of December 31 (or March 31) will sum to total SNP enrollment. Entries in other rows will not necessarily sum to the total for all SNPs.

The difference between "Enrollment as of December 31" and "Still Enrolled on January 1" represents the number of beneficiaries who disenrolled at the end of the calendar year.

[a]All percentages are calculated as a proportion of those ever enrolled during a year.

TABLE II.3

SNP ENROLLMENT, OVERALL AND BY MODE OF ENROLLMENT

	Institutional SNPs		Dual-Eligible SNPs		Chronic-Disease SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Ever Enrolled, 2005-2006[a]	**56,278**	**100.0**	**636,105**	**100.0**	**81,960**	**100.0**	**774,343**	**100.0**
In SNP January 1, 2005[b]	16,726	29.7	39,100	6.1	0	0.0	55,826	7.2
Passively enrolled	--*	--*	211,965	33.3	357	0.4	212,323	27.4
Redesignated into SNP plan	15,304	27.2	80	0.0	--*	--*	15,389	2.0
Transferred into SNP plan	1,631	2.9	82,854	13.0	53,755	65.6	138,240	17.9
Otherwise enrolled	22,616	40.2	302,106	47.5	27,843	34.0	352,565	45.5
(New) Enrollment 2007	**116,754**	**100.0**	**169,419**	**100.0**	**23,931**	**100.0**	**310,104**	**100.0**
Redesignated into SNP plan	90,367	77.4	5,490	3.2	0	0.0	95,857	30.9
Transferred into SNP plan	1,438	1.2	71,638	42.3	2,252	9.4	75,328	24.3
Otherwise enrolled	24,949	21.4	92,291	54.5	21,679	90.6	138,919	44.8

Source: HMO Payment files for enrollment and disenrollment information, and Medicare Beneficiary Database (MBD) for identifying passive enrollees.

Note: Beneficiaries are assigned to each column based on the SNP plan type they first enrolled in, so totals do not equal "ever enrolled." Passive enrollees were identified as those identified in the MBD with a Part D Opt Out reason of "SNP" and who enrolled into a SNP plan approved for passive enrollment between August 2005 and May 2006. Redesignated enrollees were identified as beneficiaries in a plan (contract number/plan ID) that became a SNP. Transfers were identified as beneficiaries moved from a non-SNP plan to a SNP plan under the same contract. Since 2004 payment file data were not available, beneficiaries in the "Already in SNP in January 2005" group may have been redesignated or transferred at that time.

The number of beneficiaries reported as "Ever Enrolled 2005-2006" represents unique individuals. This differs from the procedure followed in Table II.2. There, beneficiaries who disenroll from a SNP in 2005 and re-enroll in 2006 are counted twice, once for each enrollment. Thus, summing enrollment in 2005 and 2006 from Table II.2 may produce a total exceeding the "Ever Enrolled" figure in Table II.3.

[a]Includes people enrolled in 2004 who remained enrolled into 2005.
[b]Includes people still enrolled and newly enrolled in January 2005.

* Number too small to report.

TABLE II.4

SNP DISENROLLMENT, OVERALL AND BY MODE OF ENROLLMENT

	Institutional SNPs		Dual-Eligible SNPs		Chronic-Disease SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Disenrollment (including died), 2005-2006	**6,679**	**11.9**	**169,117**	**26.6**	**14,886**	**18.2**	**190,682**	**24.6**
Already in SNP in January 05	2,237	13.4	19,466	49.8	0	-	21,703	38.9
Passively enrolled	--*	--*	54,339	25.6	41	11.5	54,381	25.6
Redesignated into SNP plan	1,577	10.3	13	16.3	--*	--*	1,592	10.3
Transferred into SNP plan	87	5.3	16,263	19.2	10,320	19.2	26,670	19.3
Otherwise enrolled	2,777	12.3	79,036	26.2	4,523	16.2	86,336	24.5

Source: HMO Payment files for enrollment and disenrollment information, and Medicare Beneficiary Database (MBD) for identifying passive enrollees.

Note: Beneficiaries are assigned to each column based on the SNP plan type they first enrolled in, so totals do not equal "ever enrolled." Passive enrollees were identified as those identified in the MBD with a Part D Opt Out reason of "SNP" and who enrolled into a SNP plan approved for passive enrollment between August 2005 and May 2006. Redesignated enrollees were identified as beneficiaries in a plan (contract number/plan ID) that became a SNP. Transfers were identified as beneficiaries moved from a non-SNP plan to a SNP plan under the same contract. Since 2004 payment file data were not available, beneficiaries in the "Already in SNP in January 2005" group may have been redesignated or transferred at that time.

Beneficiaries who disenroll from a SNP and re-enroll in another SNP of the same type in the same year are counted as disenrollees in Table II.4, but not in Table II.2. Therefore, the number of disenrollees reported in Table II.4 may exceed the total number reported in Table II.2.

All percents are computed as a proportion of the corresponding number in Table II.3. Hence columns will not sum to 100 percent.

* Number too small to report.

B. SNP CHARACTERISTICS

Table II.5 shows the distribution of SNP enrollment in March 2007 by plan characteristics. The regional distribution is remarkable primarily in the disproportionate number of enrollees in Puerto Rico, which accounts for one quarter of all SNP enrollment. Approximately 36 percent of all Medicare beneficiaries in Puerto Rico are enrolled in a SNP.

While the absolute number of enrollees differs markedly across SNP types, the distribution of enrollees by size of SNP is similar for each of the three SNP types. Roughly three quarters of enrollees in each type (with institutional and institutional-equivalents combined) belong to SNPs with more than 5,000 members; less than one percent, in each case, belong to plans with fewer than 50 members.

For institutional and chronic condition SNPs, the remaining characteristics of Table II.5 are strongly skewed by two plans. SCAN Health Plan is a non-profit, institutional equivalent SNP with no Medicaid contract that operates as a S/HMO demonstration and is part of a larger organization. Its 90,000 members represent over 80 percent of all enrollment in institutional-equivalent SNPs in 2007. Its effect on the distribution of enrollment by plan characteristics is evident in the table. Much the same is true of Medicare y Mucho Mas (MMM), a for-profit CCP that has a limited Medicaid contract that covers Medicare deductibles and cost sharing as well as physical therapy, vision, and dental care. MMM is not a disproportionate percentage SNP and so enrolls only those beneficiaries with specific targeted conditions. It has 61,000 enrollees, 73 percent of all chronic condition SNP enrollment in 2007.

Most enrollees in dual-eligible SNPs belong to plans with no Medicaid contract of any kind. Plans with a Medicaid contract tend, on average to be larger than those without a contract—the 14 percent of dual-eligible SNPs with a Medicaid contract in 2007 (Table II.7) account for 39 percent of the dual-eligible enrollees.

The broad characteristics of SNPs operating in 2006 and 2007 are shown in Tables II.6 and II.7. The great majority of SNPs are local coordinated care plans and are operated by for-profit entities. Dual-eligible plans tend to be larger than either institutional or chronic condition SNPs, which may reflect their greater use of passive enrollment and the greater ease of identifying dual eligibles among existing managed-care enrollees. Over 28 percent of dual-eligible SNPs had more than 1,000 members in March 2007, compared to 17 percent of (combined) institutional SNPs and 7 percent of chronic condition SNPs. More rapid growth of plans relative to enrollees caused the average size of plans to shrink between 2006 and March 2007. For each of the three SNP types, the proportion of plans with fewer than 50 enrollees grew between 2006 and 2007. Over 80 percent of institutional and dual-eligible SNPs—but fewer than half of chronic condition or institutional-equivalent SNPs—were part of organizations offering other MA plans in 2007. Finally, as mentioned above, a small proportion of dual-eligible SNPs held contracts with the Medicaid program in their State.

TABLE II.5

SNP ENROLLEES, AS OF MARCH 2007

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	**31,016**	**100.0**	**108,829**	**100.0**	**632,372**	**100.0**	**84,354**	**100.0**	**856,571**	**100.0**
By U.S. Census Region										
Northeast	14,926	48.1	16,706	15.4	159,236	25.2	677	0.8	191,545	22.4
South	9,401	30.3	137	0.1	122,344	19.3	16,575	19.6	148,457	17.3
Midwest	3,667	11.8	1,978	1.8	45,147	7.1	3,167	3.8	53,959	6.3
West	2,845	9.2	90,008	82.7	154,491	24.4	2,278	2.7	249,622	29.1
Puerto Rico	177	0.6	0	0.0	151,154	23.9	61,657	73.1	212,988	24.9
By Plan Size										
<50 members	161	0.5	36	0.0	974	0.2	457	0.5	1,628	0.2
50 – 1,000 members	7,075	22.8	2,104	1.9	52,511	8.3	11,961	14.2	73,651	8.6
1,000 – 5,000 members	18,284	59.0	0	0.0	120,678	19.1	10,721	12.7	149,683	17.5
> 5,000 members	5,496	17.7	106,689	98.0	458,209	72.5	61,215	72.6	631,609	73.7
Plan Tax Status										
For profit	30,385	98.0	166	0.2	444,545	70.3	83,132	98.6	558,228	65.2
Not for profit	631	2.0	108,663	99.8	185,825	29.4	1,222	1.4	296,341	34.6
Organization Type										
Local CCP	31,016	100.0	0	0.0	584,321	92.4	74,091	87.8	689,428	80.5
Regional CCP	0	0.0	0	0.0	7,135	1.1	9,544	11.3	16,679	1.9
Demonstration	0	0.0	108,829	100.0	40,916	6.5	719	0.9	150,464	17.6
Stand-Alone Organization										
Stand-alone SNP	21,081	68.0	18,655	17.1	169,671	26.8	15,159	18.0	224,566	26.2
Part of larger contract	9,935	32.0	90,174	82.9	462,701	73.2	69,195	82.0	632,005	73.8
Medicaid Contract Status										
Medicaid contract	0	0.0	1,974	1.8	246,534	39.0	638	0.8	249,146	29.1
No Medicaid contract	31,016	100.0	106,855	98.2	376,919	59.6	83,716	99.2	598,506	69.9

TABLE II.5 *(continued)*

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Disproportionate Percentage										
Yes	216	0.7	106,707	98.1	116,680	18.5	4,621	5.5	228,224	26.6
No	30,800	99.3	2,122	1.9	515,692	81.5	79,733	94.5	628,347	73.4

Source: CMS HMO Payment Files and Health Plan Management System (HPMS) files, 2007.

Notes: Enrollees are categorized in the type of SNP in which they were enrolled during March 2007. "Stand-Alone" organization is defined as a plan that does not have other *non*-SNPs under the same contract number, or under different contract numbers for the organization. Table does not include people who had SNP payment records for March 2007 but were identified by enrollment files as having died prior to March.

Sums/percents within categories may not add to the totals due to missing values of descriptive variables.

Table II.8 shows the configuration of SNPs that would result in 2008 if all submitted applications are approved. While the general configuration of SNPs would change little (in terms of measures that are available at present), nearly half of all SNPs operating in 2008 would be new—402 of 815 plans. The three tables also show the steadily rising proportion of disproportionate-percentage SNPs, fueled largely by the increase in chronic condition SNPs with this feature.

As Table II.9 shows, over 80 percent of all SNP enrollees were dual-eligible in 2006. Even among chronic condition SNPs, which were approved for the first time in 2006, 40 percent of SNP members were enrolled in Medicaid.

As noted earlier, the CMS regulation did not restrict the type of health condition which chronic condition SNPs might target, stating instead that applications would be reviewed on a case-by-case basis.[26] Table II.10 shows the types of conditions that chronic condition SNPs targeted in 2006 and 2007. Diabetes, COPD, and heart failure were more frequently specified than other health problems. About one quarter of chronic condition SNPs in 2007 defined their target population on the basis of a single condition. Most defined their target population using four or more conditions. Nearly all of these, however, were of the form "condition A or condition B." Only a few chronic condition SNPs used multiple conditions to define a particularly ill population by limiting enrollment to those with two or more conditions simultaneously, as in "condition A and condition B." (An exception is the Evercare chronic condition SNP operating in Massachusetts, which targets, among others, beneficiaries with four or more conditions from a list including asthma, COPD, dementia, or others.)

Table II.11 shows SNP enrollment by largest organizations in 2006 and 2007. Overall, 10 organizations account for just over half of SNP enrollment. The situation is quite different, however, for each of the three SNP types. Among dual-eligible SNPs, the distribution of enrollment across the top ten organizations is relatively uniform, with the largest—Kaiser Foundation—accounting for just under nine percent of enrollment. Among institutional SNPs, two organizations—SCAN Health Plan and United Healthcare (which owns Evercare) account for nearly 85 percent of enrollment. The distribution of enrollment is equally skewed for chronic condition SNPs, where Medicare y Mucho Mas (MMM) of Puerto Rico accounts for almost 73 percent of all beneficiaries enrolled in 2007.

[26] CMS officials have stated that in 2008, CMS will work with industry experts to more clearly define the types of severe or disabling chronic conditions that might appropriately be served by SNPs.

TABLE II.6

SNP PLAN CHARACTERISTICS, 2006

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
2006 Characteristics	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Plans	32	100	5	100	226	100	13	100	276	100
New vs. Existing										
Existing	3	9.4	0	0.0	86	38.1	0	0.0	89	32.2
New in 2006	29	90.6	5	100.0	140	61.9	13	100.0	187	67.8
Census Region, 2006										
Northeast	6	18.8	1	20.0	70	31.0	0	0.0	77	27.9
South	15	46.9	0	0.0	75	33.2	4	30.8	94	34.1
Midwest	3	9.4	4	80.0	25	11.1	3	23.1	35	12.7
West	6	18.8	0	0.0	43	19.0	5	38.5	54	19.6
Puerto Rico	2	6.3	0	0.0	13	5.8	1	7.7	16	5.8
Plan Size, as of December 2006										
0 members	6	18.8	0	0.0	11	4.9	0	0.0	17	6.2
1 – 50 members	6	18.8	0	0.0	21	9.3	2	15.4	29	10.5
50 – 1,000 members	15	46.9	4	90.0	113	50.0	10	76.9	142	51.4
1,000 – 5,000 members	4	12.5	0	0.0	50	22.1	0	0.0	54	19.6
> 5,000 members	1	3.1	1	20.0	31	13.7	1	7.7	34	12.3
Tax Status										
For profit	30	93.8	0	0.0	194	85.8	10	76.9	234	84.8
Not for profit	2	6.3	5	100.0	31	13.7	3	23.1	41	14.9
Organization Type										
Local CCP	32	100.0	0	0.0	210	92.9	11	84.6	253	91.7
Regional CCP	0	0.0	0	0.0	3	1.3	0	0.0	3	1.1
Demonstration	0	0.0	5	100.0	13	5.8	2	15.4	20	7.2
Stand-Alone Organization										
Stand-alone SNP	4	12.5	5	100.0	31	13.7	9	69.2	49	17.8
Not stand-alone	28	87.5	0	0.0	195	86.3	4	30.8	227	82.2
Disproportionate Percentage										
Disproportionate	1	3.1	1	20.0	45	19.9	0	0.0	47	17.0
Exclusive	31	96.9	4	80.0	179	79.2	13	100.0	227	82.2

TABLE II.6 (*continued*)

2006 Characteristics	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Medicaid Contract Status										
Medicaid contract	4	11.1	4	80.0	45	19.9	1	7.7	54	19.6
No Medicaid contract	32	88.9	1	20.0	181	80.1	12	92.3	226	81.9
Passive Enrollment										
Passive enrollment	1	3.1	0	0.0	48	21.2	1	7.7	50	18.1
No passive	31	96.9	5	100.0	178	78.8	12	92.3	226	81.9

Source: Health Plan Management System (HPMS) for plan characteristics, HMO payment files for enrollment.

Note: Includes plans active in 2006.
Sums/percents within categories may not add to totals due to missing values of descriptive variables.

TABLE II.7

SNP PLAN CHARACTERISTICS, 2007

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total SNPs	70	100	14	100	323	100	84	100	491	100
New vs. Existing										
Existing	30	42.9	5	35.7	182	56.3	13	15.5	230	46.8
New in 2007	40	57.1	9	64.3	141	43.7	71	84.5	261	53.2
Census Region										
Northeast	19	27.1	3	21.4	75	23.2	16	19.0	113	23.0
South	30	42.9	2	14.3	117	36.2	48	57.1	197	40.1
Midwest	10	14.3	5	35.7	34	10.5	7	8.3	56	11.4
West	10	14.3	4	28.6	64	19.8	10	11.9	88	17.9
Puerto Rico	1	1.4	0	0.0	33	10.2	3	3.6	37	7.5
Plan Size, as of March 2007										
0 members	20	28.6	0	0.0	24	7.4	11	13.1	55	11.2
1 – 50 members	19	27.1	4	28.6	51	15.8	22	26.2	96	19.6
50 – 1,000 members	22	31.4	5	35.7	156	48.3	45	53.6	228	46.4
1,000 – 5,000 members	8	11.4	0	0.0	59	18.3	5	6.0	72	14.7
> 5,000 members	1	1.4	5	35.7	33	10.2	1	1.2	40	8.1
Tax Status										
For profit	64	82.1	5	82.1	265	82.0	75	89.3	409	83.3
Not for profit	6	17.9	9	17.9	56	17.3	9	10.7	80	16.3
Organization Type										
Local CCP	69	98.6	0	0.0	307	95.0	45	53.6	421	85.7
Regional CCP	0	0.0	0	0.0	3	0.9	27	32.1	30	6.1
Demonstration	1	1.4	14	100.0	13	4.0	12	14.3	40	8.1

TABLE II.7 (*continued*)

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Stand-Alone Organization										
Stand-alone SNP	8	11.4	9	64.3	60	18.6	43	51.2	120	24.4
Part of larger contract	62	88.6	5	35.7	263	81.4	41	48.8	371	75.6
Disproportionate Percentage										
Disproportionate	2	2.9	7	50.0	67	20.7	20	23.8	96	19.6
Exclusive	68	97.1	7	50.0	245	75.9	64	76.2	384	78.2
Medicaid Contract Status										
Medicaid contract	0	0.0	4	28.6	44	13.6	1	1.2	49	10.0
No Medicaid contract	70	100.0	10	71.4	270	83.6	83	98.8	433	88.2

Source: Health Plan Management System (HPMS) for plan characteristics, HMO payment files for enrollment.

Note: Includes plans active in 2007.
Sums/percents within categories may not add to totals due to missing values of descriptive variables.

TABLE II.8

SNP PLAN CHARACTERISTICS, 2008 (APPLICATIONS)

	Institutional SNPs		Institutional Equivalent SNPs		Dual-Eligible SNPs		Chronic condition SNPs		All SNPs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total SNPs	75	100	15	100	461	100	264	100	815	100
New vs. Existing										
Existing	50	66.7	12	80.0	277	60.1	74	28.0	413	50.7
New in 2008	25	33.3	3	20.0	184	39.9	190	72.0	402	49.3
Census Region										
Northeast	21	28.0	2	13.3	90	19.5	25	9.5	138	16.9
South	27	36.0	7	46.7	158	34.3	140	53.0	332	40.7
Midwest	12	16.0	2	13.3	66	14.3	38	14.4	118	14.5
West	14	18.7	4	26.7	86	18.7	42	15.9	146	17.9
Puerto Rico	1	1.3	0	0.0	40	8.7	9	3.4	50	6.1
Missing	0	0.0	0	0.0	21	4.6	10	3.8	31	3.8
Organization Type										
Local CCP	73	97.3	10	66.7	458	99.3	208	78.8	749	91.9
Regional CCP	1	1.3	0	0.0	3	0.7	43	16.3	47	5.8
Demonstration	1	1.3	5	33.3	0	0.0	13	4.9	19	2.3
Disproportionate Percentage										
Disproportionate	6	8.0	5	33.3	95	20.6	74	28.0	180	22.1
Exclusive	69	92.0	10	66.7	366	79.4	190	72.0	635	77.9

Source: 2008 SNP Application File.

TABLE II.9

PERCENT OF SNP ENROLLEES IN MEDICAID, 2006

SNP Type	Percent Medicaid
Institutional	51
Dual-Eligible	89
Chronic condition	40
All SNPs	82

Source: HMO Payment files.

Note: Medicaid is measured as any enrolled month in Medicaid, as indicated in monthly payment files.

TABLE II.10

CONDITIONS TARGETED BY CHRONIC CONDITION SNPS, 2006 AND 2007

Condition	Number of SNPs Targeting Condition in: 2006	2007
Diabetes [a]	7	72
Heart failure [b]	10	62
Chronic obstructive pulmonary disease	8	60
Chronic kidney disease [c]	8	44
Coronary artery disease [d]	9	35
Asthma	0	17
Dementia	0	14
Psychiatric disorders [e]	2	13
Hypertension	1	13
Prior cardiac events	3	9
Peripheral vascular disease	3	9
Arthritis	0	4
Ischemic stroke	1	3
Neurological conditions	0	3
HIV	1	1
Cancer	1	1
Hypercholesterolemia	0	1
Obesity	0	1
Plans targeting one condition	3	20
Plans targeting two conditions	1	1
Plans targeting three conditions	2	3
Plans targeting four or more conditions	7	60

Notes: There were 13 total CDC SNPs in 2006 and 84 in 2007. Most plans cover more than one disease.

[a]Includes retinopathy, diabetes, and peripheral neuropathy.
[b]Includes 'advanced heart failure'.
[c]Includes end-stage renal disease (ESRD), 'pre-ESRD', 'renal disease', 'renal failure', 'post transplant kidney transplant'.
[d]Includes 'cardiovascular disease,' 'chronic cardiomyopathy,' and 'chronic heart disease.'
[e]Includes depression and 'severely mentally ill'.

TABLE II.11

SNP ENROLLMENT IN TOP 10 ORGANIZATIONS, BY TYPE

Organization	Enrollment (Dec 2006)	Percent of Total	Organization	Enrollment (Mar 2007)	Percent of Total
All SNPs	635,570	100.0	All SNPs	856,571	100.0
Top 10 SNPs	362,739	57.1	Top 10 SNPs	485,605	56.7
MMM Healthcare, Inc.	99,151	15.6	MMM Healthcare, Inc.	93,101	10.9
United Healthcare	51,073	8.0	Scan Health Plan	90,514	10.6
MCS Life Insurance Company	37,181	5.9	United Healthcare	68,954	8.1
Preferred Medicare Choice, Inc.	31,756	5.0	Kaiser Foundation HP	54,836	6.4
Gateway Health Plan, Inc.	25,672	4.0	MCS Life Insurance Company	41,706	4.9
Healthspring, Inc.	25,566	4.0	Preferred Medicare Choice, Inc.	29,937	3.5
Keystone Health Plan	25,288	4.0	Humana	29,674	3.5
Managed Health, Inc.	24,495	3.9	Healthspring, Inc.	26,157	3.1
Humana	23,011	3.6	Managed Health, Inc.	25,419	3.0
Pacificare	19,546	3.1	Keystone Health Plan	25,307	3.0
All Dual-Eligible SNPs	525,134	100.0	All Dual-Eligible SNPs	632,372	100.0
Dual-Eligible SNPs - Top 10	274,546	52.3	Dual-Eligible SNPs - Top 10	326,203	51.6
MCS Life Insurance Company	37,181	7.1	Kaiser Foundation HP	54,836	8.7
United Healthcare	32,229	6.1	MCS Life Insurance Company	41,706	6.6
Preferred Medicare Choice, Inc.	31,667	6.0	United Healthcare	36,348	5.7
MMM Healthcare, Inc.	29,895	5.7	MMM Healthcare, Inc..	31,875	5.0
Gateway Health Plan, Inc.	25,672	4.9	Preferred Medicare Choice, Inc.	29,760	4.7
Healthspring, Inc.	25,562	4.9	Humana	29,674	4.7
Keystone Health Plan	25,288	4.8	Healthspring, Inc.	26,153	4.1
Managed Health, Inc.	24,495	4.7	Managed Health, Inc.	25,419	4.0
Humana	23,011	4.4	Keystone Health Plan	25,307	4.0
Pacificare	19,546	3.7	Gateway Health Plan, Inc.	25,125	4.0
All Institutional SNPs	38,511	100.0	All Institutional SNPs	139,845	100.0
Institutional SNPs - Top 10	38,554	100.0	Institutional SNPs - Top 10	139,299	99.6
United Healthcare	18,760	48.7	Scan Health Plan	90,008	64.4
ElderPlan, Inc. - SHMO	16,471	42.8	United Healthcare	28,318	20.2
Fidelis Securecare	1,115	2.9	Elderplan, Inc. - SHMO	16,683	11.9
Partnercare Health Plan, Inc.	821	2.1	Fidelis Securecare	1,318	0.9
Elder Care Health Plan Inc.	575	1.5	Partnercare Health Plan, Inc.	1,143	0.8
Selectcare	235	0.6	Elder Care Health Plan, Inc.	591	0.4
Community Care Health Plan, Inc.	235	0.6	Independent Health Association, Inc.	509	0.4
Health Plan for Community Living, Inc.	191	0.5	Oxford Health Plans	260	0.2
Preferred Medicare Choice, Inc.	89	0.2	Health Plan for Community Living, Inc.	236	0.2
Elderplan, Inc.	62	0.2	Community Care Health Plan, Inc.	233	0.2
All Chronic condition SNPs	71,925	100.0	All Chronic condition SNPs	84,354	100.0
Chronic condition SNPs - Top 10	71,917	100.0	Chronic condition SNPs - Top 10	82,984	98.4
MMM Healthcare, Inc.	69,256	96.3	MMM Healthcare, Inc.	61,226	72.6
AIDS Healthcare Foundation	580	0.8	Care Improvement Plus	9,544	11.3

TABLE II.11 (*continued*)

Organization	Enrollment (Dec 2006)	Percent of Total	Organization	Enrollment (Mar 2007)	Percent of Total
Care Improvement Associates of MD	473	0.7	United Healthcare	4,288	5.1
Universal Care	438	0.6	Cariten Health Plan Inc	2,001	2.4
Scan Health Plan	249	0.3	SD State Medical Holding Company	1,990	2.4
SD State Medical Holding Company	239	0.3	Care Improvement Associates of MD	1,289	1.5
Health Net	228	0.3	Group Health Plan, Inc.	952	1.1
Sun Health Medisun, Inc.	192	0.3	AIDS Healthcare Foundation	638	0.8
Aveta	178	0.2	Universal Care	614	0.7
United Healthcare Insurance Company	84	0.1	American Health, Inc.	442	0.5

Source: CMS HMO Payment Files, 2006-2007.

Note: Organizations are grouped by main SNP contract holders, across States.

C. SUMMARY

The number of SNPs has increased rapidly, from 137 in 2005 to 491 in 2007. In 2008, there could be over 800 approved SNPs. As of March 2007, dual-eligible SNPs accounted for two thirds of all SNPs and about 74 percent of total SNP enrollment. The concentration of enrollment in particular organizations varies by type of SNP. The largest dual-eligible SNP is operated by the Kaiser Foundation and accounted for nine percent of SNP enrollment in dual-eligible plans in 2007. By contrast, 73 percent of enrollees in a chronic condition SNP in 2007 were enrolled in plans offered by Medicare y Mucho Mas of Puerto Rico.

The way in which beneficiaries entered SNPs also differed sharply by type of SNP. Most beneficiaries entering dual-eligible and chronic condition SNPs in 2007 appeared to have actively enrolled. Over three quarters of those entering an institutional SNP were members of redesignated plans (many of those were enrolled in SCAN Health Plan). A substantial number of new enrollees to dual-eligible SNPs in 2007 were transferred from other plans operated by the same organization. Whether this pattern of varying modes of entry to SNP will continue in 2008 is impossible to determine at this point. While disenrollment rates varied by type of SNP, they did not vary substantially by mode of entry into the SNP.

Nearly 60 percent of dual-eligible SNP members are enrolled in plans with no Medicaid contract. For institutional and chronic condition SNPs, the proportion is under 2 percent. Enrollment in disproportionate-percentage SNPs varies from less than 6 percent of chronic condition SNP enrollees to over 76 percent of enrollees in institutional SNPs.

III. RESULTS FROM A SURVEY OF SNPS

A. BACKGROUND AND METHODS

To collect uniform information about their structure and operation, a mail survey of SNPs was conducted between March and May 2007. The survey questionnaire asked about their population, relationships with providers, member screening and assessment, services offered, relationship with Medicaid, and pharmacy benefits. Because many organizations offered a number of distinct SNPs that appeared to be centrally managed, we sent one questionnaire to each contact person listed in the CMS Health Plan Management System for each organization, State, and SNP type. Questionnaires were therefore sent to 193 plans that appeared to constitute distinct SNPs. SNPs that did not return the questionnaire by May were called and asked to complete the questionnaire by telephone. All SNPs reporting that they were not operating or that they had no members were declared ineligible. The disposition of this sample is shown below.

TABLE III.1

SURVEY DISPOSITION

	Institutional	Dual-Eligible	Chronic Condition	Total
Questionnaires mailed	34	147	12	193
Number ineligible	2	9	0	11
Number complete	27	108	10	145
Response rate	84%	78%	83%	80%

Note: Response rate is computed as (number complete)÷(number mailed-number ineligible).

Because the population of SNPs is so heavily skewed toward dual-eligible plans, it is difficult to make reliable statements about differences across the three plan types. Such differences will be noted below when they appear informative, but must be interpreted with caution. Table III.2 presents broad characteristics of survey respondents. Among dual-eligible SNPs that responded to the survey, 69 percent served full dual eligibles only; these 75 SNPs constituted more than half the respondent sample. Of the 21 institutional SNPs that provided information about their target population, all but one served permanent nursing-home residents. Only five served institutional-equivalent community residents. Among chronic condition SNPs that responded, most provided care for heart failure or other cardiovascular disease. More than half of the dual-eligible and institutional SNPs had more than 1,000 members. Chronic condition SNPs were smaller—7 of 10 respondents had fewer than 1,000 members.

B. RESULTS

Most SNPs Provide Medicare-Covered Services Only. Roughly one-third of SNPs who enrolled dual-eligible beneficiaries held any type of contract with Medicaid in their State. Even

among dual-eligible SNPs, only 37 percent (40 of 108 respondent SNPs) held a Medicaid contract in 2006 (See Table III.3). Most of those who did hold a Medicaid contract entered into a capitation arrangement that placed them at financial risk for the cost of services. Only about half of the contracts explicitly covered cost sharing (coinsurance and deductibles) for Medicare services provided to dual eligibles.

Most respondents indicated that their Medicaid contracts covered more than simple wrap-around services. Most covered nursing-home care, prescription drugs not covered under Medicare Part D, and behavioral health services. Fewer than half covered community services provided under Medicaid waivers.

Nearly three quarters of dual-eligible plans that did not hold a Medicaid contract stated they planned to seek one in the future. Some, however, pointed to the difficulty of maintaining capitation contracts with both Medicare and Medicaid for care of dual eligibles. When asked in an open-ended question to describe the difficulty of contracting with Medicaid, respondents referred, for example, to "two regulatory bodies or complex dual (state and federal) requirements that sometimes conflict," and the "difficulty coordinating timing of different state and federal fiscal years." Because of the open-ended nature of the question, it was not possible to quantify the extent to which these responses were representative of all plans.

Risk-Sharing Arrangements and Financial Incentives for Providers Are Common. Financial arrangements with providers are shown in Table III.4. About 70 percent of SNPs (100 of 145 respondents) had instituted some form of financial risk sharing with health care providers. Risk-sharing arrangements were much more common for primary-care physicians than for any other type of provider. A somewhat smaller number offered financial incentives of some kind for performance against a non-financial benchmark. Again, these arrangements were typically made with primary care providers and, in the case of dual-eligible and institutional SNPs, with skilled nursing facilities.

Only a handful—9 of 145 responding plans—reported that they managed their own pharmacy benefit. All others had some type of arrangement with a pharmacy benefits manager. None had risk-sharing contracts with the benefits manager.

Most SNPs Assess the Needs of New Members at Enrollment. The majority of SNPs conduct some type of risk assessment at enrollment (Table III.5). Among survey respondents, institutional and chronic-condition SNPs were more likely than dual-eligible plans to carry out the assessment using clinical staff. Dual-eligible plans were also more likely to report using a self-administered screening instrument.

Nearly all SNPs reported conducting a comprehensive assessment of members identified as at high-risk during the initial assessment. The mean percentage of members so identified varied from 43 percent among dual-eligible SNPs to 92 percent for institutional SNPs. About three quarters of survey respondents (including 34 of the 37 institutional and chronic- condition respondents) said that all their members were at high risk.

SNPs Provided an Array of Special Services to Members. All SNPs reported that they furnished care coordination services and nearly all reported providing disease management

(Table III.6). Almost all provided disease management for heart disease, diabetes, and chronic lung conditions. About half provided disease management for severe physical disability or mental illness. Institutional and chronic care SNPs reported that 80 percent or more of their members received disease management. Dual-eligible SNPs reported, on average, that 32 percent received disease management and 43 percent received care coordination.

SNPs reported that they furnished a variety of special services to their members. Most offered medical transportation, education and support groups, medication management, alcohol and drug abuse services and end-of-life care. Smaller numbers provided caregiver support, consumable supplies, or special programs for people with dementia. While numbers are small and perhaps therefore unreliable, institutional SNPs tended to be more likely than dual-eligible and chronic-condition SNPs to provide special services.

C. SUMMARY

Survey responses indicated that most SNPs enroll a disproportionate number of beneficiaries at high risk for adverse health outcomes. The average proportions at high risk as judged by the SNPs themselves varied from 43 to 92 percent. Most carry out an assessment of care needs at the time of enrollment, though dual-eligible SNPs were substantially less likely than institutional and chronic-condition SNPs to use clinical staff for this purpose. In keeping with the high-risk nature of their enrollees, all survey respondents said they provided care coordination and nearly all provided disease management as well. Though not explicitly required to do so, nearly all SNPs provided other special services such as medical transportation, pain management, and medication management.

That less than half of SNPs—even dual-eligible SNPs—reported holding Medicaid contracts is of interest. As noted earlier, there is little evidence and perhaps weak rationale for benefits associated with special needs plans for dual eligibles if the plan manages only Medicare-funded services. Nonetheless, the professed desire of three quarters of dual-eligible and institutional SNPs to enter into Medicaid contracts, combined with anecdotal evidence that such contracts can require some time to complete, provide reasonable hope that more SNPs will manage both Medicare and Medicaid services in the future.

TABLE III.2

TYPE OF ORGANIZATION AND TARGET POPULATION
(Number, Unless Noted)

	Dual-Eligible SNPs	Institutional SNPs	Chronic Condition SNPs	All SNPs
Target Population by Plan Type				
Dual Eligible SNP				
Full dual eligibles	75	--	--	75
All dual eligibles	33	--	--	33
Institutional SNP[a]				
Permanent nursing home residents	--	20	--	20
Residents in intermediate care facilities for people with mental retardation	--	0	--	0
NHC assisted/independent living facility residents	--	5	--	5
NHC senior/retirement community residents	--	4	--	4
NHC community residents	--	5	--	5
Other	--	1	--	1
Chronic or Disabling SNP[a]				
Heart failure or other heart disease (not CAD)	--	--	5	5
CAD or other cardiovascular disease	--	--	3	3
COPD	--	--	2	2
Diabetes	--	--	2	2
Serious mental illness	--	--	2	2
Physical disability	--	--	0	0
Other	--	--	5	5
Mean number of chronic or disabling conditions	--	--	1	1
Enrollment				
Current Enrollment				
1-50	8	2	1	11
51-1,000	45	12	6	63
1,001-5,000	28	6	2	36
Over 5,000	27	7	1	35
Number of Survey Respondents	**108**	**27**	**10**	**145**

Source: Mail survey of SNPs active in 2006, administered between March and May 2007.

[a]May sum to more than total because respondents could indicate more than one category.

NHC = nursing home certifiable;
CAD = coronary artery disease;
COPD = chronic obstructive pulmonary disease.

TABLE III.3

MEDICAID SERVICES
(Number of Plans)

	Dual-Eligible SNPs	Institutional SNPs	Chronic Condition SNPs	All SNPs
Has Medicaid Contract	40	5	1	46
If SNP has Medicaid contract, receives capitation payment	36	5	1	42
If SNP has capitation payment, includes Medicare cost sharing	20	3	0	23
Services Covered Under Medicaid Contract and/or Capitation Payment				
Nursing home care	26	5	1	32
Home and Community Based Waiver Services	19	5	1	25
Drugs not covered under Medicare Part D	31	5	1	37
Behavioral health care	26	5	0	31
Other	23	4	1	28
If SNP has no Medicaid contract, plans to seek Medicaid contract in future	50	15	2	67
Major disadvantages of having Medicaid contract				
Conflicting Medicare/Medicaid regulations	59	18	3	80
Difficulties with marketing materials and delays in approval process	16	0	0	16
States view integration as a way to subsidize Medicaid services with Medicare dollars	12	0	0	12
Number of Survey Respondents	**108**	**26**	**8**	**142**

Source: Mail survey of 2006 SNPs active in 2006, administered between March and May 2007.

Note: Presents information from 142 SNPs that reported enrolling dual-eligible beneficiaries. Three SNPs reported that they enrolled no dual-eligible beneficiaries.

TABLE III.4

PROVIDER ARRANGEMENTS
(Number of Plans)

	Dual-Eligible SNPs	Institutional SNPs	Chronic Condition SNPs	All SNPs
Plans with risk-sharing contracts with providers	75	21	4	100
Types of providers with risk-sharing contracts				
Primary care providers	67	21	4	92
Hospitals	5	0	2	7
Other	2	0	0	2
Types of risk-sharing arrangements				
Capitation	8	0	1	9
Percentage withheld	5	16	0	21
Other	62	5	3	70
Plans with financial incentives for providers (for improving performance, quality of care, or member outcomes)[a]	60	21	5	86
Types of providers who are offered financial incentives				
Primary care providers	56	21	2	79
Hospitals	3	0	0	3
Skilled nursing facilities	39	14	0	53
Other	3	0	1	4
Types of financial incentives				
Pay for performance	50	0	0	50
Other	10	21	5	36
Plan pharmacy benefit				
Self-administers benefit	7	0	2	9
Pharmacy benefits manager administers benefit	101	27	8	136
If uses pharmacy benefits manager, number with risk-sharing contract	0	0	0	0
Number of Survey Respondents	**108**	**27**	**10**	**145**

Source: Mail survey of SNPs active in 2006, administered between March and May 2007.

[a]Financial incentives are any partial withholding of payments from or any additional payments to providers (other than risk-sharing arrangements) that are based on *non-financial* performance.

TABLE III.5

IDENTIFICATION OF MEMBERS WHO NEED SPECIAL SERVICES
Percentage (Unless Noted)

	Dual-Eligible SNPs	Institutional SNPs	Chronic Condition SNPs	All SNPs
All members need special services	69	89	100	75
All members assessed for risk *at enrollment* using:[a]				
Risk screening survey administered at enrollment by non-clinical plan staff	58	15	50	49
Risk screening survey administered at enrollment by clinical plan staff	27	96	60	42
Self-administered risk screening survey administered at enrollment	65	11	30	52
Referral for special services by member's primary care provider at enrollment	65	67	50	65
Member risk level monitored *over time* using:[a]				
Automated alerts based on electronic patient records	49	11	50	42
Regular manual review of electronic records or hardcopy patient charts	68	74	60	68
Referral for special services by member's primary care provider	82	74	40	77
Regular reassessment by primary care provider or SNP clinical staff	86	100	90	89
Regular administration (or re-administration) of screening survey	63	89	50	67
Following risk assessment, conducts comprehensive assessment	92	100	90	93
Uses other processes to identify members in need of special services	70	74	60	70
If comprehensive assessment conducted for high risk members, mean percentage of membership identified as high risk	43	95	87	55
Number of Survey Respondents	**108**	**27**	**10**	**145**

Source: Mail survey of SNPs active in 2006, administered between March and May 2007.

[a] Category sums to more than 100 percent because respondents could mark more than one category.

TABLE III.6

SPECIAL PLAN SERVICES OFFERED
Percentage (Unless Noted)

	Dual-Eligible SNPs	Institutional SNPs	Chronic Condition SNPs	All SNPs
Special Plan Services[a]				
Disease management[b]	96	89	100	95
Care coordination[c]	100	100	100	100
Other similar service	6	11	20	8
If plan provides disease management, diseases or conditions include:				
Heart failure or other heart disease	96	100	70	95
Diabetes	100	100	90	99
Chronic lung disease	85	100	70	86
Severe physical disability	48	92	30	54
Severe mental illness	52	71	60	56
Other	66	96	100	74
Percentage of members receiving disease management	32	88	79	46
Percentage of members receiving care coordination	43	80	88	53
Other Special Services[a]				
Community-based wound care or wound care clinics	81	93	50	81
Medical transportation	92	93	60	90
Caregiver support or respite services	29	41	50	33
Disease-specific education, peer support groups, or group education meetings	90	96	90	91
Fall clinics or other services to increase (or stabilize) functional independence	49	67	40	51
Incontinence management	49	70	30	51
Pain management	85	96	40	84
Alcohol or drug abuse services	87	96	50	86
End-of-life care	32	100	50	46
Consumable supplies not covered by Medicaid	57	67	40	58
Medication management	84	100	80	87
Special programs for members with dementia	11	30	0	14
Other goods or services	16	7	60	17
Number of Survey Respondents	**108**	**27**	**10**	**145**

Source: Mail survey of SNPs active in 2006, administered between March and May 2007.

[a] Category sums to more than 100 percent because respondents could indicate more than one category.

[b]Disease management is defined as services that provide for (1) teaching members how to adhere to treatment plans, (2) monitoring member adherence and clinical status, and (3) monitoring provider adherence to evidence-based practice guidelines.

[c]Care coordination is defined as an array of services for patients with multiple conditions or who are medically complex. Care coordination often involves assigning members to a single staff member or staff team to (1) monitor the member's clinical care and support services; (2) assist with transitions between care settings; and (3) assist in accessing needed health and support services.

IV. PLAN OPERATIONS AND ENROLLEE INTERVENTIONS: FINDINGS FROM VISITS AND FOCUS GROUPS FOR SELECTED PLANS

While the MMA specified that SNPs target three groups of beneficiaries—dual eligibles, nursing home eligibles and residents, and those with severe and disabling conditions—it did not require that plans include any particular interventions or make other arrangements to meet enrollees' special needs beyond those that apply to all Medicare Advantage plans. This chapter (1) describes how SNPs chose to address enrollees' special needs, and (2) assesses the likelihood that those efforts will improve enrollee health.

The evaluation looked for three broad areas to determine what made plans "special": the level of coordination with Medicaid, the provision of special services, and the adaptation of services to individual needs. To provide insight into how plans performed in each of these areas, the evaluation visited staff of selected plans and conducted focus groups with plan enrollees (Table IV.1). Four corporate parent organizations offering multiple, but similar, plans and 10 individual plans were selected for site visits.[27] The visits were conducted by teams of two people who used a basic discussion guide that was developed for the evaluation and adapted for each plan; each visit took one full business day.

For simplicity of exposition, this section refers to "13 visited plans," which includes 8 individual plans visited, 2 individual Evercare plans visited (incorporating information from the visit with corporate Evercare staff), and the 3 other corporate parent organizations visited (each of which operated multiple, but similar, plans).

With the goal of gaining the enrollee perspective on plan implementation, the evaluation conducted focus groups between February and April 2007 with enrollees of the 10 visited *individual* plans. Overall, 93 SNP enrollees participated. Groups were conducted by experienced moderators who were briefed in advance by site visitors about plan features and who used guides developed for the evaluation to organize participant discussions. Sessions focused on (1) enrollee awareness and use of plan services, and (2) satisfaction with the enrollment process and plan services.

[27] In 2006, the four visited corporate parent organizations, HealthSpring, Molina, United Healthcare/Evercare, and Wellcare, operated 12, 4, 65, and 69 plans, respectively (for a total of 150). Staff from each corporate organization reported that the procedures and interventions provided under all their plans were similar in most respects. Thus, this chapter describes each corporate organization as if it offered a single plan, noting any important differences across its plans. In addition to Evercare's corporate organization, site visits also included two individual Evercare plans (one dual-eligible plan and one institutional plan).

TABLE IV.1

LOCATION AND DATES OF SITE VISITS

Visited Plan (abbreviation in tables, if used)	Individual or Corporate	Date of Visit	Location of Visit	Focus Group Conducted
CalOptima	Individual (D)	April 2006	Orange, CA	√
Evercare	Individual (D and I)	June 2006	Phoenix, AZ	√√
Cariten	Individual (D)	November 2006	Knoxville, KY	√
Molina	Corporate (D)	November 2006	Midvale, UT	
Colorado Access (CO Access)	Individual (D)	December 2006	Denver, CO	√
CareOregon (CareOR)	Individual (D)	December 2006	Portland, OR	√
Health Partners (HealthPtr)	Individual (D)	December 2006	Philadelphia, PA	√
Evercare[a]	Corporate (D and I)	January 2007	Minnetonka, MN	
HeartLine Plus (HrtLine+)	Individual (C)	January 2007	Eatontown, NJ	√
HealthSpring (HealthSpr)	Corporate (D)	January 2007	Nashville, TN	
Medicare y Mucho Mas (MMM)	Individual (D and C)	February 2007	San Juan, PR	√√
Wellcare	Corporate (D)	February 2007	Tampa, FL	

D = dual-eligible SNP; C = chronic and disabling condition SNP; I = institutional SNP.

√√ means focus groups were conducted with enrollees of each type of SNP visited.

[a]Information from the visit with Evercare corporate staff is integrated into the description of its two individual plans.

A. COORDINATION WITH MEDICAID

An arrangement with State Medicaid programs that renders SNPs in some way responsible for the cost or coordination of Medicaid services for their enrollees could benefit plans that serve dual-eligible beneficiaries (which includes plans targeting any of the three groups, but especially the dual-eligible SNPs). A capitated contract could potentially include all Medicaid services, including regular State plan services that "wrap around" Medicare (such as vision, dental, medical transportation, and other acute or behavioral health services that extend beyond those provided by Medicare); institutional and community-based long-term care; and drugs excluded under Medicare Part D. Having a capitated contract covering all these services would eliminate incentives to make care decisions based on payer and might give plans more leverage over service providers, thus improving enrollee access to Medicaid-covered services.

Few plans had capitated contracts that included all (or almost all) Medicaid-covered services (Table IV.2). Only two plans did; they were both in Arizona, a State with a long history of managed long-term care. A third plan, whose sponsor was the County Organized Health System administering Medicaid for its SNP's service area, had a Medicaid contract that included most services but excluded institutional long-term care, personal care, and adult day health care. Three other plans had capitated contracts just for wraparound services. One of the visited corporate sponsors had capitated contracts with three of the four States in which it operated SNPs; only one of those three included long-term care, and then only for SNP enrollees who were also part of a Medicaid integration demonstration. Plan staff noted that most States seem reluctant to enter into capitated contracts with privately held companies. Even those willing to do so faced the key difficulty of having to negotiate with plans for payment rates for long-term care.

Nevertheless, staff from several plans with Medicaid contracts noted the importance of having information about services received in both the Medicare and the Medicaid programs and of having the ability to intervene effectively, when the need arose, with both Medicare and Medicaid providers. In addition, concentrating enrollees with special needs into a single plan seemed to cause staff to focus on the depth of those needs more than when such enrollees were a minority in regular plans. Perhaps most telling was the surprise at the high proportions of SNP enrollees whose behavioral health problems and physical disabilities were noted by staff from plans whose sponsors previously had served the same people with their Medicaid or Medicare managed care products.

B. PROVISION OF SPECIAL SERVICES

In authorizing SNPs, Congress intended to provide MA plans with the explicit opportunity to serve beneficiaries known to have complex health care and health-related needs. Over the past decade, care coordination and disease management have been recognized as important tools for caring for such patients. However, there is little reliable evidence indicating precisely what these tools should entail, and rigorous evaluations of their effectiveness have produced mixed results (see, for example, Brown et al. 2007 and Congressional Budget Office 2004). Nevertheless, the literature suggests that care coordination and disease management interventions that have achieved some measure of operational success share some basic features (Chen et al. 2000). They begin with a multifaceted assessment that results in a written care plan for monitoring patient progress to specific goals, and they include ongoing patient education that not only provides factual information but also teaches techniques for making needed lifestyle changes and improving self-management. They also include structures and procedures for reducing fragmentation of care, for example, by improving communication across providers, managing transitions across care settings, identifying and addressing medication problems, and increasing access to health-related support services. Finally, staff must be highly trained and the providers actively involved, and efforts must include providing periodic feedback so that interventions not having the desired effect can be modified.

A few of the visited plans had developed other special services not covered by the Medicare and Medicaid programs, such as fall clinics or efforts to manage pain or incontinence. Some had adapted their Part D pharmacy benefits to the plans' target populations either by establishing formularies that specifically included medications recommended for conditions common among their target populations or by reducing enrollee cost sharing.

All the visited plans offered care coordination and disease management; most offered it only to enrollees determined to be "high risk" according to the plan's risk-assessment tool, a review of claims data, physician referral, or some combination of the three.[28,29] Staff at some plans

[28] Care coordination refers to an array of services for people who have multiple medical or behavioral health conditions or who are medically complex. It often involves assigning a person to a single staff member or team (1) to monitor the person's clinical care and support services, (2) to assist with transitions between care settings, and (3) to help the person access needed health and support services.

estimated that 5 to 10 percent of enrollees received care coordination at any given time. Some plans provided disease management as an education-focused component of a more holistic care coordination effort. Others viewed it as a discrete, disease-specific intervention; staff of those plans reported that between 15 and 35 percent of enrollees used the service, although all enrollees of the two visited chronic-condition SNPs were considered to need disease management, at least for their target conditions.[30]

Care coordination was conducted primarily by nurses and social workers directly employed by the plans. Disease management was conducted by plan nurses for most of the visited plans; two plans contracted this service out to a disease management vendor. Most plans required that nurses be registered nurses; only the institutional SNP required that they be nurse practitioners. A number of plans included social workers in their care coordination teams to address enrollees' psychosocial problems and support service needs. Some plans also either used multidisciplinary care coordination teams or had other in-house staff to consult with care coordinators when specific enrollee problems arose. These staff most frequently were pharmacists or behavioral health practitioners.

All visited plans conducted a comprehensive assessment of enrollees identified as eligible for care coordination or disease management services and developed care plans to guide staff interventions with the enrollees. The assessment was most commonly conducted by telephone; few plans conducted them in person. All developed enrollee care plans based on the assessments, updating them regularly or following a hospitalization or other acute episode.

Plan staff regularly monitored enrollees receiving care coordination or disease management; such monitoring was almost exclusively by telephone, although all enrollees of the institutional SNP were routinely monitored in person. None of the plans reported much use of home telemonitoring equipment (to electronically apprise staff of symptoms, weights, or other indicators). While such equipment has not been shown unequivocally to improve patient health, at a minimum it provides quick feedback on changes in clinical indicators that could signal an acute exacerbation of a chronic illness (Moreno et al. 2007). Further, if a regular reading is missed, it could provide the most timely indication that the enrollee had been hospitalized.

(continued)

[29] Disease management includes services that (1) teach people how to adhere to treatment plans, (2) monitor clinical status and adherence to treatment recommendations, and (3) monitor provider adherence to evidence-based practice guidelines. Disease management is typically targeted to people with specific chronic diseases, such as heart failure or diabetes. Such diseases often have complex treatment regimens, and maintaining adherence requires the sustained efforts of patients and physicians.

[30] Staff for a few plans did not know how many SNP members used care coordination or disease management, because they did not track use separately across the sponsors' managed care products. By contrast, mail survey respondents generally indicated that half or more of their members were high-risk and thus would have been receiving such services.

Routine contacts with enrollees receiving care coordination or disease management often included disease-specific education geared toward improving adherence to treatment recommendations. For most plans, education seemed to be an ad hoc process, with staff relying on lists of educational topics and teachable moments to educate enrollees, and with no formal approach for assessing whether individual enrollees understood educational messages or were making necessary lifestyle changes. Education was primarily the delivery of factual information, not explicit assistance and encouragement to change behavior (that is, it did not focus on understanding individual barriers to change and working to overcome them). However, a few plans used highly structured curricula; for two plans belonging to the same corporate parent, the education intervention was housed on nurses' laptop computers and used routinely during telephone or in-person visits with enrollees.

Most plans did not cultivate close working relationships between enrollee physicians and care coordinators. Physicians in most plans were not affiliated exclusively with SNPs. Thus, when care coordinators aimed to improve care provided in physicians' offices, they tried not to appear to question or criticize individual treatment decisions, which plan staff believed would reduce trust and alienate physicians. When major quality problems were identified, care coordinators tended to refer issues to the plan medical directors for possible "doctor-to-doctor" communication. Nonetheless, care coordinators for all visited plans had regular telephone contact with their enrollees' physicians or their office staff concerning patient-specific issues. Several programs supplemented these contacts with regularly mailed patient-specific profiles that included medication lists or trends in clinical indicators. Most plans did not expect physicians to update care coordinators when their patients' medical treatment plans changed.

Because they process claims for Medicare acute care and pharmacy benefits, and because their care coordinators have regular contact with (at least high-risk) enrollees, SNPs are uniquely equipped to improve management of care setting transitions and medications. In managing transitions, most commonly hospital discharges, finding out about the hospitalization in a timely way is crucial to making sure that enrollees understand discharge instructions and changes in medication regimens, and that health and support services are in place at discharge. Some of the visited plans themselves contacted hospitals in their networks each day to track the status of hospitalized enrollees, while other plans relied on regular reports from hospital admissions or discharge staff. Plans typically responded by assisting with discharge planning, including arranging for support services and following up with enrollees after discharge to identify ways to avoid a repeat admission.[31] The importance of managing medications was a clear focus of almost all visited plans. In addition to discussing medications directly with enrollees, some plans fed claims data from their pharmacy benefits managers (PBMs) into their own software to identify potential problems, while others contracted with the PBMs to identify and report

[31] The visited institutional SNP had as a primary goal to reduce "cycling" between nursing homes and hospitals by treating members in the nursing home whenever possible (for example, for pneumonia or urinary tract infections). When members did go to the hospital, care coordinators had the responsibility of providing all necessary information about the member to hospital staff. Nursing home staff were instructed to notify the care coordinators prior to or concurrent with any emergency room visit or hospital admission for any SNP member (although staff noted that in practice this did not always happen).

problems. Plans typically responded to problems by reviewing them with their own pharmacists or medical directors and then following up with enrollees' physicians.

Assisting with activities of daily living for those who need it, providing transportation to medical appointments, or ensuring regular meals consistent with a physician's dietary recommendations can be critical to beneficiary health and well-being. All visited plans identified such needs through their assessments of enrollees receiving care coordination and through their ongoing contacts with enrollees. In some cases, plans gave enrollees lists of providers to contact for services, and in others they arranged for the services directly. None reported directly providing or paying for services not covered by Medicare or Medicaid.

From what the literature on care coordination and disease management cites as important, it is unclear whether many of the visited plans could improve enrollee health substantially. The literature suggests that success requires having highly trained staff and actively involved providers, as well as offering a structured intervention that can be adapted to individual patient needs. Recent evaluations of CMS's fee-for-service care coordination demonstrations suggest that in-person contact with enrollees may also contribute to success (Brown et al. 2007).

- All the visited plans had some of the features recommended by the literature. They had nurses providing care coordination and disease management, and most required that they be registered nurses or have some experience in community nursing. Further, all the plans conducted comprehensive assessments of those enrollees using care coordination or disease management and from them derived care plans.
- However, 8 of the 13 visited plans lacked many of the recommended features (Table IV.3). Taken as a group, few of these 8 plans integrated physicians into the delivery of their special services, and few took a structured approach to enrollee education but relied instead on nurse-judgment-driven approaches. Few had the ability to contact enrollees in person, and few had software systems that supported special service delivery or could generate quality-monitoring reports. Among these plans, staff reported that care coordination and disease management were very similar to services already provided in their sponsors' Medicare or Medicaid managed care plans. Staff from some of those plans noted, however, that for the SNPs, these services had either been made more structured (for example, by adopting forms and protocols rather than relying primarily on individual nurse judgment) or more intense (for example, by being longer-term rather than episodic, or by giving staff smaller enrollee caseloads).
- The other five plans might have greater potential to improve enrollee health. These plans based their special SNP services on previous experience either operating demonstration programs or as commercial chronic disease management providers. All had relatively structured self-care education and regular monitoring by nurses and other professionals with a frequency at least at a pre-set minimum. Three had the ability to contact enrollees in person (although one of those plans did so infrequently). All five had also developed sophisticated software to guide staff in providing care coordination and disease management services, to warehouse data on enrollees using those services, and to

produce monitoring reports from those data upon which to make decisions on refining intervention features as necessary.

C. ADAPTATION OF SERVICES TO INDIVIDUAL NEEDS

All the visited SNPs adapted their services to at least some degree in recognition of the fact that, collectively, beneficiaries in all three target groups are more likely to have limited literacy, poor English proficiency, needs for basic services (such as food and housing), complex medical problems, cognitive limitations, and behavioral health problems. Having trained staff and clear procedures to address these problems allows enrollees and their health care providers to focus on improving health. Usually the visited plans employed social workers or behavioral health professionals to assist nurses with enrollees who had complex psychosocial problems or mental health disorders (Table IV.3). Further, most plans either had staff who were bilingual or had their written materials translated into the languages commonly spoken by their enrollees. A few plans also provided cultural competency training or hired staff familiar with the culture of the service area.

D. ENROLLEE SATISFACTION WITH ENROLLMENT AND PLAN SERVICES

Most focus group participants said that they enrolled in their SNPs (or chose not to opt out) either because their physicians were participating or because they found plan benefits attractive (Table IV.4). However, most enrollees of three plans (who either were passively enrolled or "rolled into" the SNP from a demonstration program) believed they had no choice but to remain enrolled, even though staff reported having notified them of their choice.

Most focus group participants from most plans were satisfied overall with the services. However, for only two plans (one dual-eligible plan and one chronic-condition plan) did most enrollees believe their care was better under the SNP than previously. Enrollees in the dual-eligible plan particularly liked the SNP because it lacked the stigma they had previously felt as enrollees in a Medicaid plan (even though it was operated by the same sponsor as the SNP). They also liked the plan's pharmacy benefit and disease management services. Enrollees in the chronic-condition plan liked the regular calls from nurses.

Most focus group participants at one plan and some enrollees at a few plans believed their care was worse under the SNP. However, since for many in the dual-eligible plans, "previous care" would have been (1) Medicaid managed care with the old Medicaid pharmacy benefit that seldom included a copayment, and (2) fee-for-service Medicare with providers of their choosing, this is not surprising.

E. CONCLUSION

The 13 visited plans, while not a random sample of all plans operating in 2006, were a geographically diverse group serving the three SNP target populations and having substantial membership. Moreover, including all the individual plans of the visited corporate parent

organizations, they represented 158 of the 276 plans operating that year. At the time of evaluation visits, few had achieved full integration with Medicaid, and most were providing the same relatively unstructured care coordination and disease management services to SNP enrollees that their sponsors provide to enrollees in their other managed care products.

For most of the visited plans, it was not possible to say whether efforts to adapt basic plan services to individual member differences in language, literacy, and cognitive ability went beyond those typical of MA plans. Nevertheless, staff said that concentrating enrollees with special needs into a single plan seemed to focus staff attention on the depth of enrollees' special problems more intensely than when such enrollees were a minority in regular plans. The year 2006, the first year of operations for most of the visited plans, presented SNP staff with complications related to the start of the Medicare Part D benefit and the competitive bidding process, and to CMS's new enrollment database, MARX. During 2006, some of the visited plans were focused on resolving various enrollment problems, and others were just starting to realize they needed to refine their special services. It is thus too early to tell whether the SNPs will ultimately improve beneficiary health beyond what might be expected in a regular MA plan.

On the other hand, several visited plans did appear to provide more specialized services than would be found in regular MA plans. These plans based their special SNP services on previous experience either operating demonstration programs or as commercial chronic disease management providers. All had relatively structured self-care education and regular monitoring by nurses and other professionals with a frequency at least at a pre-set minimum. Some of these plans had the ability to contact enrollees in person. All had also developed sophisticated software to guide staff in consistently providing care coordination and disease management services, to warehouse data on enrollees using those services, and to produce monitoring reports from those data upon which to make decisions on refining intervention features as necessary.

TABLE IV.2

COORDINATION WITH MEDICAID

	CalOptima	Evercare	Cariten	Molina	CO Access	CareOR	HealthPtr	HrtLine+	HealthSpr	MMM	Wellcare
SNP type	Dual	Dual (D) Institutional (I)	Dual	Dual	Dual	Dual	Dual	Chronic	Dual[a]	Dual (D) Chronic (C)	Dual
Sponsor held Medicaid contract *prior to* SNP	√	D: √ (for one county only)	√	√	√ (mental health only)	√	√				√
SNP has contract with Medicaid											
Has capitated contract	√	√ (D and I)		√[b]		√				√ (D and C)	
Contract includes:											
Wrap-around services[c]	√	√		√[b]		√				√	
Community-based long-term care	√[d]	√		√ WA only							
Institutional long-term care		√		√ WA only							

Source: Discussions with plan staff during site visits conducted between April 2006 and February 2007

Notes: Staff visited two Evercare SNPs (one dual-eligible and one institutional) and two MMM SNPs (one dual-eligible and one chronic-condition). Descriptions presented in the tables apply to both plan types unless otherwise noted. Descriptions of the visited Evercare plans generally apply to all United Healthcare/Evercare SNPs (by type) in 2006, as do descriptions of the HealthSpring, Molina, and Wellcare plans. (These corporate sponsors operated 65, 12, 4, and 69 plans, respectively, in 2006, for a total of 150 plans.)

[a]HealthSpring also operated institutional SNPs; however, they had very few members in 2006.

[b]Molina receives a capitated payment from California and Michigan and from Washington only for SNP enrollees who are also in the Washington Medicaid Integration Partnership (WMIP). Molina has a fee-for-service contract with Medicaid in Utah. Washington enrollees who are not in the WMIP receive Medicaid services through the regular fee-for-service program.

[c]"Wraparound services" pertains to Medicaid benefits that "wrap around" Medicare coverage, such as vision, dental, medical transportation, and other acute or behavioral health services that extend those provided by Medicare.

[d]CalOptima's capitated payment excludes personal care and adult day health care but includes home health, durable medical equipment, and other community-based long-term care services.

TABLE IV.3

OVERVIEW OF CARE COORDINATION AND DISEASE MANAGEMENT
AND PLAN ADAPTATIONS TO INDIVIDUAL NEEDS

	CalOptima	Evercare	Cariten	Molina	CO Access	CareOR	HealthPtr	HrtLine+	HealthSpr	MMM	Wellcare
Staff providing Care Coordination (CC)	RNs, MSW	D: Nurses, social workers I: NPs, social workers	RNs	RNs, social workers	RNs	Nurses, MSWs	RNs, social workers	RNs	RNs, LPNs, LVNs	RNs, social workers	RNs, LPNs, LVNs
Staff providing Disease Management (DM)	RNs	D: Nurses I: NPs	Nurses	RNs, health educators	Nurses	Nurses	RNs	RNs	Nurses	RNs	Nurses
CC/DM developed for SNP[a]		D: √ I: √						√		D: √ C: √	
CC/DM assessment ever in person	√	√			√			[b]			
Routine CC/DM monitoring in person	√	√			√			[b]	[b]		
Routine CC/DM monitoring has minimum frequency specified		√	√		√			√	√	√	
CC/DM education structured[c]		√			√	√		√	√	√	√
SNP software supports CC/DM[d]	√	√		√				√	√	√	
Software produces quality monitoring reports		√		√		√		√	√	√	
SNP involved physicians in CC/DM[e]	√	√				√		√		√	√

	CalOptima	Evercare	Cariten	Molina	CO Access	CareOR	HealthPtr	HrtLine+	HealthSpr	MMM	Wellcare
Adaptations to Individual Differences[f]											
Social workers/ behavioral staff available	√	√		√	√	√	√		√	√	√
Bilingual and culturally appropriate staff or materials	√	√	√	√	√		√		√	√	√
Materials adapted for low literacy				√	√			√	√		
Materials adapted for vision/hearing impaired			√	√					√		

Source: Discussions with plan staff during site visits conducted between April 2006 and February 2007.

Notes: Staff visited two Evercare SNPs (one dual-eligible and one institutional) and two MMM SNPs (one dual-eligible and one chronic-condition). Descriptions presented in the tables apply to both plan types unless otherwise noted. Descriptions of the visited Evercare plans generally apply to all United Healthcare/Evercare SNPs (by type) in 2006, as do descriptions of the HealthSpring, Molina, and Wellcare plans. (These corporate sponsors operated 65, 12, 4, and 69 plans, respectively, in 2006, for a total of 150 plans.)

[a]Plans with check marks developed their CC and DM interventions specifically for the SNP (or as part of a demonstration). Those without check marks used the same general interventions for enrollees of SNP and non-SNP products.

[b]HeartLine Plus staff reported that South Dakota-based nurses could assess or contact enrollees in person, but did so very infrequently. HealthSpring staff reported that nurses contacted some enrollees in person when they were hospitalized and contacted those who were part of a clinic pilot project for one plan.

[c]Staff described enrollee education as either somewhat or highly structured, rather than based simply on checklists of topics and teachable moments.

[d]Software supports care coordination and disease management by tracking intervention intensity or intermediate outcomes, or by generating task lists or reminders for staff.

[e]Physician involvement includes collaboration with nurses (that is, participating in multidisciplinary team meetings, providing CCs with clinical or other information about enrollees, calling plan staff with information about changes in enrollees' conditions or to request assistance for enrollees), or physicians providing input to CC/DM care plans, as well as the SNP actively providing physician education (as compared with simply providing care guidelines).

[f]Adaptations of plan interventions based on limited literacy, limited English proficiency, needs for basic services (such as food and housing), complex medical problems, cognitive limitations, or behavioral health problems.

RN = registered nurse; NP = nurse practitioner; MSW = Master of Social Work; BH = behavioral health.

TABLE IV.4

ENROLLEES' ENROLLMENT EXPERIENCES AND SATISFACTION WITH PLAN SERVICES

	CalOptima	Evercare	Cariten	CO Access	CareOR	HealthPtr	HrtLine+	MMM
Plan passively enrolled[a]	√	√[a]	√	√	√	√		
Enrollees contacted were aware of membership	Almost all/most	D: Almost all/ most I: All	Almost all/most	All	Almost all/most	All	All	All
Main reason for enrolling[b]								
Physician in network/physician or agency recommendation	Almost all/most	D: Some	None	Some	Few	None	None	None
Attractive benefits	Few	D: Few	All	Some	Few		Almost all/most	Almost all/most
Did not think had choice		I: Almost all/most			Most	Almost all/ most		
Satisfied overall	Most	D: Few I: All	Most	Most	Some	Few	Most	C: Most D: Most
Plan care better than previous arrangement	None	D: Few I: Some	Most	Some	Few	Few	All	C: Some D: Few
Plan care worse than previous arrangement	Few	D: Few I: Some	None	Some	Some	Most	None	C: Few D: Few
Number of participants	7	D: 8 I: 11	7	6	11	10	14	D: 8 C: 11

Source: All information from focus groups with plan enrollees conducted between February and April 2007 except that on use of passive enrollment which came from plan staff during site visits.

Notes: Staff visited and conducted focus groups with enrollees of two Evercare SNPs (one dual-eligible and one institutional) and two MMM SNPs (one dual-eligible and one chronic-condition). Plan descriptions and focus group responses presented in the tables apply to both plan types unless otherwise noted.

[a]See page 16 for an explanation of passive enrollment. Evercare's dual-eligible SNP passively enrolled in one county only; its institutional plan was redesignated from a demonstration to a SNP, and all participants were automatically enrolled in the SNP.

[b]Including decision/reasons not to opt out if passively enrolled. HeartLine Plus and MMM did *not* use passive enrollment. Evercare-D did *not* use passive enrollment in Pima county (Tucson). Evercare-I enrollees were automatically switched from the Evercare nursing home demonstration to the SNP in August 2005.

V. STATE MEDICAID PERSPECTIVES

State interest in and involvement with SNPs depends largely on each State's history with Medicaid managed care and the State's future plans for such care. States that cover at least some benefits for dual eligibles in Medicaid managed care or have plans to extend it to cover services heavily used by dual eligibles, such as long-term care, are likely to have a substantial interest in SNPs. For other States, the benefits of contracting or working with SNPs are less apparent.

A. MEDICAID CONTRACTING ARRANGEMENTS AND SNP ENROLLMENT

As Table V.1 shows, current SNP activity is heavily concentrated in a small number of States. Over ninety percent of the total SNP enrollment of 842,840 in March 2007 was in just 11 States (Pennsylvania, California, New York, Arizona, Texas, Minnesota, Florida, Tennessee, Oregon, Alabama, and Massachusetts) and Puerto Rico.[32] As the table also shows, 212,520 full dual eligibles were passively enrolled[33] in SNPs in late 2005 and early 2006, although some subsequently disenrolled. All but 14,525 of the initial passive enrollees were in the 11 States mentioned. Initial passive enrollment from Medicaid plans thus accounts for one quarter of total SNP enrollment, with passive enrollment heavily concentrated in a small number of States.

Nationally, 14 percent of dual eligibles with full Medicaid benefits were enrolled in a SNP in February 2007, and the percentage of full duals enrolled in SNPs exceeded 14 percent in nine States. Over 90 percent of the remaining full-benefit dual eligibles are enrolled in stand-alone Medicare prescription drug plans, into which they were auto-enrolled in late 2005 and early 2006. Although SNPs have the potential to increase their enrollment by persuading full-benefit dual eligibles who are enrolled in prescription drug plans to switch to SNPs, dual eligibles can be difficult to identify and contact, and polls indicate that the great majority of them are content with their current Medicare coverage. Table V.1 also shows that of 18 States that contracted with SNPs for provision of some Medicaid services, eight included some form of long-term care benefit in the contract. The reasons for this relationship are discussed in more detail in Section C.

[32] Note that the SNP enrollment totals shown in Table V.1 differ somewhat from enrollment totals used elsewhere in this report, since the SNP enrollment data for this table are based on a Kaiser Family Foundation (KFF) analysis of enrollment data publicly reported by CMS in March 2007, and posted on the KFF statehealthfacts.org web site. These data permit consistent measurement of SNP enrollment and the number of full-benefit dual-eligible beneficiaries by state.

[33] See page 16 for an explanation of passive enrollment.

TABLE V.1

SNP ACTIVITY BY STATE, 2006-2007

State	SNP Type	Number of SNP Contracts by Type[a] (March 2007)	Total SNP Enrollment by Type[b] (March 2007)	Total Passive Enrollment Into SNPs From Medicaid Managed Care Plans (2005-2006)	Total Full Duals[c] (February 2007)	Total SNP Enrollment (March 2007) as a Percentage of Total Full Duals (February 2007)	SNPs Contract with Medicaid for Some Medicaid Benefits[d]	Medicaid Managed Care Includes LTC Benefits[e]	Some Dual Eligibles Enrolled in Capitated Medicaid Managed Care, June 2006[f]
Totals	**DE**	**172**	**621,986**						
	I	**63**	**139,761**						
	CC	**44**	**81,093**						
	All	**224**	**842,840**	**212,520**	**5,985,723**	**14.1%**			
Alabama	DE	3	14,496						
	I	2	*						
	CC	1	*	0	87,924	16.4%	No	No	No
Alaska	DE	0	0						
	I	0	0						
	CC	0	0	0	11,977	0.0%	No	No	No
Arizona	DE	9	46,341						
	I	1	1,163						
	CC	4	563	32,819	98,928	48.6%	Yes	Yes	Yes (MCO)
Arkansas	DE	3	342						
	I	0	0						
	CC	1	1,237	0	63,859	2.5%	No	No	No
*California	DE	13	82,211						
	I	3	89,292				Yes, in some counties	Yes, in some counties	Yes (HIO, MCO, PACE)
	CC	5	1,878	20,955	1,012,909	17.1%			
*Colorado	DE	4	6,060						
	I	2	2,280					No, except in PACE	Yes (MCO, PIHP, PACE)
	CC	0	0	1,887	51,671	16.1%	Yes		
*Connecticut	DE	5	1,499						
	I	2	1,493						
	CC	1	127	0	66,869	4.7%	No	No	No
Delaware	DE	1	*						
	I	1	287						
	CC	0	0	0	9,494	3.0%	No	No	No
District of Columbia	DE	1	4,233						
	I	1	31						
	CC	0	0	0	16,567	25.7%	No	No	Yes (MCO, PIHP)

TABLE V.1 *(continued)*

State	SNP Type	Number of SNP Contracts by Type[a] (March 2007)	Total SNP Enrollment by Type[b] (March 2007)	Total Passive Enrollment Into SNPs From Medicaid Managed Care Plans (2005-2006)	Total Full Duals[c] (February 2007)	Total SNP Enrollment (March 2007) as a Percentage of Total Full Duals (February 2007)	SNPs Contract with Medicaid for Some Medicaid Benefits[d]	Medicaid Managed Care Includes LTC Benefits[e]	Some Dual Eligibles Enrolled in Capitated Medicaid Managed Care, June 2006[f]
*Florida	DE	18	25,977						
	I	5	2,380					Only in some	
	CC	2	1,794	789	291,973	10.3%	No	small demos	Yes (MCO, PACE)
Georgia	DE	6	2,329						
	I	2	2,498						
	CC	3	2,918	0	126,549	6.1%	No	No	Yes (PIHP)
Hawaii	DE	3	1,037						
	I	0	0						
	CC	0	0	0	25,426	4.1%	No	No	No
Idaho	DE	1	164						
	I	0	0					Planned; not	
	CC	0	0	0	19,219	0.9%	Planned; not yet implemented	yet implemented	No
Illinois	DE	5	3,992						
	I	2	*						
	CC	3	812	0	228,232	2.1%	Yes, in 2007	No	No
Indiana	DE	1	344						
	I	0	0						
	CC	0	0	0	78,559	0.4%	No	No	No
Iowa	DE	1	44						
	I	2	117						
	CC	0	0	0	56,353	0.3%	No	No	Yes (PIHP)
*Kansas	DE	1	*						
	I	0	0					No, except in	
	CC	0	0	0	38,348	0.0%	No	PACE	Yes (PACE)
Kentucky	DE	1	9,745						
	I	0	0					Yes, home health in one	
	CC	0	0	9,598	90,351	10.8%	Yes (one plan)	plan	Yes (MCO)
Louisiana	DE	3	1,591						
	I	0	0						
	CC	0	0	0	94,049	1.7%	No	No	No
Maine	DE	2	*						
	I	1	19						
	CC	1	*	0	47,250	0.0%	No	No	No

TABLE V.1 *(continued)*

State	SNP Type	Number of SNP Contracts by Type[a] (March 2007)	Total SNP Enrollment by Type[b] (March 2007)	Total Passive Enrollment Into SNPs From Medicaid Managed Care Plans (2005-2006)	Total Full Duals[c] (February 2007)	Total SNP Enrollment (March 2007) as a Percentage of Total Full Duals (February 2007)	SNPs Contract with Medicaid for Some Medicaid Benefits[d]	Medicaid Managed Care Includes LTC Benefits[e]	Some Dual Eligibles Enrolled in Capitated Medicaid Managed Care, June 2006[f]
Maryland	DE	2	4,277						
	I	2	2,585						
	CC	2	1,150	0	61,732	13.0%	No	No	Yes (PACE)
Massachusetts	DE	4	7,402						
	I	2	5,631					Yes, in dual demos and PACE	
	CC	3	75	0	202,452	6.5%	Yes, in dual demos		Yes (MCO and PACE)
Michigan	DE	2	272						
	I	2	644						
	CC	1	17	0	195,407	0.5%	No	No	Yes (PACE)
Minnesota	DE	6	35,630						
	I	0	0					Yes, in dual demos	
	CC	0	0	23,700	96,190	37.0%	Yes, in dual demos		Yes (MCO)
Mississippi	DE	2	855						
	I	1	*						
	CC	0	0	0	71,158	1.2%	No	No	No
Missouri	DE	1	861						
	I	0	0						
	CC	2	1,873	0	127,122	2.2%	No	No	Yes (PACE)
Montana	DE	0	0						
	I	0	0						
	CC	0	0	0	12,629	0.0%	No	No	No
Nebraska	DE	1	44						
	I	1	117						
	CC	0	0	0	32,630	0.5%	No	No	No
Nevada	DE	1	*						
	I	0	0						
	CC	2	*	0	18,355	0.0%	No	No	No
New Hampshire	DE	0	0						
	I	0	0						
	CC	0	0	0	17,096	0.0%	No	No	No
New Jersey	DE	1	1,844						
	I	2	225						
	CC	2	114	1,460	151,965	1.4%	Yes	No	Yes (MCO)

TABLE V.1 *(continued)*

State	SNP Type	Number of SNP Contracts by Type[a] (March 2007)	Total SNP Enrollment by Type[b] (March 2007)	Total Passive Enrollment Into SNPs From Medicaid Managed Care Plans (2005-2006)	Total Full Duals[c] (February 2007)	Total SNP Enrollment (March 2007) as a Percentage of Total Full Duals (February 2007)	SNPs Contract with Medicaid for Some Medicaid Benefits[d]	Medicaid Managed Care Includes LTC Benefits[e]	Some Dual Eligibles Enrolled in Capitated Medicaid Managed Care, June 2006[f]
New Mexico	DE	2	153						
	I	1	118						
	CC	0	0	0	33,532	0.8%	Yes, in 2007	No	Yes (PACE)
*New York	DE	15	42,938						
	I	7	21,857					Yes, in small	
	CC	1	145	7	554,372	11.7%	Yes, in small pilots	pilots	Yes (MCO, PIHP, PACE)
North Carolina	DE	1	1,624						
	I	2	1,300						
	CC	0	0	0	218,040	1.3%	No	No	Yes (PIHP)
North Dakota	DE	0	0						
	I	0	0						
	CC	0	0	0	9,573	0.0%	No	No	No
Ohio	DE	2	1,991						
	I	2	2,365						
	CC	0	0	0	169,251	2.6%	No	No	Yes (PACE)
Oklahoma	DE	2	76						
	I	1	183						
	CC	0	0	0	78,705	0.3%	No	No	No
*Oregon	DE	7	17,006						
	I	2	131				Yes, for Medicare cost sharing for plans that have Medicaid		
	CC	0	0	11,066	52,641	32.6%	contracts	No, except in PACE	Yes (MCO, PIHP, PACE)
*Pennsylvania	DE	10	100,475						
	I	2	894					No, except in	
	CC	1	34	78,735	279,247	36.3%	No	PACE	Yes (MCO, PIHP, PACE)
*Rhode Island	DE	2	2,413						
	I	1	1,026						
	CC	0	0	0	29,584	11.6%	No	No	Yes (PACE)
South Carolina	DE	1	125						
	I	0	0						
	CC	1	2,800	0	117,034	2.5%	No	No	Yes (PACE)
South Dakota	DE	1	*						
	I	0	0						
	CC	1	1,927	0	11,826	16.3%	No	No	No

TABLE V.1 *(continued)*

State	SNP Type	Number of SNP Contracts by Type[a] (March 2007)	Total SNP Enrollment by Type[b] (March 2007)	Total Passive Enrollment Into SNPs From Medicaid Managed Care Plans (2005-2006)	Total Full Duals[c] (February 2007)	Total SNP Enrollment (March 2007) as a Percentage of Total Full Duals (February 2007)	SNPs Contract with Medicaid for Some Medicaid Benefits[d]	Medicaid Managed Care Includes LTC Benefits[e]	Some Dual Eligibles Enrolled in Capitated Medicaid Managed Care, June 2006[f]
Tennessee	DE	7	23,265						
	I	2	14						Yes (MCO, PIHP,
	CC	1	1,582	13,853	191,424	13.0%	Yes in 2006	No	PACE)
*Texas	DE	12	33,566						
	I	4	261				Yes, for some plans in some counties for Medicare cost sharing; developing plans to capitate some Medicaid	Yes, in four urban counties, but only for	
	CC	5	3,142	16,071	339,286	10.9%	wraparound services	community services	Yes (MCO, PIHP, PACE)
Utah	DE	2	1,779						
	I	1	*						
	CC	0	0	1,520	22,484	7.9%	Yes	No	Yes (PIHP)
Vermont	DE	0	0						
	I	0	0						
	CC	0	0	0	16,357	0.0%	No	No	Yes (MCO)
Virginia	DE	1	*					Planned; not	
	I	3	2497				Planned; not yet	yet	
	CC	1	12	0	104,387	2.4%	implemented	implemented	No
Washington	DE	3	762						
	I	1	234					No, but developing	Yes (MCO, PIHP,
	CC	0	0	60	97,772	1.0%	Yes, in a small pilot	plan to do so	PACE)
West Virginia	DE	0	0						
	I	0	0						
	CC	0	0	0	41,133	0.0%	No	No	No
*Wisconsin	DE	2	1,508						
	I	4	2,586				Yes, in dual demos; considering for other	Yes, in dual demos, Family Care, and	
	CC	1	38	0	110,125	3.8%	SNPs	PACE	Yes (MCO, PACE)
Wyoming	DE	0	0						
	I	0	0						
	CC	0	0	0	5,707	0.0%	No	No	No
Puerto Rico	DE	10	146,917						
	I	1	84						
	CC	2	63,237	0	--	--	Yes	No	Yes (MCO, PIHP)

*States visited or interviewed for the evaluation.

TABLE V.1 *(continued)*

[a]DE = Dual Eligible; I = Institutional; CC = Chronic Condition. Note that the number of contracts is smaller than the total number of SNP plans, since a single contract may include multiple plans and more than one type of SNP. The distribution of contracts by State is from the Kaiser Family Foundation, statehealthfacts.org, at http://www.statehealthfacts.org/comparetable.jsp?ind=333&cat=6 (accessed October 10, 2007), and is based on data from the CMS MA Personal Plan Finder.

[b]Source: Kaiser Family Foundation, statehealthfacts.org, at http://www.statehealthfacts.org/comparetable.jsp?ind=334&cat=6 (accessed October 10, 2007), based on March 2007 CMS Special Needs Plan Enrollment Report by SNP Type. Note that State enrollment subtotals do not add to national totals, since enrollment in contracts that span two States is shown in the table for both States.

[c]Source: CMS monthly count of full duals for State Part D "clawback" payments

[d]Sources: CMS report of SNPs with dual capitation arrangements with States (2006), MPR site visits to State Medicaid agencies and CMS regional offices (2007), and CHCS survey of States (December 2006).

[e]Sources cited in footnote 3, supplemented by Saucier and Burwell (2007), Saucier and Fox-Grage (2005), Kronick and LLanos (2007), and State and health plan web sites.

[f]CMS 2007b, p. 12. Capitated managed care includes Health Insuring Organization (HIO), Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), and Program for All-Inclusive Care for the Elderly (PACE), but not Primary Care Case Management (PCCM), Prepaid Ambulatory Health Plan (PAHP), and Other. PIHPs are generally specialized behavioral health plans that cover less than comprehensive services on an at-risk basis. See CMS 2007b, p. 55 for detailed explanations of all these managed care entities.

B. MEDICAID AGENCY SITE VISITS AND INTERVIEWS: VARIATIONS IN STATE INTEREST IN SNP

SNPs provide a natural mechanism for improved coordination and integration of Medicare and Medicaid services for dual eligibles in those States that seek such coordination. Nonetheless, few SNPs have entered into contracts with State Medicaid agencies, whether from a lack of interest on the part of States, or an absence of attempts by the SNPs, or some combination of the two. Table V.1 shows SNP enrollment and State contracting with SNPs in 2007.

The evaluation conducted site visits to State Medicaid agencies and CMS regional offices between January and April 2007, to elicit their perspectives and opinions on the role SNPs can play in their local environment. Prior to the site visits, to facilitate discussion about specific SNPs, we provided interviewees with publicly available summary and enrollment information on the SNPs operating in their State or region. We also sent interviewees copies of the interview protocols we planned to use so they could have the appropriate people available to respond to questions. The States we visited or interviewed are marked with an asterisk (*) in Table V.1. States were chosen to reflect a range of SNP activity and State experience with Medicare/Medicaid contracting.

In general, State attitudes toward SNPs ranged from enthusiasm to indifference, with varying degrees of selective interest in between. Arizona (not visited for this project) indicated the greatest degree of enthusiasm for SNPs, followed by the dual-demonstration States (Minnesota, Wisconsin, and Massachusetts), and then Texas, Florida, New York, California, and Oregon. The dual-demonstration States, while very enthusiastic about integrating Medicare and Medicaid, commented that in some ways SNPs are less effective than their previous programs for such integration. Some other States not specifically visited for this evaluation, including New Mexico, Washington, Maryland, Virginia, and Michigan, reported that they are also exploring the potential for SNPs. In most cases, States said that they are focusing on managed care organizations (MCOs) that already contract with the State for Medicaid services and that are also SNPs or plan to become SNPs. Medicaid representatives stated they were looking for SNPs that understand the specific care needs of the Medicaid population, and who understand how to work with state governments. Most States visited for the evaluation expressed skepticism that SNPs, whose primary experience is typically with Medicare, had that kind of understanding. Some States, such as Arizona, Texas, and Florida, indicated that they were more open to SNPs that are new to the State, but even those States said that they are looking for SNPs with Medicaid experience.

The reasons for this selective interest flow from the incentives, discussed in more detail in Section C, for States to work with SNPs. States that cover or plan to cover long-term care services in managed care see the greatest potential benefit from SNPs over the longer term. Out of the 18 States shown in Table V.1 that currently or soon plan to contract with SNPs for some Medicaid benefits, at least 8 either include some long-term-care services in Medicaid managed care, or plan to do so in the near future. Several other States that are in early planning stages for Medicaid managed long-term care, such as New Mexico and Virginia, see SNPs as a potential component in their managed care plans.

Another factor in State decisions to contract with SNPs relates to State familiarity and experience with particular SNPs. If a SNP has been a Medicaid managed care contractor in a State for a number of years, the State is likely to be more willing and able to contract with that plan when it becomes a SNP. This was the situation in California, Oregon, and several other States when Medicaid managed care plans were authorized as SNPs in 2005 and 2006, and the State agreed to contract with the new SNP. State Medicaid agencies often believe that their programs, beneficiaries, and providers require MCOs that understand the specific needs of Medicaid and the context in which Medicaid programs operate, and they are not confident that "outside" Medicare-only MCOs have such understanding and experience. They are therefore interested primarily in SNPs with demonstrated experience in Medicaid. It can also be difficult in many States to contract with new managed care plans without going through a new State procurement process, which may not be necessary in the case of SNPs with which the State already has a Medicaid managed care contract.

1. Why Some States Want to Work with SNPs

Based on site visits to States and CMS regional offices for the evaluation, recent published reports (Saucier and Burwell 2007; Verdier and Au 2006; Saucier and Fox-Grage 2005), and industry and Medicaid conferences on SNPs, the major reasons States appear to want to work with SNPs include:

- ***The opportunity to fully integrate Medicaid and Medicare acute and long-term care benefits.*** Minnesota, Wisconsin, and Massachusetts are now doing this in their dual demonstration programs; Arizona is close to full integration as well, although its SNPs currently operate Medicaid and Medicare managed care programs on a "side-by-side" rather than a fully integrated basis.

- ***The desire to accommodate existing Medicaid plans that wished to become SNPs.*** California and Oregon are in this category. Medicaid plans in both States had significant dual-eligible enrollment in 2005 and wanted to build on it to become SNPs. Both States have been working for years on initiatives to further integrate Medicaid acute and long-term care benefits through managed care, but stakeholder and legislative opposition has hindered the development of these initiatives, so SNPs are not currently viewed as a major step toward fully integrated care in these States, at least in the short term.

- ***The desire to fit SNPs into current or emerging Medicaid managed care initiatives.*** Texas has an existing Medicaid managed care program (STAR+PLUS) that covers Medicaid acute care and community long-term care benefits in several urban counties through MCOs. Some of these MCOs are also SNPs, so Medicaid and Medicare benefits can be provided to dual eligibles, albeit on a side-by-side rather than a fully integrated basis. Texas is exploring ways to integrate SNPs more fully into STAR+PLUS. New York is trying to meld two pre-existing Medicaid managed care programs into a program that will cover both acute and long-term care on the Medicaid side, and attract SNP contractors who could add Medicare benefits. Similarly, Florida is developing a Medicaid managed care program that would integrate Medicaid acute and long-term care benefits. This program, Florida Senior Care, has not been implemented yet, but the State

expects that it will attract considerable SNP interest and may present opportunities to fully integrate Medicaid and Medicare managed care for dual eligibles. Other States such as New Mexico, Washington, Virginia, Maryland, and Michigan, are not as far along in developing Medicaid initiatives that could include SNPs, but there is interest in all these States.

As shown in Table V.1, all 18 States that currently or soon plan to contract with SNPs for some Medicaid benefits either included some duals in capitated Medicaid managed care in 2006 or include long-term care benefits in Medicaid managed care, so those two factors appear to be a significant element in State decisions to contract with SNPs.

2. Why Most States Are Not Currently Interested in SNPs

As of June 30, 2006, dual eligibles were enrolled in some form of capitated Medicaid managed care in 26 States plus Puerto Rico. In 10 of those States the only managed care programs were Prepaid Inpatient Health Plans (PIHP), which are primarily specialized behavioral health plans that offer less-than-comprehensive benefits, or Program for All-Inclusive Care for the Elderly (PACE) programs. Of the 7.5 million full and partial dual eligibles in 2006, about 1.4 million (19 percent) were enrolled in some form of capitated Medicaid managed care (Centers for Medicare & Medicaid Services 2007b). For the 0.7 million enrolled in comprehensive managed care plans, their capitated benefit often included only limited Medicaid services, such as Medicare cost sharing. For States that do not include dual eligibles in managed care, there is generally no mechanism or procedure for contracting with SNPs for Medicaid services, and little reason to enter such arrangements. If States have no plans to include duals or long-term care services in Medicaid managed care, that further diminishes their interest in SNPs. To get a better sense of the factors that led to their apparent lack of interest, we visited or interviewed five States (Colorado, Connecticut, Kansas, Pennsylvania, and Rhode Island) that have had limited or no involvement with SNPs. The main reasons for their lack of interest fell into three categories:

- ***Few or no SNPs in the State.*** Kansas fell most clearly into this category. While the State covered some duals in a small PACE program in 2006, there is only one SNP in the State (Evercare) and it had fewer than 10 enrollees in March 2007. State staff were not very familiar with SNPs in general or with the Evercare SNP.
- ***Limited coverage of Medicaid acute-care benefits that overlap with Medicare benefits.*** Pennsylvania is in this category. As noted earlier, Medicaid coverage of services that overlap with Medicare is quite limited, and behavioral health services for duals are covered by separate behavioral health MCOs, so the State does not believe that there is anything to be gained by contracting with SNPs, particularly after implementation of Part D. As a result, all duals were removed from Medicaid managed care as of January 2006.
- ***No coverage of long-term care benefits in Medicaid managed care, or current plans to do so.*** All five States were in this category, even though there were factors in some of them that might have led them to be interested in SNPs. Colorado covers some dual

eligibles in Medicaid managed care and has four SNPs (Evercare, Kaiser, Colorado Access, and Denver Health Medical Plan), but the State has no current plans to extend Medicaid managed care to long-term care services or to contract with SNPs. Connecticut has four SNPs (Evercare, WellCare, Health Net, and Senior Whole Health), but no plans to extend Medicaid managed care to long-term care services. However, the legislature in its 2007 session included language in a budget measure recommending that the State contract with SNPs "to provide for the integration of Medicaid funding and benefits with the Medicare SNPs" operating in the State, and allocated $10 million in fiscal year 2008 and $15 million in fiscal year 2009 "to establish integrated care plans." Rhode Island has had tentative and preliminary discussions with the two SNPs in the State (Evercare and Blue Chip), but appears to be in a "wait and see" mode and is not actively pursuing relationships with the SNPs. Although some duals are covered by Medicaid managed care in a small PACE program, there are no current plans to cover Medicaid long-term care services in the State's broader managed care program.

C. ANALYSIS OF STATE INCENTIVES TO WORK WITH SNPS

As described above, State interest in working with SNPs varies substantially, reflecting the incentives that flow out of the State's existing and planned Medicaid programs and the specific context of each State. This interest is also likely to change over time as State Medicaid programs and SNPs evolve, and as changes occur in State government leadership and other aspects of the State context. This section describes the incentives for States to work with SNPs that flow out of the current and planned structure of State Medicaid programs.

States that currently cover some or all Medicaid long-term care benefits through managed care may see SNPs as a way of expanding their integrated care model to include Medicare services, though there is opposition in some of these States to including "outside" MCOs in their Medicaid program, and concern about the administrative and other complexities involved in dealing with Medicare (Verdier 2006; Saucier and Burwell 2007). If there are no SNPs in a State, or if those that are present have not enrolled a significant number of Medicaid beneficiaries, States may see few benefits to working with SNPs. Even if there is significant enrollment of dual eligibles in SNPs in a State, there may be limited incentives for the State to develop a relationship with the SNPs if it involves only dealing with Medicare cost sharing or the limited remaining Medicaid acute care services for duals. In Pennsylvania, for example, where more dual eligibles were passively enrolled than in any other State, dual eligibles were removed from Medicaid managed care with the advent of Part D in January 2006, because the State did not believe it had anything to gain by including the minimal remaining Medicaid acute care benefits for dual eligibles in managed care.

1. Acute Care Services

While State Medicaid programs are responsible for Medicare cost sharing[34] and some acute care benefits for dual eligibles, States can fulfill that responsibility by providing those benefits to

[34] States are legally responsible for Medicare cost sharing only to the extent that Medicaid payment for the service exceeds the Medicare payment minus the beneficiary cost sharing responsibility. (Social Security Act, Section 1902(n)(2)). Since Medicaid payments are often below or only slightly above Medicare payments, the

duals on a fee-for-service basis without contracting with SNPs. It is potentially more efficient administratively for States, SNPs, beneficiaries, and providers if States are willing to contract with SNPs to pay for Medicare cost sharing and these limited Medicaid acute care benefits through an up-front capitated payment to the SNP for each dual-eligible SNP enrollee. However, it can be costly in terms of time and resources for States to develop capitated rates and negotiate contracts with SNPs, so States do not typically do so unless they already have contractual or other relationships with SNPs or have broader reasons for wanting to develop such relationships (Verdier 2006).

Some States, such as New York, have sought to capture savings for Medicaid that may result when SNPs and other MA plans cover services that Medicaid also covers, such as vision, dental, transportation, and home health, or when provision of Medicaid services (personal care assistance, care coordination, community-based services) reduces use of inpatient hospitalization and other Medicare acute care services. Doing so requires willingness on the part of Medicare plans to provide information to the State on Medicare services they provide that overlap with Medicaid, and plans will generally provide such information only if the State requires it as a condition for contracting with Medicaid. Even if Medicare plans are willing to share these data with the State, it may not be easy for the State and the plans to agree on how to calculate savings to Medicare from Medicaid programs, and how those savings should be divided between the plans and the State (Verdier 2006).

2. Managed Long-Term Care

It is generally only when States see SNPs as a way of providing Medicaid long-term care services through managed care and coordinating those services with Medicare that States evidence substantial interest in contracting with SNPs. A number of States already contract with SNPs to cover Medicaid long-term care services for dual eligibles (Arizona, California, Massachusetts, Minnesota, Texas, and Wisconsin), and others are considering doing so (Florida, Washington) (Saucier and Burwell 2007; Kronick and Llannos 2007). However, Medicaid officials noted that beneficiary advocates and providers sometimes oppose the inclusion of long-term care services into managed-care contracts. Those States that have done so have typically introduced managed long-term care in limited areas of the State (Saucier and Fox-Grage 2005; Saucier and Burwell 2007). This evaluation did not otherwise pursue the sources and extent of opposition to managed long-term care.

One of the other obstacles to Medicaid managed long-term care in the past has been the limited number of MCOs with the experience and capability needed to provide this kind of care. States that have implemented Medicaid managed care programs for long-term care have often relied on locally sponsored MCOs developed by counties, nursing facilities, and other traditional Medicaid long-term care providers rather than on the multi-State MCOs that have become increasingly common in Medicaid, and that are heavily represented among SNPs.

(continued)
extent of the Medicaid responsibility for this Medicare cost sharing can be quite limited, although some states choose to pay a greater share than federal law requires.

With the advent of SNPs, there are now more MCOs that States may be able to contract with to cover Medicaid long-term care services. In States like Wisconsin and Minnesota, however, where plans are required to be non-profits and most are locally sponsored, some State Medicaid staff express doubt that national MCOs know how to serve the Medicaid population with long-term care needs. With some exceptions, most current multi-State SNPs do not have extensive experience in managing Medicaid long-term care services, especially the home and community-based services that are an important part of Medicaid. (Some organizations, including Evercare, have considerable experience in managing nursing facility care, but less with community services.) In addition, to the extent that these national MCOs are viewed by beneficiary advocates and providers as "outsiders" without strong ties to the State, they may not be in a good position to help State Medicaid agencies allay provider and beneficiary concerns about managed long-term care. Further, some national MCOs may be reluctant to contract with local community-based service providers or other long-term care providers that Medicaid enrollees have relied on in the past, or may want to establish financial or performance accountability conditions that these providers are unwilling to accept. As States and SNPs gain more experience with managed long-term care in specific States, enough evidence should accumulate about the strengths and limitations of this approach to help resolve these provider and beneficiary concerns one way or the other. State interest in contracting with SNPs is likely to increase or diminish accordingly.

3. CMS Efforts to Reduce Obstacles

As noted above, developing Medicaid contracts with dual eligible SNPs presents added challenges for both States and plans. For States, contracting just for those Medicaid services that are not covered by Medicare may increase the State's rate-setting burden. It also means that States must adapt their monitoring and oversight procedures to accommodate the fact that dual-eligible SNPs are also subject to monitoring and oversight by Medicare. There is added complexity for plans as well. The addition of a second payer makes financial planning and bid submissions more challenging, as does the addition of a Medicaid monitoring and oversight process with requirements that are sometimes inconsistent with those of Medicare. Recognizing these challenges, CMS launched an Integrated Care Initiative in December 2005 when an intra-agency workgroup was formed at the request of the CMS Administrator. The workgroup sought input from both States and plans through groups such as the Center for Health Care Strategies and the National SNP Alliance. The purpose of this workgroup was to reduce administrative barriers to implementing Special Needs Plans (SNPs) and to increase State awareness of the opportunity to better integrate care for dual eligible beneficiaries. Detailed information about the Integrated Care Initiative is available at http://www.cms.hhs.gov/IntegratedCareInt/ and a summary of the guidance provided by the group is attached as Appendix V.

D. SUMMARY

The attitudes of State Medicaid agencies toward contracting with SNPs for Medicaid services vary widely. For States that currently have Medicaid managed long-term care programs, or plan to develop them in the near future, SNPs present an important opportunity to move

toward full integration of Medicare and Medicaid acute and long-term care services. Other States that include dual eligibles in Medicaid managed care only for acute care services may view contracting with SNPs as a way of at least modestly improving the coordination of Medicaid and Medicare acute care for these beneficiaries. States that had contracts with plans for Medicaid managed care services before the plans became SNPs are also likely to be inclined to contract with these new SNPs. For most of the States that do not currently include dual eligibles in any kind of managed care, do not have pre-existing Medicaid contractual relations with specific SNPs, or do not have plans to extend managed care to cover disabled and chronically ill populations or long-term care services, there is generally little interest in contracting with SNPs.

VI. CHARACTERISTICS OF SNP AND NON-SNP BENEFICIARIES

There is no reason to expect, *a priori*, that SNP enrollees should be older, frailer, or in poorer health than the overall population of beneficiaries eligible to enroll in SNPs. The question is nonetheless of interest, particularly because of the absence of currently available data on health outcomes or utilization of SNP enrollees. This chapter compares the demographic and health characteristics in 2005 of beneficiaries who enrolled in a SNP in 2006, with those of Medicare beneficiaries who appeared, on the basis of their 2005 characteristics, to meet the eligibility criteria for each SNP type.

We first compare—for each SNP type—the characteristics in 2005 among 2006 SNP enrollees with those of beneficiaries eligible to enroll in the SNP. We also focus on three subsets of SNP enrollees who might be expected to differ from the larger group of SNP enrollees: those in dual-eligible and institutional demonstration plans and those who were passively enrolled into dual eligible SNPs. Because some SNP plans are disproportionate-percentage plans that do not limit enrollment to those meeting the stated eligibility criteria, we also make comparisons restricting SNP enrollees to those who meet the relevant target criteria based on available data.

A. METHODS

To compare 2006 SNP enrollees with other beneficiaries who might have joined SNPs, we constructed comparison groups of eligible non-enrollees (ENEs) from residents of the market area for each SNP, using CMS service-area and enrollment files. ENE members were selected based on their apparent eligibility for SNP enrollment, given characteristics and diagnoses from 2005. Groups were further defined as follows:

Dual-Eligible SNPs. The ENE group for dual SNPs was defined either as all dual eligibles or all dual eligibles with full Medicaid benefits (as appropriate to SNPs' defined population) residing in a market area served by dual-eligible SNPs. Dual-eligible status was drawn from the Medicare Beneficiary Database (MBD) in the last quarter of 2005.

Institutional SNPs. The ENE group for institutional SNPs was defined as all Medicare beneficiaries with at least two nursing-home Minimum Data Set (MDS) assessments or one 90-day assessment in 2005.

Chronic condition SNPs. The ENE group for each SNP was defined as all Medicare beneficiaries with evidence of the specific conditions covered by the SNP, identified by indicators for the corresponding Hierarchical Condition Categories (HCCs) in the CMS 2006 Budget Neutrality file (which reflects utilization for CY 2005). [35]

[35] For plans covering ESRD beneficiaries, we also used ESRD enrollment status from CMS enrollment files.

Beneficiaries who were first enrolled in a SNP in 2005 or were new to Medicare in 2006 (and thus had no 2005 data) were excluded from the analysis, so SNP totals do not equal those presented earlier in this report. Separate ENE groups were constructed for beneficiaries who entered a SNP from another MA plan and for those who entered a SNP from fee-for-service Medicare, based on their HMO enrollment status in the month prior to enrollment. We compared 2005 demographic and enrollment characteristics, as well as the presence of common health conditions, as measured by HCCs based on 2005 diagnoses, for SNP enrollees with those of the appropriate ENE group. For those entering from fee-for-service, we also compared Medicare utilization and spending in 2005 using the Medicare Chronic Condition Warehouse[36] (CCW).

The comparisons are intended to be indicative rather than definitive, especially for institutional and chronic condition SNPs. Subject to CMS approval, chronic care SNPs define both the chronic conditions they will serve and the criteria which they will use to determine whether applicants meet the criteria for the targeted conditions. We used HCC indicators to identify the target population populations in chronic condition SNPs but it is possible that this approach may not precisely match the criteria actually used by plans. For dual eligible SNPs, we used the Medicaid indicator from the HMO payment files in the month of SNP enrollment and for institutional SNPs we used the long-term nursing home indicator (LTI) flag.

Tables VI.1 through VI.3 present comparisons of demographic characteristics, health indicators, and utilization for each of the three SNP types. Tables VI.4 and VI.5 present characteristics for SNP enrollees in the dual eligible and institutional demonstration plans separately.[37] Table VI.6 presents results for dual eligible SNP enrollees, broken out by passive enrollment status. The next set of tables – VI.7 through VI.11 – repeats these tables restricting SNP enrollees to those who appear to meet the plan target criteria based on available data; we do not repeat the table for institutional demonstrations since the data to identify the target populations were not available. Because these comparisons cover the entire population of SNP enrollees and their ENE counterparts and because we do not draw inferences about SNP behavior in any other period, no statistical tests of these results were performed. Results from this chapter should not be interpreted as an indication of behavior or outcomes in any other period.

[36] Section 723 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 723 required the Secretary to make Medicare data readily available to researchers who are studying chronic illness in the Medicare population. To support this effort, CMS contracted with the Iowa Foundation for Medical Care (IFMC) to establish the Chronic Condition Data Warehouse (CCW). The CCW contains existing CMS beneficiary data (from multiple data sources) linked by a unique identifier, allowing researchers to analyze information across the continuum of care. The CCW currently contains data from fee-for-service Institutional and Non-institutional claims, enrollment/eligibility, and assessment (all payers) data (Minimum Data Set, Outcome and Assessment Information Set, swing bed assessments, and Inpatient Rehabilitation Facility Patient Assessment Instrument) from January 1, 1999 forward for a random 5 percent Medicare beneficiary population, and 100 percent of the Medicare beneficiary population for January 1, 2005 forward.

[37] Since a few of the institutional SNPs (Wisconsin Partnership and Elderplan SHMO) plans enrolled community-based nursing home certifiable beneficiaries, our ENE group (and target identification) is not ideal; they are left out of the SNP target group comparison.

B. RESULTS

SNP enrollees were more likely to enroll from managed care arrangements than from fee-for-service, except for dual eligible SNPs. Most dual eligible SNP enrollees were in fee-for-service the month prior to first SNP enrollment (Table VI.1), perhaps due to the larger number who were passively enrolled from Medicaid managed care. On the other hand, the majority of institutional and chronic condition SNP enrollees were likely to be in managed care arrangements in the month prior to SNP enrollment. (This is consistent with the findings in Table II.3 that found that institutional and chronic care SNP enrollees were more likely to have been redesignated or transferred from managed care plans.)

In very broad terms, SNP enrollees resemble their ENE counterparts in terms of age and gender, but are more likely to be minorities. Members of chronic condition SNPs tend to be younger than their ENE counterparts, reflecting the greater proportion of disabled beneficiaries in such SNPs compared to the eligible population (Table VI.1). SNP enrollees in all types were generally less likely to be white, with the exception of the dual eligible demonstrations (Table VI.4).

The comparison of health characteristics suggests that SNP enrollees are uniformly in better health and have lower utilization than the members of the comparison groups. Members of the comparison group are more likely to have been institutionalized in 2005, more likely to die in 2006, and more likely to have had an inpatient stay, outpatient visit, or physician visit in 2005 than were SNP enrollees. SNP enrollees have lower risk scores than the comparison groups in all SNP types. In nearly every instance, SNP enrollees are less likely to exhibit chronic conditions as indicated by presence of HCC codes for COPD, diabetes, heart failure, and other common conditions, than were members of the comparison group.

In part, these results surely reflect the presence of SNP members who did not meet the target criteria who were enrolled in disproportionate-percentage SNPs; this is examined below. But the presence of some beneficiaries who are not in the target population cannot account for all of the differences in Tables VI.2 and VI.3. Though none of the chronic-condition SNPs operating in 2006 was approved as a disproportionate-percentage SNP, the differences between SNP and ENE groups are no smaller for chronic-condition SNPs than for dual-eligible and institutional SNPs.

Enrollees in dual eligible demonstration plans resemble their eligible non-enrolled counterparts more closely than do other SNP enrollees. Table VI.4 shows the same comparisons for dual-eligible demonstration plans and their comparison group. Because the demonstration SNPs have been operating for a longer period with "SNP-like" enrolled populations, they might constitute a more reliable indicator of differences among mature SNPs. The comparisons do suggest differences, at least in some respects, from results seen in the earlier tables. While SNP enrollees do seem to be more likely to reside in rural areas (see Table VI.1), enrollees in demonstration SNPs were 10 times more likely to live in a rural county than were members of the comparison groups. Those who entered the SNP from Medicare fee-for-service (though not those entering from MA) were also more likely to have been institutionalized in 2005 than were members of the comparison group. While most of the chronic health conditions

shown in the table appear more prevalent in the comparison group, Medicare utilization in 2005 is quite similar for SNP enrollees and members of the comparison group. The risk scores are also closer between the two groups than in the earlier tables. For members entering from fee-for-service, the dual demonstration enrollees had a slightly higher death rate than those in the ENE group.

Table VI.5 presents the characteristics of enrollees in the two institutional equivalent SNP demonstration plans in 2005 and 2006 – the Wisconsin Partnership plans and the Elderplan SHMO.[38] Since the data to identify the appropriate comparison group of nursing home certifiable community beneficiaries is unavailable, the table presents only the SNP enrollee data. Compared to the entire institutional SNP sample (Table VI.1), the demonstration enrollees were younger (due to age restrictions) and less likely to be white. The WPP plans and Elderplan had fewer institutionalized enrollees, which is to be expected since these plans serve beneficiaries who are nursing home certifiable but able to remain in the community with the support of the services provided by the plans. The institutional-equivalent enrollees appear healthier than the overall institutional SNP group in Tables VI.2 and VI.3: they had lower risk scores, were less likely to die, and generally had lower prevalence of health conditions and lower utilization and spending.

Enrollees who were passively enrolled from fee-for-service Medicare were more likely to be disabled, but were otherwise similar in health status to SNP enrollees who were not passively enrolled. Table VI.6 compares dual-eligible SNP members who were passively enrolled, dual-eligible SNP members who were not passively enrolled, and beneficiaries in the dual eligible ENE group from Table VI.1.[39] Beneficiaries passively enrolled from fee-for-service Medicare into dual-eligible SNPs were more likely to be disabled, to be institutionalized, and to die, while less likely to be nonwhite than those who were not passively enrolled. Health conditions of the two groups, as measured by risk score and by proportion with specified health conditions, were similar. Both groups were less likely to be institutionalized or to die and were in slightly better health than enrollees in the ENE group. While patterns were different for those passively enrolled, the total number so enrolled was only about 8,000 beneficiaries, less than 5 percent of all those passively enrolled.

SNP enrollees who met the eligibility criteria for their SNP type were somewhat healthier (in terms of HCC risk scores) than their eligible-but-not-enrolled counterparts in other MA plans and in Medicare FFS. The results presented in Tables VI.1 and VI.2 include some enrollees who did not meet the stated target criteria for the SNP, either because they were in a

[38] As of 2007, the WPP plans were re-classified as dual eligible SNPs with Medicaid subsets. The Medicare beneficiaries they serve are both dual eligible and nursing home certifiable. New enrollees must be community resident or, if residing in a nursing home, able to return to the community on admission to the program.

[39] This table does not include the small number of people passively enrolled by chronic condition and institutional SNPs.

disproportionate percentage SNP plan, or possibly because the SNP inadvertently enrolled people not meeting the eligibility criteria.[40] Tables VI.7 through VI.11 present comparisons that are similar to those presented in the earlier tables, but exclude SNP enrollees who did not meet the SNP eligibility criteria. In general Tables VI.7 and VI.11 show that SNP enrollees (with the possible exception of enrollees in chronic condition SNPs) appear healthier than their ENE counterparts and have lower rates of pre-enrollment institutionalization and mortality along with lower utilization and expenditure levels.

C. SUMMARY

The comparisons between SNP enrollees and eligible non-enrollees are limited by data availability. Our construction of eligible non-enrolled groups for any plan may not reflect the flexibility CMS provided to chronic condition SNPs in identifying eligible enrollees. For example, the data are incomplete in identifying 2006 chronic care SNP enrollees who had the conditions targeted by their plan at the time of enrollment in 2006. More recent data from 2006 and further study would aid the accuracy of these comparisons of the SNP target population with those who did not enroll.

Nonetheless, the results do suggest that SNP enrollees are consistently healthier than the eligible but not enrolled population, even when comparisons are restricted to target groups. Dual demonstration enrollees and those passively enrolled into SNPs appear to resemble the non-enrolled population more closely than do enrollees in other SNPs, but are nevertheless slightly healthier than the non-enrolled population. It should be noted that the comparisons shown in this chapter are based on early beneficiary enrollment experience in SNPs. The comparison groups used here are composed of beneficiaries who, in 2006, remained in their 2005 arrangements – whether fee-for-service or MA. The SNP enrollees used in the comparison all *moved* from either fee-for-service or MA to a SNP. If beneficiaries who are particularly ill or at higher-than-average risk are less likely to change their current status, as seems plausible, then the observed differences between SNP enrollees and the two comparison groups may be in part an artifact of a reluctance of those who are currently ill to enter new plans. If this is the case, one might expect to see the differences between the groups diminish over time. The study period for this analysis could not include the several years of enrollment experience that would be necessary to determine whether observed differences persist over longer periods of enrollment.

[40] The data available to identify the target group for the chronic care SNPs are not ideal in that they only indicate presence of health conditions in 2005, where as beneficiaries did not enroll in a SNP until 2006.

TABLE VI.1

DEMOGRAPHIC CHARACTERISTICS OF SNP ENROLLEES AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**388,715**	**2,154,744**	**125,552**	**300,130**	**16,515**	**903,913**	**50,002**	**419,503**	**14,768**	**198,777**	**26,060**	**14,691**
Age												
<65	42.3	47.5	24.7	19.7	30.8	13.1	21.0	7.0	10.0	10.2	4.2	6.1
65-74	29.9	23.6	38.9	33.0	37.1	34.4	47.1	38.4	20.0	14.5	36.7	15.6
75-84	19.4	18.3	25.8	31.9	23.9	36.3	24.5	40.5	32.8	34.5	34.2	37.0
85+	8.5	10.6	10.6	15.4	8.2	16.2	7.5	14.1	37.2	40.9	25.0	41.4
Gender												
Male	38.8	43.3	36.7	36.6	46.9	44.2	44.6	46.6	29.6	35.7	37.1	36.2
Female	61.2	56.7	63.3	63.4	53.1	55.8	55.4	53.4	70.3	64.3	62.9	63.8
Race												
White	62.4	64.5	63.4	63.6	63.1	72.7	65.9	77.9	74.8	79.8	63.7	71.5
African American	17.6	22.2	17.0	21.8	9.8	12.1	6.5	9.7	20.1	16.7	29.1	22.0
Other	19.8	13.1	19.4	14.4	27.0	15.1	27.5	12.3	4.9	3.4	7.0	6.4
Missing Race	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.2
Medicare Eligibility												
Aged	57.4	52.2	75.1	80.2	68.4	86.7	78.9	92.8	89.9	89.6	95.4	93.8
Disabled	40.2	47.7	24.0	19.8	24.0	12.8	20.6	7.0	9.1	10.3	4.2	6.2
ESRD	0.5	0.1	0.2	0.1	2.1	0.4	0.1	0.2	0.0	0.1	0.3	0.0
None/missing	1.9	0.0	0.7	0.0	5.4	0.0	0.4	0.0	1.0	0.0	0.1	0.0
Urban/Rural												
Urban	89.9	91.7	90.9	97.0	94.7	98.2	95.9	99.8	94.3	95.0	99.1	98.8
Rural	10.0	8.3	9.1	3.0	5.2	1.8	4.1	0.2	5.6	5.0	0.8	1.2
Missing	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.0

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Notes: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by dual SNPs who met the eligibility criteria for the dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. Institutional SNP ENEs were identified as people living in Institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005.

TABLE VI.2

INDICATORS OF HEALTH FOR SNP ENROLLEES AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**388,715**	**2,154,744**	**125,552**	**300,130**	**16,515**	**903,913**	**50,002**	**419,503**	**14,768**	**198,777**	**26,060**	**14,691**
Meets Target Criteria for SNP Type												
Yes	80.8	n.a.	72.4	n.a.	47.2	100.0	58.8	100.0	n.a.	n.a.	n.a.	n.a.
No	19.2	n.a.	27.6	n.a.	52.8	0.0	41.2	0.0	n.a.	n.a.	n.a.	n.a.
Institutional Status												
Institutionalized (any in year)	3.8	13.7	4.6	12.3	0.1	4.4	0.0	1.5	56.9	71.9	29.5	68.5
In community	95.8	86.2	94.0	87.6	99.5	95.6	99.0	98.5	42.9	28.0	69.9	31.4
Missing	0.4	0.1	1.4	0.1	0.3	0.0	1.0	0.0	0.1	0.1	0.7	0.1
Risk Score												
Community score	1.32	1.54	1.40	1.64	1.30	1.88	1.34	1.68	2.32	2.90	1.67	3.22
Institutionalized score	1.55	1.67	1.58	1.68	1.60	1.92	1.63	1.82	1.93	2.31	1.66	2.52
New enrollee score	1.01	1.03	1.01	1.13	0.81	1.02	0.77	0.87	0.81	1.33	0.69	1.55
Percent missing risk score	0.46	0.04	1.25	0.06	0.39	0.00	1.00	0.00	0.18	0.07	0.68	0.11
Death												
Proportion died in 2006	3.8	7.0	4.1	8.6	2.9	7.6	2.7	7.4	15.8	26.9	11.9	28.1
Health Conditions												
HCC108: COPD	14.5	18.7	16.1	19.5	12.0	31.2	14.7	25.5	22.5	29.2	16.3	30.7
HCC19: Diabetes without complication	17.4	16.9	22.8	18.6	21.3	27.0	31.1	28.4	16.2	18.9	21.6	20.0
HCC80: CHF	12.4	15.9	15.5	19.1	13.6	32.0	14.6	25.6	29.0	38.6	22.3	47.0
HCC105: Vascular disease	12.2	17.1	16.7	17.7	13.2	23.9	21.6	16.2	35.7	41.8	26.1	41.4
HCC92: Specified heart arrhythmias	7.0	9.3	8.3	12.5	6.2	21.2	5.7	17.1	19.6	25.9	14.0	31.4
HCC55: Major Depression, Bipolar, Paranoid Disorders	8.9	11.3	7.9	7.5	7.4	8.8	11.5	8.3	13.8	16.8	6.2	15.8
HCC131: Renal Failure	4.6	6.3	5.5	8.2	4.3	11.6	5.0	11.9	12.6	17.2	8.3	21.1
HCC83: Angina Pectoris/old MI	5.1	5.2	7.4	7.3	7.8	11.4	12.2	14.0	5.5	6.4	6.6	8.7

TABLE VI.2 (*continued*)

Characteristics	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
HCC10: Breast, Prostate, Colorectal, Other Cancers	4.1	4.6	5.9	6.5	5.4	12.7	8.2	13.7	6.3	7.3	7.2	8.1
HCC96: Ischemic or unspecified stroke	4.3	6.6	5.5	7.4	5.2	7.9	6.2	6.1	15.9	21.7	8.7	23.1

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Notes: Includes SNP enrollees first enrolled in a SNP in 2006. Risk score and health conditions apply to CY 2005. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by dual SNPs who met the eligibility criteria for the dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. Institutional SNP ENEs were identified as people living in Institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005.

TABLE VI.3

UTILIZATION AND EXPENDITURE FOR SNP ENROLLEES AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**388,715**	**2,154,744**	**125,552**	**300,130**	**16,515**	**903,913**	**50,002**	**419,503**	**14,768**	**198,777**	**26,060**	**14,691**
Utilization												
Percent with any IP stay	21.8	25.8	n.a.	n.a.	17.3	34.1	n.a.	n.a.	36.5	57.4	n.a.	n.a.
Percent with any OPD visit	67.9	74.4	n.a.	n.a.	44.6	71.4	n.a.	n.a.	75.2	86.7	n.a.	n.a.
Percent with any physician visit	66.6	77.2	n.a.	n.a.	14.2	86.2	n.a.	n.a.	55.3	55.4	n.a.	n.a.
Percent with any SNF days	3.6	7.8	n.a.	n.a.	1.0	8.1	n.a.	n.a.	29.3	53.6	n.a.	n.a.
Utilization When >0 (Mean Visits/Days)												
Number of IP stays	1.8	2.0	n.a.	n.a.	1.7	1.9	n.a.	n.a.	1.9	2.3	n.a.	n.a.
Number of OPD visits	6.4	6.7	n.a.	n.a.	4.3	5.3	n.a.	n.a.	6.6	7.5	n.a.	n.a.
Number of physician visits	8.1	8.7	n.a.	n.a.	9.4	12.0	n.a.	n.a.	6.1	6.9	n.a.	n.a.
Number of SNF days	35.5	50.2	n.a.	n.a.	24.3	38.8	n.a.	n.a.	52.9	56.8	n.a.	n.a.
Medicare Payments (Mean Dollars)												
Inpatient	2,966	4,244	n.a.	n.a.	1,610	5,892	n.a.	n.a.	6,135	12,833	n.a.	n.a.
OPD	856	1,057	n.a.	n.a.	963	1,169	n.a.	n.a.	1,114	1,576	n.a.	n.a.
Physician	1,526	2,477	n.a.	n.a.	634	3,698	n.a.	n.a.	2,498	4,490	n.a.	n.a.
SNF	369	1,061	n.a.	n.a.	72	998	n.a.	n.a.	4,243	8,597	n.a.	n.a.
Home health	424	593	n.a.	n.a.	196	727	n.a.	n.a.	636	1,160	n.a.	n.a.
DME	275	443	n.a.	n.a.	64	374	n.a.	n.a.	299	545	n.a.	n.a.
Hospice	87	227	n.a.	n.a.	36	139	n.a.	n.a.	486	1,143	n.a.	n.a.
Total payments	6,504	10,102	n.a.	n.a.	3,575	12,996	n.a.	n.a.	15,410	30,344	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Notes: Includes SNP enrollees first enrolled in a SNP in 2006. Utilization and Medicare spending apply to CY 2005. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by dual SNPs who met the eligibility criteria for the dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. Institutional SNP ENEs were identified as people living in Institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005.

TABLE VI.4

CHARACTERISTICS OF *DUAL-ELIGIBLE DEMONSTRATION* SNP ENROLLEES AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Previously in Medicare FFS		Previously in Medicare MA	
Beneficiary Characteristics	SNP	ENE	SNP	ENE
Total Number	**32,162**	**53,281**	**14,826**	**9,266**
Age				
<65	1.8	0.0	2.0	0.0
65-74	30.5	41.6	34.5	21.5
75-84	33.6	33.9	35.1	37.9
85+	34.2	24.5	28.5	40.6
Gender				
Male	27.7	33.3	25.9	24.9
Female	72.3	66.7	74.1	75.1
Race				
White	84.5	82.9	75.6	92.4
African American	4.6	8.2	7.5	4.5
Other	10.6	8.6	16.5	2.9
Missing Race	0.3	0.2	0.4	0.1
Medicare Eligibility				
Aged	97.3	99.3	97.3	99.8
Disabled	1.5	0.7	2.1	0.2
ESRD	0.6	0.0	0.6	0.0
None/missing	0.5	0.0	0.0	0.0
Urban/Rural				
Urban	56.9	95.7	74.4	98.5
Rural	43.1	4.3	25.5	1.5
Missing	0.0	0.0	0.0	0.0
Meets Target Criteria for SNP Type				
Yes	89.5	n.a.	92.5	n.a.
No	10.5	n.a.	7.5	n.a.
Missing	0.0	n.a.	0.0	n.a.
Nursing Home Certifiable				
NHC Yes	20.7	n.a.	26.6	n.a.
NHC No	79.3	n.a.	73.4	n.a.
Institutional Status				
Institutionalized (any in year)	33.7	26.2	27.3	44.8
In community	66.1	73.7	71.7	55.2
Missing	0.3	0.1	1.1	0.0
Risk Score				
In community	1.64	1.79	1.64	1.92
Institutionalized	1.53	1.70	1.56	1.66
New	1.09	1.27	1.05	0.0

TABLE VI.4 (*continued*)

Beneficiary Characteristics	Previously in Medicare FFS		Previously in Medicare MA	
	SNP	ENE	SNP	ENE
Death				
Proportion died in 2006	12.7	12.0	11.2	18.2
Health Conditions				
HCC108: COPD	15.7	21.6	16.4	21.8
HCC19: Diabetes w/o complication	19.0	17.3	20.0	16.6
HCC80: CHF	22.6	21.1	21.8	27.1
HCC105: Vascular disease	13.7	26.6	16.3	31.3
HCC92: Specified heart arrhythmias	16.3	16.5	15.2	21.0
HCC55: Major Dep, Bipolar, Paranoid Disorders	6.5	10.6	6.8	11.9
HCC131: Renal Failure	8.3	8.8	7.8	9.4
HCC83: Angina Pectoris/old MI	4.9	6.2	5.0	6.5
HCC10: Breast, Prostate, Colorectal, Other Cancers	5.2	7.4	5.5	8.0
HCC96: Ischemic or Unspecified Stroke	6.3	8.1	6.4	9.9
Utilization				
Percent with Any Inpatient stay	29.5	28.3	n.a.	n.a.
Percent with Any OPD visit	85.7	83.5	n.a.	n.a.
Percent with Any Physician visit	74.1	74.1	n.a.	n.a.
Percent with Any SNF days	16.0	14.9	n.a.	n.a.
Utilization when > 0 (mean visits/days)				
Number of Inpatient stays	1.8	1.9	n.a.	n.a.
Number of OPD visits	8.8	8.1	n.a.	n.a.
Number of Physician visits	6.4	7.2	n.a.	n.a.
Number of SNF days	39.4	48.5	n.a.	n.a.
Medicare Payments (mean dollars)				
Inpatient	3,696	4,621	n.a.	n.a.
OPD	1,337	1,196	n.a.	n.a.
Physician	1,441	2,142	n.a.	n.a.
SNF	1,798	2,022	n.a.	n.a.
Home health	283	659	n.a.	n.a.
DME	226	258	n.a.	n.a.
Hospice	133	324	n.a.	n.a.
Total payments	8,915	11,223	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Notes: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. Risk score, health conditions, utilization, and Medicare spending apply to CY 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual demonstration ENE group was identified as people living in counties served by dual demonstration plans who met the Medicaid and age eligibility criteria for the plans in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare beneficiary database.

TABLE VI.5

CHARACTERISTICS OF *INSTITUTIONAL EQUIVALENT* SNP ENROLLEES
(WPP AND SHMO), 2005

Characteristics	Previously in Medicare FFS	Previously in Medicare MA
Total Number	**2,649**	**17,972**
Age		
<65	16.2	3.1
65-74	45.7	47.9
75-84	26.7	34.8
85+	11.4	14.2
Gender		
Male	38.7	41.9
Female	61.3	58.1
Race		
White	50.3	55.2
African American	34.4	35.5
Other	15.1	9.2
Missing Race	0.1	0.2
Medicare Eligibility		
Aged	83.8	96.5
Disabled	11.5	3.0
ESRD	0.0	0.4
None/missing	4.7	0.1
Urban/Rural		
Urban	96.9	98.9
Rural	3.0	0.9
Missing	0.1	0.2
Meets Target Criteria for SNP Type		
Yes	5.7	33.5
No	94.3	66.5
Nursing Home Certifiable		
NHC Yes	5.3	32.1
NHC No	94.7	67.9
Institutional Status		
Institutionalized (any in year)	1.2	1.9
In community	98.5	97.5
Missing	0.4	0.7
Risk Score		
Community score	1.41	1.37
Institutionalized score	1.56	1.57
New enrollee score	0.73	0.69
Death		
Proportion died in 2006	2.9	5.3
Health Conditions		

TABLE VI.5 (*continued*)

Characteristics	Previously in Medicare FFS	Previously in Medicare MA
HCC108: COPD	11.7	13.2
HCC19: Diabetes w/o complication	15.8	24.2
HCC80: CHF	14.9	18.0
HCC105: Vascular disease	13.7	16.3
HCC92: Specified heart arrhythmias	9.1	11.2
HCC55: Major Dep, Bipolar, Paranoid Disorders	3.8	2.7
HCC131: Renal Failure	5.1	5.8
HCC83: Angina Pectoris/old MI	5.2	6.8
HCC10: Breast, Prostate, Colorectal, Other Cancers	5.1	7.6
HCC96: Ischemic or Unspecified Stroke	4.5	5.5
Utilization		
Percent with Any Inpatient stay	21.9	n.a.
Percent with Any OPD visit	51.7	n.a.
Percent with Any Physician visit	70.2	n.a.
Percent with Any SNF days	4.6	n.a.
Utilization When > 0 (Mean Visits/Days)		
Number of Inpatient stays	2.0	n.a.
Number of OPD visits	6.8	n.a.
Number of Physician visits	9.0	n.a.
Number of SNF days	42.3	n.a.
Medicare Payments (Mean Dollars)		
Inpatient	4,480	n.a.
OPD	552	n.a.
Physician	1,928	n.a.
SNF	669	n.a.
Home health	446	n.a.
DME	209	n.a.
Hospice	32	n.a.
Total Payments	8,316	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Those meeting target population were identified as those with a LTI flag in 2005 from the CMS LTI/ESRD file. No eligible non-enrolled (ENE) group of nursing home certifiable beneficiaries could be identified for these plans. Demographic characteristics were measured in late 2005. Risk score, health conditions, utilization, and Medicare spending apply to CY 2005. SNP enrollees were identified from the payment files.

TABLE VI.6

CHARACTERISTICS OF *DUAL-ELIGIBLE* SNP ENROLLEES, BY PASSIVE ENROLLMENT, AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Previously in Medicare FFS			Previously in Medicare MA		
Characteristics	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE
Total Number	**195,613**	**193,102**	**2,154,744**	**8,060**	**117,492**	**300,130**
Age						
<65	47.6	36.9	47.5	19.3	25.0	19.7
65-74	25.1	34.7	23.6	32.8	39.3	33.0
75-84	18.3	20.5	18.3	29.8	25.6	31.9
85+	9.0	7.9	10.6	18.1	10.1	15.4
Gender						
Male	38.9	38.7	43.3	29.5	37.2	36.6
Female	61.1	61.3	56.7	70.5	62.8	63.4
Race						
White	67.9	56.8	64.5	80.9	62.2	63.6
African American	15.4	19.9	22.2	10.8	17.5	21.8
Other	16.5	23.1	13.1	8.1	20.1	14.4
Missing Race	0.2	0.2	0.2	0.2	0.2	0.2
Medicare Eligibility						
Aged	52.0	62.9	52.2	80.2	74.7	80.2
Disabled	47.1	33.2	47.7	19.5	24.3	19.8
ESRD	0.8	0.2	0.1	0.3	0.2	0.1
None/missing	0.1	3.6	0.0	0.0	0.7	0.0
Urban/Rural						
Urban	87.5	92.3	91.7	67.6	92.5	97.0
Rural	12.4	7.6	8.3	32.4	7.5	3.0
Missing	0.1	0.1	0.0	-	0.0	0.0
Meets Target Criteria for SNP Type						
Yes	97.7	63.7	n.a.	97.0	70.7	n.a.
No	2.3	36.3	n.a.	3.0	29.3	n.a.
Institutional Status						
Institutionalized (any in year)	5.9	1.8	13.7	10.3	4.2	12.3
In community	93.8	97.7	86.2	88.0	94.4	87.6
Missing	0.3	0.5	0.1	1.7	1.3	0.1
Risk Score						
Community score	1.32	1.31	1.54	1.67	1.38	1.64
Institutionalized score	1.55	1.54	1.67	1.69	1.57	1.68
New enrollee score	1.02	1.01	1.03	1.04	1.01	1.13
Death						
Proportion died in 2006	5.0	2.6	7.0	8.5	3.8	8.6
Health Conditions						
HCC108: COPD	15.2	13.9	18.7	20.6	15.8	19.5
HCC19: Diabetes w/o complication	15.9	19.0	16.9	21.4	22.8	18.6
HCC80: CHF	12.1	12.7	15.9	22.4	15.0	19.1
HCC105: Vascular disease	11.6	12.8	17.1	16.0	16.7	17.7
HCC92: Specified heart arrhythmias	7.7	6.3	9.3	14.3	7.9	12.5
HCC55: Major Dep, Bipolar, Paranoid Disorders	9.7	8.2	11.3	6.2	8.0	7.5
HCC131: Renal Failure	4.9	4.3	6.3	8.2	5.3	8.2
HCC83: Angina Pectoris/old MI	4.2	6.0	5.2	7.0	7.4	7.3

TABLE VI.6 (*continued*)

Characteristics	Previously in Medicare FFS			Previously in Medicare MA		
	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE
HCC10: Breast, Prostate, Colorectal, Other Cancers	3.7	4.5	4.6	5.5	5.9	6.5
HCC96: Ischemic or Unspecified Stroke	4.0	4.6	6.6	5.7	5.5	7.4
Utilization						
Percent with Any Inpatient stay	23.0	20.5	25.8	n.a.	n.a.	n.a.
Percent with Any OPD visit	73.9	61.6	74.4	n.a.	n.a.	n.a.
Percent with Any Physician visit	78.9	53.8	77.2	n.a.	n.a.	n.a.
Percent with Any SNF days	4.2	2.8	7.8	n.a.	n.a.	n.a.
Utilization when > 0 (mean visits/ days)						
Number of Inpatient stays	1.9	1.8	2.0	n.a.	n.a.	n.a.
Number of OPD visits	6.7	6.0	6.7	n.a.	n.a.	n.a.
Number of Physician visits	7.9	8.5	8.7	n.a.	n.a.	n.a.
Number of SNF days	35.1	36.3	50.2	n.a.	n.a.	n.a.
Medicare Payments (Mean Dollars)						
Inpatient	3,350	2,566	4,244	n.a.	n.a.	n.a.
OPD	1,045	659	1,057	n.a.	n.a.	n.a.
Physician	1,752	1,290	2,477	n.a.	n.a.	n.a.
SNF	430	305	1,061	n.a.	n.a.	n.a.
Home health	428	420	593	n.a.	n.a.	n.a.
DME	322	226	443	n.a.	n.a.	n.a.
Hospice	107	66	227	n.a.	n.a.	n.a.
Total Payments	7,436	5,532	10,102	n.a.	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File. Medicare Beneficiary Database (MBD) for passive enrollment information.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. Risk score, health conditions, utilization, and Medicare spending apply to CY 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by Dual SNPs who met the eligibility criteria for the Dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database.

As described in Chapter II, passive enrollment was permitted on a one-time basis in January, 2006. Passive enrollees were identified as those identified in the MBD with a Part D opt-out reason code of "SNP" and who were enrolled into a SNP approved for passive enrollment between August 2005 and May 2006. This table does not include the small number of beneficiaries who were passively enrolled by chronic disease or institutional SNPs.

TABLE VI.7

DEMOGRAPHIC CHARACTERISTICS OF SNP ENROLLEES MEETING TARGET CRITERIA AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**314,018**	**2,154,744**	**90,838**	**300,130**	**7,800**	**903,913**	**29,388**	**419,503**	**8,378**	**198,777**	**7,345**	**14,691**
Age												
<65	43.2	47.5	23.2	19.7	26.8	13.1	19.3	7.0	9.0	10.2	6.7	6.1
65-74	29.2	23.6	38.5	33.0	35.2	34.4	46.5	38.4	14.0	14.5	11.7	15.6
75-84	19.4	18.3	27.3	31.9	28.3	36.3	26.3	40.5	33.8	34.5	32.6	37.0
85+	8.1	10.6	11.1	15.4	9.7	16.2	7.9	14.1	43.2	40.9	49.1	41.4
Gender												
Male	37.6	43.3	34.6	36.6	46.0	44.2	45.1	46.6	28.0	35.7	26.3	36.2
Female	62.4	56.7	65.4	63.4	54.0	55.8	54.9	53.4	72.0	64.3	73.7	63.8
Race												
White	61.9	64.5	63.2	63.6	59.4	72.7	65.0	77.9	79.2	79.8	82.4	71.5
African American	19.3	22.2	19.3	21.8	11.2	12.1	6.3	9.7	18.1	16.7	15.2	22.0
Other	18.6	13.1	17.3	14.4	29.3	15.1	28.5	12.3	2.5	3.4	2.2	6.4
Missing Race	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.1	0.2	0.2
Medicare Eligibility												
Aged	56.5	52.2	76.5	80.2	71.7	86.7	80.6	92.8	90.9	89.6	93.0	93.8
Disabled	41.8	47.7	22.7	19.8	23.8	12.8	19.3	7.0	8.9	10.3	6.9	6.2
ESRD	0.6	0.1	0.3	0.1	4.2	0.4	0.1	0.2	0.0	0.1	0.1	0.0
None/missing	1.2	0.0	0.5	0.0	0.2	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Urban/Rural												
Urban	89.2	91.7	89.5	97.0	95.0	98.2	95.8	99.8	94.0	95.0	99.6	98.8
Rural	10.7	8.3	10.4	3.0	4.8	1.8	4.1	0.2	5.9	5.0	0.4	1.2
Missing	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by Dual SNPs who met the eligibility criteria for the Dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. SNP Enrollees meeting the target criteria for dual eligible SNPs were identified by a current status of Medicaid on the HMO payment file in the month they enrolled. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. SNP enrollees meeting the target criteria for chronic disease SNPs were identified by indicators for the relevant disease conditions for the SNP in the CY 2005 HCC file. HCCs for 2006 were not available for this report. Institutional SNP ENEs were identified as people living in institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005. Enrollees meeting target criteria for institutional SNPs were identified by a long term institutional (LTI) flag in CY 2005 from the CMS LTI/ESRD file.

TABLE VI.8

INDICATORS OF HEALTH FOR SNP ENROLLEES MEETING TARGET CRITERIA AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**314,018**	**2,154,744**	**90,838**	**300,130**	**7,800**	**903,913**	**29,388**	**419,503**	**8,378**	**198,777**	**7,345**	**14,691**
Institutional Status												
Institutionalized (any in year)	4.2	13.7	5.1	12.3	0.2	4.4	0.0	1.5	1.0	71.9	1.0	68.5
In community	95.4	86.2	93.5	87.6	99.8	95.6	100.0	98.5	0.0	28.0	0.0	31.4
Missing	0.4	0.1	1.4	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1
Risk Score												
Community score	1.34	1.54	1.46	1.64	1.75	1.88	1.66	1.68	2.55	2.90	2.34	3.22
Institutionalized score	1.56	1.67	1.60	1.68	1.97	1.92	1.89	1.82	2.03	2.31	1.85	2.52
New enrollee score	1.05	1.03	1.08	1.13	0.00	1.02	0.00	0.87	1.10	1.33	0.00	1.55
Percent missing risk score	0.47	0.04	1.31	0.06	0.01	0.00	0.00	0.00	0.01	0.07	0.00	0.11
Death												
Proportion died in 2006	4.0	7.0	4.4	8.6	4.0	7.6	3.4	7.4	19.8	26.9	27.7	28.1
Health Conditions												
HCC108: COPD	15.1	18.7	17.1	19.5	25.1	31.2	24.7	25.5	25.3	29.2	23.1	30.7
HCC19: Diabetes without complication	16.7	16.9	22.3	18.6	43.5	27.0	52.3	28.4	16.9	18.9	15.6	20.0
HCC80: CHF	12.4	15.9	16.1	19.1	28.6	32.0	24.6	25.6	33.1	38.6	32.0	47.0
HCC105: Vascular disease	11.8	17.1	16.5	17.7	21.1	23.9	27.9	16.2	45.0	41.8	49.6	41.4
HCC92: Specified heart arrhythmias	7.4	9.3	9.1	12.5	10.4	21.2	7.6	17.1	21.3	25.9	19.8	31.4
HCC55: Major Depression, Bipolar, Paranoid Disorders	8.7	11.3	7.5	7.5	9.7	8.8	12.5	8.3	17.7	16.8	14.1	15.8
HCC131: Renal Failure	4.8	6.3	5.9	8.2	9.0	11.6	8.4	11.9	14.4	17.2	14.0	21.1
HCC83: Angina Pectoris/old MI	4.7	5.2	7.2	7.3	12.0	11.4	15.6	14.0	4.9	6.4	6.0	8.7
HCC10: Breast, Prostate, Colorectal, Other Cancers	3.9	4.6	5.9	6.5	7.1	12.7	9.6	13.7	6.2	7.3	6.2	8.1
HCC96: Ischemic or unspecified stroke	4.1	6.6	5.5	7.4	8.1	7.9	8.0	6.1	19.7	21.7	15.8	23.1

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by Dual SNPs who met the eligibility criteria for the Dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. SNP Enrollees meeting the

TABLE VI.8 (*continued*)

target criteria for dual eligible SNPs were identified by a current status of Medicaid on the HMO payment file in the month they enrolled. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. SNP enrollees meeting the target criteria for chronic disease SNPs were identified by indicators for the relevant disease conditions for the SNP in the CY 2005 HCC file. HCCs for 2006 were not available for this report. Institutional SNP ENEs were identified as people living in institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005. Enrollees meeting target criteria for institutional SNPs were identified by a long term institutional (LTI) flag in CY 2005 from the CMS LTI/ESRD file.

TABLE VI.9

UTILIZATION AND EXPENDITURE FOR SNP ENROLLEES MEETING TARGET CRITERIA AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Dual-Eligible SNP Previously in Medicare FFS		Dual-Eligible SNP Previously in Medicare MA		Chronic-Condition SNP Previously in Medicare FFS		Chronic-Condition SNP Previously in Medicare MA		Institutional SNP Previously in Medicare FFS		Institutional SNP Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE	SNP	ENE
Total Number	**314,018**	**2,154,744**	**90,838**	**300,130**	**7,800**	**903,913**	**29,388**	**419,503**	**8,378**	**198,777**	**7,345**	**14,691**
Utilization												
Percent with any IP stay	22.4	25.8	n.a.	n.a.	26.7	34.1	n.a.	n.a.	34.0	57.4	n.a.	n.a.
Percent with any OPD visit	72.0	74.4	n.a.	n.a.	57.3	71.4	n.a.	n.a.	81.6	86.7	n.a.	n.a.
Percent with any physician visit	77.8	77.2	n.a.	n.a.	20.6	86.2	n.a.	n.a.	40.4	55.4	n.a.	n.a.
Percent with any SNF days	3.8	7.8	n.a.	n.a.	1.4	8.1	n.a.	n.a.	32.7	53.6	n.a.	n.a.
Utilization When >0 (Mean Visits/Days)												
Number of IP stays	1.8	2.0	n.a.	n.a.	1.8	1.9	n.a.	n.a.	1.8	2.3	n.a.	n.a.
Number of OPD visits	6.6	6.7	n.a.	n.a.	4.9	5.3	n.a.	n.a.	6.9	7.5	n.a.	n.a.
Number of physician visits	8.1	8.7	n.a.	n.a.	10.7	12.0	n.a.	n.a.	3.6	6.9	n.a.	n.a.
Number of SNF days	34.7	50.2	n.a.	n.a.	27.0	38.8	n.a.	n.a.	56.4	56.8	n.a.	n.a.
Medicare Payments (Mean Dollars)												
Inpatient	3,256	4,244	n.a.	n.a.	2,784	5,892	n.a.	n.a.	5,124	12,833	n.a.	n.a.
OPD	955	1,057	n.a.	n.a.	1,671	1,169	n.a.	n.a.	1,321	1,576	n.a.	n.a.
Physician	1,772	2,477	n.a.	n.a.	1,120	3,698	n.a.	n.a.	2,369	4,490	n.a.	n.a.
SNF	391	1,061	n.a.	n.a.	114	998	n.a.	n.a.	4,784	8,597	n.a.	n.a.
Home health	464	593	n.a.	n.a.	309	727	n.a.	n.a.	247	1,160	n.a.	n.a.
DME	320	443	n.a.	n.a.	112	374	n.a.	n.a.	285	545	n.a.	n.a.
Hospice	84	227	n.a.	n.a.	33	139	n.a.	n.a.	663	1,143	n.a.	n.a.
Total payments	7,243	10,102	n.a.	n.a.	6,144	12,996	n.a.	n.a.	14,794	30,344	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by Dual SNPs who met the eligibility criteria for the Dual SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database. SNP Enrollees meeting the target criteria for dual eligible SNPs were identified by a current status of Medicaid on the HMO payment file in the month they enrolled. Chronic condition SNP ENEs were identified as people living in chronic condition SNP counties who had the health conditions served by that chronic condition SNP(s), as identified by HCC condition flags in HCC data from CMS for 2005. SNP enrollees meeting the target criteria for chronic disease SNPs were identified by indicators for the relevant disease conditions for the SNP in the CY 2005 HCC file. HCCs for 2006 were not available for this report. Institutional SNP ENEs were identified as people living in institutional SNP counties who had MDS assessments (one 90-day or two or more) in 2005. Enrollees meeting target criteria for institutional SNPs were identified by a long term institutional (LTI) flag in CY 2005 from the CMS LTI/ESRD file.

TABLE VI.10

CHARACTERISTICS OF *DUAL-ELIGIBLE DEMONSTRATION* SNP ENROLLEES MEETING TARGET CRITERIA AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

	Previously in Medicare FFS		Previously in Medicare MA	
Characteristics	SNP	ENE	SNP	ENE
Total Number	**28,786**	**53,281**	**13,709**	**9,266**
Age				
<65	1.7	-	2.0	-
65-74	32.5	41.6	36.3	21.5
75-84	33.4	33.9	35.3	37.9
85+	32.5	24.5	26.3	40.6
Gender				
Male	27.2	33.3	26.0	24.9
Female	72.8	66.7	74.0	75.1
Race				
White	83.2	82.9	74.1	92.4
African American	4.8	8.2	7.8	4.5
Other	11.7	8.6	17.6	2.9
Missing Race	0.3	0.2	0.4	0.1
Medicare Eligibility				
Aged	97.3	99.3	97.3	99.8
Disabled	1.5	0.7	2.1	0.2
ESRD	0.6	0.0	0.5	0.0
None/missing	0.6	0.0	0.0	-
Urban/Rural				
Urban	57.1	95.7	73.7	98.5
Rural	42.9	4.3	26.2	1.5
Missing	0.0	-	0.0	-
Nursing Home Certifiable at Enrollment				
NHC Yes	19.8	n.a.	27.7	n.a.
NHC No	80.2	n.a.	72.3	n.a.
Institutional Status				
Institutionalized (any in year)	33.3	26.2	24.3	44.8
In community	66.4	73.7	74.7	55.2
Missing	0.3	0.1	1.0	0.04
Risk Score				
Community score	1.61	1.79	1.62	1.9
Institutionalized score	1.52	1.70	1.56	1.7
New enrollee score	1.09	1.3	1.06	0.0
Death				
Proportion died in 2006	12.5	12.0	10.4	18.2
Health Conditions				
HCC108: COPD	15.4	21.6	16.5	21.8
HCC19: Diabetes w/o complication	19.1	17.3	20.0	16.6
HCC80: CHF	21.7	21.1	21.0	27.1
HCC105: Vascular disease	13.3	26.6	15.7	31.3
HCC92: Specified heart arrhythmias	15.5	16.5	14.5	21.0
HCC55: Major Dep, Bipolar, Paranoid Disorders	6.3	10.6	6.5	11.9
HCC131: Renal Failure	7.8	8.8	7.8	9.4
HCC83: Angina Pectoris/old MI	4.7	6.2	5.0	6.5
HCC10: Breast, Prostate, Colorectal, Other Cancers	5.0	7.4	5.5	8.0
HCC96: Ischemic or Unspecified Stroke	5.8	8.1	5.9	9.9

TABLE VI.10 (*continued*)

Characteristics	Previously in Medicare FFS		Previously in Medicare MA	
	SNP	ENE	SNP	ENE
Utilization				
Percent with Any Inpatient stay	27.8	28.3	n.a.	n.a.
Percent with Any OPD visit	85.5	83.5	n.a.	n.a.
Percent with Any Physician visit	73.9	74.1	n.a.	n.a.
Percent with Any SNF days	14.2	14.9	n.a.	n.a.
Utilization When > 0 (Mean Visits/Days)				
Number of Inpatient stays	1.7	1.9	n.a.	n.a.
Number of OPD visits	8.8	8.1	n.a.	n.a.
Number of Physician visits	6.4	7.2	n.a.	n.a.
Number of SNF days	38.1	48.5	n.a.	n.a.
Medicare Payments (Mean Dollars)				
Inpatient	3,433	4,621	n.a.	n.a.
OPD	1,305	1,196	n.a.	n.a.
Physician	1,394	2,142	n.a.	n.a.
SNF	1,531	2,022	n.a.	n.a.
Home health	270	659	n.a.	n.a.
DME	221	258	n.a.	n.a.
Hospice	116	324	n.a.	n.a.
Total Payments	8,269	11,223	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. Risk score, health conditions, utilization, and Medicare spending apply to CY 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual demonstration ENE group was identified as people living in counties served by dual demonstration plans who met the Medicaid and age eligibility criteria for the plans in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare beneficiary database. SNP enrollees meeting the target criteria for dual eligible SNPs were identified by a current status of Medicaid on the HMO payment file in the month they enrolled.

TABLE VI.11

CHARACTERISTICS OF *DUAL-ELIGIBLE* SNP ENROLLEES MEETING TARGET CRITERIA, BY PASSIVE ENROLLMENT, AND THEIR ELIGIBLE NON ENROLLEE (ENE) COUNTERPARTS, 2005

Characteristics	Previously in Medicare FFS			Previously in Medicare MA		
	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE
Total Number	**191,085**	**122,933**	**2,154,744**	**7,816**	**83,022**	**300,130**
Age						
<65	47.1	37.0	47.5	19.0	23.6	19.7
65-74	25.3	35.3	23.6	32.9	39.0	33.0
75-84	18.5	20.9	18.3	30.1	27.0	31.9
85+	9.1	6.7	10.6	18.0	10.4	15.4
Gender						
Male	38.7	35.8	43.3	29.3	35.1	36.6
Female	61.3	64.1	56.7	70.7	64.9	63.4
Race						
White	67.9	52.6	64.5	81.3	61.5	63.6
African American	15.3	25.6	22.2	10.4	20.2	21.8
Other	16.7	21.7	13.1	8.1	18.2	14.4
Missing Race	0.2	0.2	0.2	0.2	0.2	0.2
Medicare Eligibility						
Aged	52.4	62.7	52.2	80.6	76.2	80.2
Disabled	46.7	34.2	47.7	19.1	23.0	19.8
ESRD	0.8	0.2	0.1	0.2	0.3	0.1
None/missing	0.1	2.9	0.0	0.0	0.6	0.0
Urban/Rural						
Urban	87.4	92.0	91.7	66.9	91.7	97.0
Rural	12.5	7.9	8.3	33.1	8.3	3.0
Missing	0.1	0.1	0.0	0.0	0.0	0.0
Institutional Status						
Institutionalized (any in year)	5.8	1.7	13.7	10.0	4.6	12.3
In community	93.9	97.7	86.2	88.3	93.9	87.6
Missing	0.3	0.6	0.1	1.7	1.4	0.1
Risk Score						
Community score	1.32	1.36	1.54	1.67	1.45	1.64
Institutionalized score	1.55	1.57	1.67	1.69	1.59	1.68
New enrollee score	1.03	1.07	1.03	1.06	1.08	1.13
Death						
Proportion died in 2006	5.0	2.4	7.0	8.4	4.1	8.6
Health Conditions						
HCC108: COPD	15.2	14.9	18.7	20.6	16.8	19.5
HCC19: Diabetes w/o complication	15.9	17.8	16.9	21.3	22.4	18.6
HCC80: CHF	12.1	12.8	15.9	22.3	15.5	19.1
HCC105: Vascular disease	11.6	12.2	17.1	15.5	16.8	17.7
HCC92: Specified heart arrhythmias	7.7	6.9	9.3	14.2	8.7	12.5
HCC55: Major Dep, Bipolar, Paranoid Disorders	9.6	7.4	11.3	6.1	7.6	7.5
HCC131: Renal Failure	4.9	4.7	6.3	8.2	5.7	8.2
HCC83: Angina Pectoris/old MI	4.2	5.6	5.2	7.0	7.3	7.3
HCC10: Breast, Prostate, Colorectal, Other Cancers	3.7	4.2	4.6	5.5	6.0	6.5
HCC96: Ischemic or Unspecified Stroke	4.0	4.3	6.6	5.7	5.5	7.4

TABLE VI.11 (*continued*)

Characteristics	Previously in Medicare FFS			Previously in Medicare MA		
	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE	SNP Passively Enrolled	SNP Not Passively Enrolled	ENE
Utilization						
Percent with Any Inpatient stay	22.9	21.6	25.8	n.a.	n.a.	n.a.
Percent with Any OPD visit	73.8	69.1	74.4	n.a.	n.a.	n.a.
Percent with Any Physician visit	79.0	75.9	77.2	n.a.	n.a.	n.a.
Percent with Any SNF days	4.2	3.2	7.8	n.a.	n.a.	n.a.
Utilization When > 0 (Mean Visits/ Days)						
Number of Inpatient stays	1.9	1.8	2.0	n.a.	n.a.	n.a.
Number of OPD visits	6.7	6.5	6.7	n.a.	n.a.	n.a.
Number of Physician visits	7.9	8.5	8.7	n.a.	n.a.	n.a.
Number of SNF days	34.6	34.9	50.2	n.a.	n.a.	n.a.
Medicare Payments (Mean Dollars)						
Inpatient	3,325	3,148	4,244	n.a.	n.a.	n.a.
OPD	1,041	819	1,057	n.a.	n.a.	n.a.
Physician	1,747	1,812	2,477	n.a.	n.a.	n.a.
SNF	425	337	1,061	n.a.	n.a.	n.a.
Home health	427	524	593	n.a.	n.a.	n.a.
DME	321	319	443	n.a.	n.a.	n.a.
Hospice	103	55	227	n.a.	n.a.	n.a.
Total Payments	7,388	7,013	10,102	n.a.	n.a.	n.a.

Source: CMS enrollment, claims, HCC, and HMO payment files; MDS; CCW Beneficiary Annual Summary File.

Note: Includes SNP enrollees first enrolled in a SNP in 2006. Demographic characteristics were measured in late 2005. Risk score, health conditions, utilization, and Medicare spending apply to CY 2005. SNP enrollees were identified from the payment files. Sample excludes people who died in 2005, or who were new to Medicare in 2006. Dual SNP ENE group was identified as people living in counties served by Dual SNPs who met the eligibility criteria for the DE SNP(s)–Full or partial Medicaid–in the last quarter of 2005. Dual eligibility was drawn from MMA variables in the Medicare Beneficiary Database.

As described in Cahpter II, passive enrollment was permitted on a one-time basis in January, 2006. Passive enrollees were identified as those identified in the MBD with a Part D opt-out reason code of "SNP" and who were enrolled into a SNP approved for passive enrollment between August 2005 and May 2006. This table does not include the small number of beneficiaries who were passively enrolled by chronic disease or institutional SNPs. Enrollees meeting the target criteria for dual eligible SNPs were identified by a current status of Medicaid on the HMO payment file in the month they enrolled.

VII. ANALYSIS OF SNP AND MA PLAN BIDS

SNPs receive monthly capitation payments from the Medicare program under the same payment methodology as other Medicare coordinated care plans for each of their enrollees. They are at full financial risk for the cost of services in their benefit packages. To assess the cost effectiveness of SNPs relative to other MA plans, we reviewed whether the bids of SNP plans are systematically different from those of other MA plans in relation to the benchmarks. This chapter compares 2006 and 2007 bid data for SNP plans with other MA plan bids in overlapping service areas.

A. BACKGROUND

Since 2006, CMS payment has been based on bids submitted by MAOs for the MA plans they offer and the bids' relation to a county benchmark for Medicare Part A and B benefits. Plans with bids exceeding the benchmark are required to charge a premium equal to the difference between the bid and the benchmark amount. Plans with bids less than the benchmark receive a payment equal to the bid plus a beneficiary rebate of 75 percent of the difference between the bid and the benchmark. This rebate must be returned to enrollees in the form of additional services or reduced member premiums and cost sharing as defined by the plan in its benefit package. The Medicare program retains the 25 percent difference as "savings." (Note: for plans with bids below benchmark, the statute refers to 100 percent of the bid-benchmark difference as "savings," but the term "savings" is also commonly used to refer to that 25 percent of the bid-benchmark difference retained by the government.)

B. METHODS

Confidentiality of MA plan bids rules out reporting of bid dollar values or of any bid analysis stratified by geographic area or type of plan. We therefore computed the mean of the ratio of plan bids to benchmark values for SNPs and MA plans that offered prescription drug coverage and that shared overlapping market areas. The steps in this computation are outlined below.

Select SNP and MA plans with overlapping market areas. Using the Health Plan Management System (HPMS), we identified 220 SNPs with defined market areas that overlapped with those of one or more MA plans in 2006. We identified 424 such SNPs in 2007. By requiring the market areas to be overlapping, the possibility that bid-to-benchmark ratios might be affected by systematic differences in benchmark values for SNPs and comparison MA plans was minimized.[41]

[41] All plans in this analysis are coordinated care plans (CCPs) – SNPs and non-SNP CCPs. (SNPs are required to be CCPs.) Private Fee for Service (PFFS) were excluded because unlike SNPs they are not CCPs. Employer-sponsored plans (both CCPs and PFFS plans) are also excluded from this analysis because they often have specialized benefits and are not available to all beneficiaries.

Compute the ratio of bid to benchmark values. For each SNP, we first computed the ratio of the bid to the benchmark value. We then computed the enrollment-weighted mean of the ratio of bid to benchmark values for all coordinated care MA plans having market areas that overlap with that of the SNP.[42] Each SNP's bid-to-benchmark value was then paired with the enrollment-weighted mean of bid-to-benchmark values of all MA plans whose market areas overlap with that of the SNP. Comparing SNP bids with those of MA plans in overlapping market areas tends to eliminate differences due to variation in benchmark values. Note that this latter mean is exactly equal to the mean of bid-to-benchmark ratios that would prevail in the market area if all SNP enrollees left the SNP and joined other MA plans operating in overlapping market areas in proportion to the existing enrollment of these MA plans. It is thus a reasonable estimate of the mean bid-to-benchmark ratio that would prevail in the market in the absence of SNPs.

Compute overall weighted means of bid-to-benchmark ratios. That is, compute the SNP-enrollment-weighted average of both the SNP bid-to-benchmark ratios and their paired mean MA plan bid-to-benchmark ratios. This procedure effectively produces the mean bid-to-benchmark ratio associated with all SNP enrollees in the selected plans and the mean counterfactual bid-to-benchmark ratio for those same enrollees.

C. RESULTS

Table VII.1 displays the results of the calculations described above. Mean bid-to-benchmark ratios in 2006 were about the same on average, for SNPs compared to non-SNP coordinated care MA plans in the same market area. In 2007, the mean ratio was about three percent lower for SNPs.[43]

TABLE VII.1

MEAN BID-TO-BENCHMARK RATIOS FOR SNP AND MA PLANS WITH OVERLAPPING MARKET AREAS: 2006 AND 2007

	2006	2007
SNP	0.815	0.794
MA plan	0.818	0.818
Percentage difference	-0.4	-3.0
Number of SNPs in calculation & (% of total SNPs)	220 (91%)	424 (89%)
% of total SNP enrollment captured by overlapping market analysis	99%	99%

Note: Calculation includes SNPs and MA plans offering prescription-drug coverage and whose market areas contain at least one county in common. PFFS and employer-sponsored plans are excluded.

[42] Appendix IV provides more precise expressions for the bid-to-benchmark ratios presented here.

[43] In other analyses not reported here, we computed bid-to-benchmark ratios for SNPs and MA plans sharing *identical* market areas. Although only 139 SNPs shared market areas with one or more MA plans, the results were similar to those seen in Table VII.1. The percentage difference was 2.0 percent in 2006 and –3.3 percent in 2007.

None of the SNP plans charged a Part C basic beneficiary premium in either year (that is, SNP bids were all below the benchmark in every case), while 3 to 4 percent of non-SNP MA comparison plans charged a Part C basic beneficiary premium in 2006 or 2007 (that is, 3 to 4 percent of non-SNP MA plans bid over the benchmark). Note that although the mean bid-to-benchmark ratio for SNPs and non-SNPs in 2006 were almost the same, the highest values of the bid-to-benchmark ratio in both 2006 and 2007 were submitted by comparison MA plans. These data do not include any information on other cost sharing of MA plan enrollees.

D. DISCUSSION

The results shown in Table VII.1 indicate that bids of SNPs and MA plans are about the same, on average, suggesting that SNPs entail neither costs nor savings to the Medicare program relative to non-SNP coordinated care MA plans. Given that payment rates and risk adjustment for SNPs are identical to those of other MA plans, this result is to be expected.

It is important to note that, while bids are actuarially certified estimates of expected expenditures for the contract year, they are estimates nonetheless. A plan's actual expenditures in the contract year are likely to differ from its bid for a variety of reasons. The plan may simply make erroneous assumptions about changes in costs in its market place, or about anticipated changes in the health status of its enrollment for the contract year, or about a host of other factors that may influence utilization of services. The accuracy of a plan's estimates will depend, in part, on the amount of experience the plan has had in serving the targeted population and its ability to use that experience in formulating its estimates. Plans may also be more or less cautious in making assumptions about costs and about their ability to control them. Larger plans, with more experience might be more comfortable making aggressive assumptions about managing costs than smaller plans with less experience. Plans that submitted bids for contract year 2006 would have preliminary indications of how accurate their projections were from their early 2006 financial reports and could adjust their 2007 bids accordingly. Similarly, plans with more financial resources might initially be more aggressive bidders in order to realize anticipated economies of scale.

With only two years of bids available for analysis and the somewhat uncertain relationship between bids and actual financial performance, it is clearly too early to reach any conclusions about whether SNPs will be more cost effective than non-SNPs for the populations they serve. The bid analysis does suggest, however, that as of the 2007 contract year, SNP bids are comparable to non-SNP plan bids.

VIII. CONCLUSIONS

This report does not and cannot provide definitive conclusions about the effect of SNPs on the cost and quality of care provided to their enrollees. The due date for the report precluded use of data for 2005 and 2006 from the Health Plan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans (CAHPs), and the Health Outcomes Survey (HOS). Because MA plans, including SNPs, do not submit claims to CMS for services they provide, the use of claims-based measures of treatment outcomes and quality was ruled out.

Moreover, most SNPs were relatively new, many in their first year of operation, and still in the process of developing and refining their specialized programs. Thus SNP members would have had limited exposure to the programs that had been implemented. This is important because interventions directed at chronic conditions can require two or three years before their impact can be reliably detected.

Despite limitations imposed by data availability, the material contained in this report provides important information about the variety of new models of care that SNPs are developing, the populations they are serving, and some preliminary indications of what they are accomplishing.

The opportunity that SNPs provide for specializing in care of particular groups of Medicare beneficiaries has proven to be attractive to industry. Organizations wishing to offer new SNPs or expand existing SNPs submitted over 400 applications to CMS for 2008. If all applications were approved, there would be 815 SNPs in 2008—nearly triple the number operating in 2006. The number of chronic-condition SNPs has grown especially rapidly, from 13 in 2006 to 84 in 2007, with 264 applications for new and existing plans submitted for 2008. Despite this rapid growth in the number of SNPs, a substantial proportion—about 30 percent in 2007—had fewer than 50 enrollees, suggesting that some plans are unlikely to be sustainable over a longer term.

While SNP enrollment grew rapidly from 2005 to 2007, their ultimate appeal to Medicare beneficiaries is not yet clear. Enrollment in dual-eligible SNPs grew substantially in 2006 due in part to the one-time passive enrollment policy implemented by CMS and the redesignation of some MA contractors to SNP status. Growth continued more slowly between 2006 and 2007. Enrollment in institutional SNPs increased more rapidly during that time period, but this was due, in large part, to the conversion of a large demonstration plan to SNP institutional-equivalent status. While passive enrollment and plan redesignation accounted for a substantial share of SNP enrollment, at least 45 percent of beneficiaries ever enrolled in a SNP between 2004 and 2006 (353,000 out of 774,000) made an active choice to do so, either by leaving fee-for-service Medicare to enroll in a SNP or by leaving an MA plan to enroll in a SNP operated by a different parent organization. Rates of disenrollment from SNPs have declined over time and resemble rates of disenrollment from other MA plans.

Still it is impossible to tell what the long-term enrollment in SNPs is likely to be. If about half of those who enrolled in SNPs made an active decision to do so, then about half did not. Some events that contributed significantly to early enrollment trends, such as passive enrollment and the conversion of demonstration plans to SNP status, were one-time occurrences, while

others, such as plan redesignations and transfers within MCO's will play a diminishing role in the future. As current enrollees leave SNPs due to death, loss of eligibility, or disenrollment, total enrollment in SNPs will be maintained only if an equal number are attracted to actively enroll in SNPs. This in turn will require that SNPs convince prospective enrollees of the value of the special services and interventions they offer.

Integration of Medicare and Medicaid services through SNPs may require several years to achieve in many States. With the exception of demonstration SNPs, few dual-eligible SNPs have entered into risk-based contracts with States for coverage of full Medicaid services. In some States with experience and current interest in promoting managed Medicaid long-term care, the barriers to Medicare/Medicaid integration may consist primarily of conflicts between State and Federal policy or other procedural problems. But in a majority of States, Medicaid officials appear to feel that other competing issues are more pressing at this point than developing and contracting for integrated approaches to Medicaid long-term care. State reluctance may stem from a suspicion of large for-profit managed care organizations or from concern that managed care will be disruptive to providers in their State. Managed care organizations, for their part, may be unwilling to engage in long-term negotiations and discussions with Medicaid agencies and may also be concerned about shifting State requirements.

Staff members from several of the plans visited for the evaluation pointed out that joint contracting provides information that permits more effective coordination of care and helps them intervene more effectively when the need arises. Perhaps for this reason, 75 percent of health plans responding to the survey of SNPs in this study indicated an interest in pursuing Medicaid contract arrangements. In the States without a defined interest in SNPs, the process of contracting with SNPs to provide full Medicaid coverage might require several years of ongoing contact between a SNP, CMS, and a State Medicaid agency, as it did in Massachusetts, Minnesota, and Wisconsin.

In 2007, 18 States had entered into Medicaid contracts with one or more SNPs. Of these, eight included some form of long-term care benefit. Because incentives to contract with SNPs appear limited for States that do not include long-term care services in their Medicaid managed-care contracts, we will need to improve our understanding of State attitudes and decision-making regarding managed long-term care. Without better information on this issue, it will be difficult to understand or anticipate the prospects for growth in the number of dually contracted SNPs.

It is too early to tell whether SNPs improve care and thus outcomes for their members. As noted above, SNPs are so new that quality measures derived from CAHPS, HEDIS, and HOS are not yet available. That said, visits to SNPs turned up promising indications. SNP staff at most of the visited sites displayed a strong sense of mission and a keen desire to do whatever is necessary to address member's health problems and concerns. Such active concern would seem to be a prerequisite for effective intervention and care. To the extent that these motivations are shared by non-sampled SNPs and are sustained over time, impacts on cost and quality may emerge and be measured in data collected in 2008 and beyond.

At the same time, some evidence indicates that SNP enrollees may have somewhat lower care needs than comparable beneficiaries who did not enroll in SNPs. Whether this pattern stems primarily from a reluctance of beneficiaries with the most severe health problems to enroll in

managed care plans or whether this is a result of specific SNP marketing strategies is difficult to ascertain. In any case, the introduction of HCC risk adjusted payments has substantially reduced the likelihood that plans enjoying favorable selection will be overpaid.[44] HCC risk adjustment, takes diagnostic information into account and consequently does a much better job of matching payments to medical complexity and cost than the previous payment system that relied only on demographic information to predict expenditures.

There is no evidence at this point that Medicare payments to SNPs differ from payments to other MA plans. Because SNPs are paid in the same way as all MA plans, they will impose the same costs on the Medicare program unless (1) their enrollees are more or less likely, on average, to transition to higher-paying HCCs than are similar beneficiaries enrolled in MA plans, or (2) their bids are systematically lower than those of other MA plans. Assessment of SNP and MA bids indicated that the ratios of plan bids to local benchmarks were nearly identical for SNPs and MA plans with overlapping market areas. There is no reason at this point to suggest that result will change in future years. A potential avenue for cost reduction through SNPs, is the prospect that improved care might retard the progression of chronic illness, benefiting SNP enrollees and lowering cost to Medicare by slowing the growth of capitation payments. It is still too early to examine this possibility because HCC scores reflecting beneficiary health conditions in 2006 were not available in time for this analysis.

[44] While HCC risk adjustment has improved payment accuracy, plans are currently paid more than Medicare pays for comparable beneficiaries enrolled in traditional Medicare for reasons unrelated to the risk adjustment payment process. CMS is in the process of implementing changes that will address these other issues and bring payments to MCOs into line with payments in traditional Medicare.

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APPENDIX I

KEY SECTIONS OF US CODE PERTAINING TO SPECIAL NEEDS PLANS

TITLE 42--THE PUBLIC HEALTH AND WELFARE

CHAPTER 7--SOCIAL SECURITY

SUBCHAPTER XVIII--HEALTH INSURANCE FOR AGED AND DISABLED

Part C--Medicare+Choice Program

Sec. 1395w-**21**. Eligibility, election, and enrollment

Pub. L. 108-173, title II, Sec. 231(a), Dec. 8, 2003, 117 Stat. 2207, provided that subsection (a)(2)(A) of this section, as amended by section 221(a) of Pub. L. 108-173, is amended by adding at the end the following new clause:

> ``(ii) Specialized MA plans for special needs individuals
>
> ``Specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title) may be any type of coordinated care plan."

Authority To Designate Other Plans as Specialized MA Plans

Pub. L. 108-173, title II, Sec. 231(d), Dec. 8, 2003, 117 Stat. 2208, provided that: ``In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act [subsec. (a)(2)(A)(ii) of this section] (as added by subsection (a)) and section 1859(b)(6) of such Act [section 1395w-28(b)(6) of this title] (as added by subsection (b)), the Secretary [of Health and Human Services] may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals."

Report on Impact of Specialized MA Plans for Special Needs Individuals

Pub. L. 108-173, title II, Sec. 231(e), Dec. 8, 2003, 117 Stat. 2208, provided that: ``Not later than December 31, 2007, the Secretary [of Health and Human Services] shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the Medicare program as a result of amendments made by subsections (a), (b), and (c) [amending this section and section 1395w-28 of this title]."

Sec. 1395w-28. Definitions; miscellaneous provisions

Pub. L. 108-173, title II, Sec. 231(a), Dec. 8, 2003, 117 Stat. 2207, provided that subsection (a)(2)(A) of this section, as amended by section 221(a) of Pub. L. 108-173, is amended by adding at the end the following new clause:

> ``(ii) Specialized MA plans for special needs individuals
>
> "Specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title) may be any type of coordinated care plan."

Sec. 1395w-28. Definitions; miscellaneous provisions

(b) Definitions relating to Medicare+Choice plans

In this part--

::

(6) Specialized MA plans for special needs individuals

(A) In general

The term ``specialized MA plan for special needs individuals" means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)).

(B) Special needs individual

The term ``special needs individual" means an MA eligible individual who--

(i) is institutionalized (as defined by the Secretary);
(ii) is entitled to medical assistance under a State plan under subchapter XIX of this chapter; or
(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

The Secretary may waive application of section 1395w-21(a)(3)(B) of this title in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and may apply rules similar to the rules of section 1395eee(c)(4) of this title for continued eligibility of special needs individuals.

(f) Restriction on enrollment for specialized MA plans for special needs individuals

In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6) of this section), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2009, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

Regulations

Pub. L. 108-173, title II, Sec. 231(f)(2), Dec. 8, 2003, 117 Stat. 2208, provided that: ``No later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [subsec. (b)(6)(B)(iii) of this section], as added by subsection (b)."

Authority To Designate Other Plans as Specialized MA Plans

Secretary of Health and Human Services authorized, in promulgating regulations to carry out subsection (b)(6) of this section, to provide, notwithstanding subsection (b)(6)(A) of this section, for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals, see section 231 (d) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

APPENDIX II. CONFERENCE AGREEMENT ON SECTION 231 OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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Subtitle D – Additional Reforms

Section 231. Specialized MA plans for special needs beneficiaries

Present Law

One model for providing a specialized M+C plan, Evercare, operates as a demonstration program. Evercare is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. Evercare received a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees.

House Bill

Section 233. A new MA option would be established-specialized MA plans for special needs beneficiaries (such as the Evercare demonstration). Special needs beneficiaries are defined as those MA eligible beneficiaries who were institutionalized, entitled to Medicaid, or met requirements determined by the Administrator. Enrollment in specialized MA plans could be limited to special needs beneficiaries until January 1, 2007. Interim final regulations would be permitted to offer specialized MA plans for plans that disproportionately serve beneficiaries with special needs who are the frail elderly. No later than December 31, 2005, the Administrator would be required to submit a report to Congress that assessed the impact of specialized MA plans for special needs beneficiaries on the cost and quality of services provided to enrollees.

Senate Bill

Section 222. A new M+C option would be established-specialized M+C plans for special needs beneficiaries (such as the Evercare demonstration). Special needs beneficiaries are defined as those M+C eligible beneficiaries who were institutionalized, entitled to Medicaid, or met requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2008. No later than December 31, 2006, the Secretary would be required to submit a report to Congress that assessed the impact of specialized M+C plans for special needs beneficiaries on the cost and quality of services provided to enrollees. No later than 1 year after enactment of this Act, the Secretary would be required to issue final regulations to establish requirements for special needs beneficiaries.

Conference Agreement

Section 231. The establishment of a specialized plan designation provides health plans the authority and incentives to develop targeted clinical programs to more effectively care for high-risk beneficiaries who have multiple chronic conditions or have complex medical problems. This provision designates two specific segments of the Medicare population as special needs beneficiaries, but also provides the Secretary the authority to designate other chronically ill or disabled beneficiaries as "special needs beneficiaries" to allow plans to serve additional high risk groups who would benefit from enrollment in plans that offer targeted geriatric approaches and

innovations in chronic illness care. The Secretary should consider Medicare demonstrations for guidance regarding other potential special needs beneficiary designations.

The provision would establish a new Medicare Advantage option-Specialized Medicare Advantage plans for Special Needs Beneficiaries. Specialized Medicare Advantage plans are plans that exclusively serve special needs beneficiaries such as the Evercare and Wisconsin Partnership demonstrations and, at the discretion of the Secretary, those that serve a disproportionate number of such beneficiaries. Special needs beneficiaries are defined as Medicare Advantage enrollees who are institutionalized, or entitled to Medicaid, or individuals with severe and disabling conditions that the Secretary deems would benefit from a specialized plan. Specialized Medicare Advantage plans can limit enrollment to special needs beneficiaries until January 1, 2009. No later than 1 year after enactment of this act, the Secretary is required to submit a report to Congress that assessed the impact of Specialized Medicare Advantage plans on the cost and quality of care. The provision does not change current Medicare+Choice quality, oversight or payment rules.

The legislation also allows the Secretary to define as Specialized Medicare Advantage plans those that "disproportionately" serve special needs beneficiaries. Since there is no existing standard for measuring "disproportionate," the provision gives the Secretary discretion in promulgating this part of the regulation with a view toward establishing quantitative criteria for defining "disproportionate." The Secretary may identify such means of measuring "disproportionate" as are feasible to capture appropriate risk levels for designation as a "Specialized Medicare Advantage Plan for Special Needs Beneficiaries." The Secretary may wish to require further validation that "disproportionate" plans are "specialized" by requiring evidence of processes or clinical programs designed to address the unique needs of the special needs beneficiaries served.

APPENDIX III. GLOSSARY

ADL	Activities of Daily Living
CCP	Coordinated Care Plan
CCW	Chronic Condition Warehouse
CDC	Chronic or disabling condition
CHF	Congestive heart failure
COPD	Chronic Obstructive Pulmonary Disease
CMS	Centers for Medicare & Medicaid Services
DE	Dual eligible
DME	Durable medical equipment
ENE	Eligible non-enrolled
ESRD	End State Renal Disease
FFS	Fee-for-service
HCBS	Home and community-based services
HCC	Hierarchical condition category
HEDIS	Health Plan Employer Data and Information Set
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
INST	Institutional
LTC	Long term care
LTI	Long-term institutionalized
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	Medicare Advantage-Prescription Drug
MBD	Medicare Beneficiary Database
MCO	Managed care organization
MDS	Minimum Data Set
MHSO	Minnesota Senior Health Options
MnDHO	Minnesota Disability Health Options
MMA	Medicare Modernization Act
OPD	Outpatient department
PACE	Program for All Inclusive Care for the Elderly
PIHP	Prepaid Inpatient Health Plan
QI	Qualifying Individual
QMB	Qualified Medicare Beneficiary
SCAN	Senior Care Action Network
SCO	Senior Care Options
SHMO	Social Health Maintenance Organization
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
WPP	Wisconsin Partnership Plan

APPENDIX IV. TECHNICAL APPENDIX TO CHAPTER VII

Define the following quantities:

bb_i^{SNP}	Bid-to-benchmark value for SNP *i*.
bb_i^{MA}	Enrollment-weighted mean bid-to-benchmark value for MA plans with market areas that overlap with that of SNP *i*.
bid_i^{SNP}	Bid for SNP *i*.
bid_{ij}^{MA}	Bid for MA plan *j*, whose market area overlaps that of SNP *i*.
e_i^{SNP}	Enrollment in SNP *i* as a proportion of total SNP enrollment.
e_{ij}^{MA}	Enrollment in MA plan *j*, whose market area overlaps that of SNP *i*, as a share of enrollment in all MA plans with market areas overlapping that of SNP *i*.
$bnch_i^{SNP}$	Benchmark value for SNP *i*.
$bnch_{ij}^{MA}$	Benchmark value for MA plan *j*, whose market area overlaps that of SNP *i*.

The bid-to-benchmark value for SNP *i* and the enrollment-weighted mean of MA plans in the same market area, both introduced in Section 1.b are computed as:

$$bb_i^{SNP} = bid_i^{SNP} / bnch_i^{SNP}$$

$$bb_i^{MA} = \sum_j e_{ij}^{MA} \; bid_{ij}^{MA} / bnch_{ij}^{MA}$$

The overall average of SNP bid-to-benchmark values and their paired MA plan bid-to-benchmark means are given by:

$$\overline{bb}^{SNP} = \sum_i e_i \cdot bb_i^{SNP}; \qquad \overline{bb}^{MA} = \sum_i e_i \cdot bb_i^{MA}$$

APPENDIX V. CMS GUIDANCE ON INTEGRATION OF MEDICARE AND MEDICAID

A CMS workgroup has identified areas in which Medicare and Medicaid regulations appeared to conflict and has issued a series of working papers to provide guidance to States, health plans, and CMS regional offices on how to accommodate Medicare and Medicaid requirements in ways that facilitate the integration of the two programs at the plan level. The work group also focused on ways to eliminate or minimize duplicative oversight and monitoring activities, an effort that is ongoing. A summary of the output of this workgroup, along with guidance from other sources, is presented below. Detailed information is available at http://www.cms.hhs.gov/IntegratedCareInt/.

- **"At-A-Glance" Guide to Medicaid Authorities for Integrated Programs**

  This chart provides a list and description of the authorities available to States that may be utilized in the development of an integrated care program. The key flexibilities and/or limitations of each type of authority is provided. This tool can be downloaded from the bottom of the page.

- **State Guide to Integrated Medicare and Medicaid Models**

  The State Guide to Integrated Medicare and Medicaid Models was developed to educate States and other stakeholders on the possible models that may be employed to better integrate Medicare and Medicaid services for dual eligibles.

- **Long Term Care Capitation Models**

  Provides States with information on Medicaid and Medicare program authorities that can be used to implement capitated LTC models.

- **Integrated Care Program Design, Rate Setting, and Risk Adjustment: A Checklist for States**

  A tool that developed by the Center for Health Care Strategies (CHCS), Inc that outlines the issues that States need to examine during the process of designing an integrated care program.

- **“How To" Guides on Enrollment, Marketing and Quality**

  Provides guidance to State authorities and plans on how plans with dual Medicare and Medicaid managed care contracts can comply with the separate requirements of both programs in the areas of Enrollment, Marketing, Appeals and Grievances, and Quality. The guides provide clarification of Medicare and Medicaid rules and suggest streamlined processes that States and plans can use to fulfill these requirements.

- **State Medicaid Directors' Letter regarding the Subset Policy for Special Needs Plans**

  This letter provides information regarding the CMS policy that allows Medicare Advantage Special Needs Plans to target enrollment of dual eligible beneficiaries in States that are providing an integrated Medicaid benefit package.

- **CHCS Primer: Medicare Advantage Rate Setting and Risk Adjustment**

  A primer on Medicare managed care rate setting and risk-adjustment aimed at helping State Medicaid agencies better understand how the Medicare rate setting system works so that States can work more effectively with Special Need Plans and other Medicare Advantage Plans to integrate Medicaid and Medicare services.

- **Medicaid Obligations in Cost Sharing in Medicare Advantage Plans**

  Information regarding Medicaid's obligation to pay cost-sharing for individuals who are eligible for both Medicare and Medicaid (dual eligibles) and who are enrolled in a Medicare Advantage Plans is provided in a letter and chart.