SNP Alliance Issue Brief

Highlights of 2013 SNP Alliance Annual Survey

February 2014

Background

SNPs are a specialty care program for beneficiaries dually eligible for Medicare and Medicaid and other high-risk/high-need beneficiaries, such as persons who are eligible for nursing home care and persons with HIV-AIDs, ESRD, SPMI, and other severe and disabling chronic conditions. 2013 was a particularly good year for SNPs with overall SNP enrollment growing by 16%. C-SNP enrollment grew by 22%, D-SNPs by 15% and I-SNPs grew by 4%.

As of December 2013, 644 Medicare Special Needs Plans (SNPs) were providing benefits and services to 1,877,346 enrollees. This included 362 D-SNPs with an enrollment of 1,527,676; 214 C-SNPs with an enrollment of 297,901, and 48 I-SNPs with an enrollment of 51,769.

Last year was the 6th consecutive year that the SNP Alliance produced a Member Profile and Advanced Practice Report. The Report, survey process and analysis were developed and managed by Joel Menges of The Menges Group. The purpose of the SNP Alliance Profile Report series is two-fold: 1) to inform policymakers about the degree to which Special Needs Plans demonstrate added value for government payors and beneficiaries; and 2) to provide benchmarking opportunities for members of the SNP Alliance in seeking to improve total quality and cost performance in care of high-risk/high-need beneficiaries.

The NHPG published the first SNP Alliance Profile and Advanced Practice Report in December 2008. The information captured for each year's report has largely remained consistent, although some new information has been added to each year's survey to address emerging issues and policy-relevant metrics.

The Report analyzed enrollee demographics, conditions, risk scores, utilization and cost information for calendar years 2010, 2011 and 2012. The Report includes comparisons of fee-for-service (FFS) data for each SNP type, including a subset of fully integrated dual SNPs (FIDESNPs) that were national integration demonstrations prior to transitioning to Special Needs Plans. Comparison statistics were also tabulated on the Medicare FFS population using the 2008 CMS 5% sample database.

The 2013 Annual Survey statistics are based on more than 660,000 enrollees, including approximately 145,000 C-SNP enrollees, 430,000 D-SNP enrollees, 40,000 FIDESNP enrollees, and 45,000 I-SNP enrollees. Six of the data-contributing organizations operate multiple SNP types. Eight organizations operate FIDESNPs; 12 organizations operate other D-SNPs. Five organizations provided C-SNP data and seven organizations provided I-SNP data. The plans contributing data reported CY2013 information on nearly all (94%) of the nation's I-SNP enrollees, 62% of C-SNP enrollees, and 28% of D-SNP enrollees.

SNP Alliance plans have targeted and enrolled a high-need Medicare population

The average risk score for persons enrolled in SNP Alliance plans participating in the survey is 40% higher than the average risk score for those enrolled in traditional Medicare. The average risk score for the FIDESNP legacy plans was 1.49, compared to an average risk score of 1.27 for dual beneficiaries in FFS. The average risk score for D-SNPs not meeting the CMS criteria for the FIDESNP definition was 1.21. The average risk score for C-SNPs participating in the survey was 1.74, which is significantly above the average risk score of 1.40 for persons with diabetes in traditional Medicare and not far below the average of 1.84 for FFS beneficiaries with congestive heart failure (CHF). The average risk score for persons enrolled in Institutional SNPs was 2.23, compared with an average risk score of 1.84 for FFS beneficiaries living in institutions.

SNP Alliance plans serve a higher percentage of people with high-impact conditions. The survey found that SNP Alliance Plan enrollees have significantly higher rates for nearly all high-impact conditions, as defined by the National Quality Forum.[1] Diabetes is highly prevalent in all SNP types. Within C-SNP enrollees, 74% have diabetes – a high

[1]The National Quality Forum (NQF) defines high-impact conditions as conditions that have a high-impact on aspects of health, such as affecting large numbers of patients and/or having a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of illness/societal consequences of poor quality.

but unsurprising statistic given that many of the C-SNPs focus on diabetes. However, the significant presence of diabetes among the other SNP types – 30% in D-SNPs, 48% in FIDESNPs, and 51% in I-SNPs – is an important finding. Only 28% of the general Medicare population has this condition. Major depression, stroke and chronic obstructive pulmonary disease were also significantly higher among SNP beneficiaries than the FFS population.

There is strong evidence of the potential for significant cost savings

SNP Alliance Plans serving the highest-risk beneficiaries dramatically reduced inpatient usage rates. The 2013 survey found all SNP types had reduced inpatient utilization in comparison with their FFS benchmarks, with reductions of more than half (relative to FFS) occurring in the C-SNP and I-SNP settings. In 2012, I-SNPs reduced hospitalization rates by 72% (2,131 days/1000 compared to 7,497 days/1000 for institutionalized beneficiaries in FFS). The average utilization rate for C-SNPs reporting data was 2,293 days/1000. Using a merged utilization for diabetes and CHF of Medicare FFS beneficiaries of 5,939 days per 1,000, C-SNPs achieved a 61% reduction in hospital utilization.

The 2012 SNP Alliance D-SNP average (enrollment-weighted mean) was 2,870 and the FIDESNP average was 3,080. These figures are 25% and 14% lower than the FFS average, respectively. However, taken in the context of patient acuity or risk scores (1.21 for D-SNPs, 1.49 for FIDESNPs); it becomes evident that large-scale inpatient usage reductions have been achieved.

SNP Alliance Plans were also extremely effective in keeping people out of the hospital. The average percentage of enrollees *not* requiring hospitalization ranged from 76.5% among FIDESNPs to 82.9% for I-SNPs. In 2012, 83.2% of D-SNP enrollees and 79.2% of C-SNP enrollees had no hospital admissions. Tabulations using the Medicare 5% sample indicated that 73% of dual eligibles had no admissions during 2008. Only 1.3% of I-SNP enrollees had 3 or more inpatient admissions versus a FFS rate of 15.5%. These statistics clearly suggest that I-SNPs have had extraordinary success in reducing hospital admissions.

All SNP types also reduced hospital admission rates between 2011 and 2012, with C-SNPs having a hospital admission rate in 2012 of 400 hospitalizations per 1,000 persons, D-SNPs having a rate of 475, FIDESNPS 589, and I-SNPs 359 per 1,000 persons.

The annual value of these inpatient usage reductions is estimated to be over $2 billion. The derivation of this figure is based on the usage impacts and an assumption that the nationwide Medicare average daily payment for hospital care ($2,333 in CY2011 per a MedPAC report). The Report also estimates reduction in average per enrollee inpatient costs of more than $12,000 for I-SNPs and more than $8,000 for C-SNPs.

Conclusion

The reduction in hospitalization rates by SNP Alliance Plans offers great promise for controlling costs for dual beneficiaries through integration. Figures for all SNP types compare favorably against comparable national FFS populations. The statistics regarding persons with multiple admissions suggest that when beneficiaries enrolled in SNPs experience a clinical crisis requiring hospitalization, the SNP setting is superior to the FFS setting in averting additional crises post-discharge.

This survey, consistent with prior annual surveys, suggests that the SNP Model of Care (MOC) is effective in keeping members' health status stable—preventing crises that require hospitalization—as well as reducing the need for further admissions once a person has been hospitalized. Each SNP's MOC is crafted to address the unique needs of the beneficiaries being targeted by each plan. While SNPs specialize in caring for many different types of problems, each SNP enrollee must receive: a) an annual comprehensive assessment of physical, functional and psychosocial health; b) an individualized care plan developed with input from beneficiaries, and if desired, families; and c) an interdisciplinary care team with composition based on special needs of the enrollee. These MOCs are understood to be an important underpinning for the results achieved.

More progress is yet to be realized. Frail, disabled, chronically ill persons are among healthcare's most vulnerable, costly and fast-growing groups. The vast majority of high-need Medicare beneficiaries remain covered via the traditional FFS program. For example, only 15% of the nation's dual eligibles are enrolled in a SNP. About 70% of Medicaid costs for duals are spent on long-term care and 80 percent of Medicare costs relate to the 20% highest-need beneficiaries. Unfortunately, SNPs continue to function under financing, policy and oversight structures that are inconsistent with the multidimensional, interdependent and ongoing care needs of high-risk/high-need persons. With renewed efforts on the part of Congress, the Administration, states, and SNPs to advance policies and procedures consistent with the specialty care mandate of SNPs, this survey should represent only the beginning of more good news to come.