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Do We Know If Medicare Advantage Special Needs Plans Are Special?

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EXECUTIVE SUMMARY

Special Needs Plans (SNPs) are expanding rapidly in Medicare, drawing increased attention among policy makers. In 2008, 772 SNPs are expected to be offered, up from 477 in 2007 and 276 in 2006. SNP enrollment has also grown substantially, rising from 531,507 in July 2006 to 1,080,593 in November 2007. Almost half of all Medicare Advantage contracts in 2007 included at least one SNP among its plan offerings and SNP enrollees accounted for 11 percent of all MA enrollees in mid-2007. This rapid growth has raised questions about insurers' interests in offering SNPs, the value SNPs add for beneficiaries, and the implications for beneficiaries and the Medicare program if SNPs continue to grow over time.

SNPs were authorized in the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. They are a new type of Medicare Advantage (MA) managed care plan that can limit enrollment to subgroups of Medicare beneficiaries in three categories: (1) those dually eligible for Medicare and Medicaid; (2) those who are institutionalized; and (3) those with severe or disabling chronic conditions. SNPs are paid in the same way as other MA plans and are subject to the same regulatory requirements. The rationale for SNPs is that specialization will allow them to achieve economies of scale and better coordinate care for Medicare beneficiaries whose needs may not be currently well served either within regular MA plans or traditional Medicare.

The authority for SNPs to limit enrollment to specified subgroups was scheduled to expire at the end of 2008, but Congress extended that authority through 2009 in late December 2007, accompanied by a one-year moratorium on new SNPs.[1] The critical policy issue for authorization beyond 2009 is whether in fact SNPs live up to the promise of their rationale, and what impact they have on quality of care and costs within the Medicare program. The MMA requires CMS to submit an evaluation of SNPs to Congress by the end of 2007. This paper aims to inform the policy debate over continued authorization with an analysis of how SNPs have developed so far, how they fit into the larger MA marketplace, and how CMS, Congress, beneficiaries, and others can determine whether SNPs are doing things that are different from what other MA plans are or could be doing. Are SNPs doing anything special, and if so, how will we know?

The paper is based on Mathematica Policy Research (MPR) tracking of SNPs and other MA plans from 2005 to 2007, and interviews and discussions during this period with health plans, state and federal officials, and consumer advocates. It also takes advantage of the lead author's participation in many SNP industry conferences and work with the Center for Health Care Strategies (CHCS) to help states implement Medicare-Medicaid integration.[2]

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[1] Medicare, Medicaid, and SCHIP Extension Act of 2007 (S. 2499, Section 108).

[2] While CMS has contracted with Mathematica Policy Research Inc. to assist in preparing CMS's required Report to Congress on the impact of SNPs, due December 31, 2007, this paper is completely separate from that effort and does not rely on any of the data or analyses prepared by Mathematica for CMS.

FINDINGS

- ***SNPs are being offered in large number because industry has concluded that they are an attractive growth opportunity.*** The industry views SNPs as an attractive opportunity for the following reasons: 1) the Medicare population is growing rapidly but only a minority of beneficiaries are now enrolled in private managed care plans, 2) the new CMS risk-adjusted MA payment system makes it financially feasible to serve beneficiaries with predictably high costs—most of whom have not previously been enrolled in private managed care plans, and 3) new SNPs have been relatively easy to establish for companies that are already in the MA business. SNPs have thus been a relatively low-cost, low-risk way for companies to position themselves in a potentially growing market. Some new entrants are companies that also have specialized expertise in disease management, institutional care, and Medicaid that can make SNPs a good fit for them.

- ***The growth in SNPs is less dramatic than it may appear.*** Most SNPs have very low enrollment (over half have fewer than 500 enrollees, and over a quarter have fewer than 100), and much of the current enrollment results from the movement of companies' current managed care enrollment into newly created SNPs operated by the same companies. It appears that only about half of current enrollment represents "active" choices by beneficiaries to enroll in SNPs.

- ***Though many companies seek SNP enrollment, attracting large numbers of new enrollees to these products is challenging, so the ultimate size and composition of the SNP market is uncertain.*** Dual eligible SNPs still dominate SNP enrollment. However, over 90 percent of current dual eligible beneficiaries have been auto-enrolled by CMS into stand-alone prescription drug plans (PDPs), and it can be difficult for SNPs to identify and market to dual eligibles. Institutional SNPs must have contracts with each nursing facility in which they have enrollees, and nursing facilities are often unwilling to enter into such contracts. Chronic condition SNPs are one type that may be ripe for new enrollment, which may explain the sharp increase in the number of chronic condition SNPs approved for 2008 (244, up from 73 in 2007). To date, only one stand-alone chronic condition SNP (Care Improvement Plus) has experienced rapid enrollment growth over the last year. Chronic condition SNPs that are part of larger companies that offer other MA plans and PDPs may find it easier to grow their SNP enrollment by marketing to enrollees in their other plans.

- ***While many companies offer SNP plans, SNP enrollment is concentrated in a small number of companies (almost two-thirds is in 13 companies).*** At least in 2007, companies enrolling most SNP enrollees have considerable prior experience in Medicare and/or Medicaid managed care, although not necessarily with all special needs populations and with the full range of services they may require.

- ***SNP enrollment is concentrated among a small number of states and Puerto Rico. Nearly 59 percent of SNP enrollees in November 2007 lived in nine states, and another 23 percent (almost 250,000) were in Puerto Rico.*** The states with the greatest SNP enrollment have generally covered dual eligibles in some form of Medicaid managed care in the past, and many of them contract with SNPs for some

Medicaid services. There is thus potential in these states to encourage better coordination between Medicare and Medicaid through SNPs.

- ***While about half of current SNP enrollees appear to have made an active choice to sign up for a SNP, the other half appear to have moved into SNPs from other Medicaid or Medicare plans as a result of processes that may have required less active enrollee involvement.*** About 200,000 enrollees were "passively enrolled" in 2005-2006 from Medicaid managed care organizations that established new SNPs. While the SNP enrollees in Puerto Rico were not passively enrolled, most of them moved into SNPs from existing Medicaid plans. Another 100,000 transferred from five Social HMO demonstration plans in California and New York that were established as SNPs in 2007. And, over 50,000 were in Kaiser plans in California, Colorado, and Georgia that transferred their existing MA enrollment to newly created SNPs in 2007.

- ***In the context of this industry concentration, the structure of the current SNP market reinforces policy concerns over whether SNPs have something unique to offer.*** Nearly three quarters of current SNP enrollment is in plans that are offered through companies offering general MA products. SNPs that are part of larger MA companies may find it hard to demonstrate that they are doing something special, given the current limited availability of SNP-specific performance measures. Inclusion of SNPs with other MA offerings, however, could mean fewer risks for SNP enrollees since they likely would have other enrollment options within the same company if the SNP is not successful.

- ***Policymakers who want to know how SNPs are performing will find it valuable to distinguish among dual eligible, institutional, and chronic condition SNPs, since each SNP type presents different opportunities and risks for companies and beneficiaries.*** Dual eligible SNPs face the challenges of coordinating Medicare and Medicaid services, institutional SNPs must partner with sometimes-reluctant nursing facilities, and chronic condition SNPs must identify, enroll, and care for a potentially very high concentration of beneficiaries with multiple complex and costly physical and mental health conditions.

- ***Current MA monitoring information, particularly that made public, makes it difficult to determine whether SNPs are doing anything special, since SNP-specific quality and performance measures are limited.*** While CMS is taking steps to improve the availability of information on SNPs for beneficiaries and other stakeholders, more could be done. The MA health plan quality and performance measures that now appear on the CMS "Medicare Options Compare" web site, along with benefit package, provider network, and other information, is a valuable resource, but much of this information is not yet tailored to SNPs and the special needs of their enrollees, although CMS is working on improvements. SNP performance reporting requirements could also be expanded to cover more measures aimed at chronic conditions, institutional care, and coordination with Medicaid that are more relevant to the SNP population. CMS is currently working on such refinements with the National Committee for Quality Assurance (NCQA).

OPPORTUNITIES AND RISKS OF SNPs FOR BENEFICIARIES AND MEDICARE

From a beneficiary perspective, there are two related questions: (1) would an MA plan meet a beneficiary's needs better than traditional Medicare, and (2) if so, would a SNP be better than a regular MA plan? At this point, the jury is still out and the answers to these questions are not yet fully known. Getting beneficiaries the necessary information to help them make informed choices is challenging. Furthermore, disenrollment as the main means of dealing with bad choices is a limited form of protection against such choices. From the beneficiary perspective, concerns relate to the enrollment decision, ongoing monitoring, and systems to address problems that occur once they are enrolled, as well as potential issues that may arise if their SNP ceases to be a Medicare option.

Whether SNPs are valuable from a public policy perspective depends on how much value such plans add to the program as a whole. From the perspective of firms sponsoring SNPs, the question is whether there is a business case for the plans (sufficient business gains to justify the costs involved in initiating and operating such a plan). For Medicare (as an agent for beneficiaries) the public policy case depends on whether SNPs improve care for Medicare beneficiaries, and at what cost to taxpayers. SNPs can potentially draw on expertise in the private sector in disease management, institutional care, or serving Medicaid beneficiaries. By specialization, SNPs may be able to tailor benefit packages that fit the needs of particular populations. On the other hand, the enrollees targeted by the SNP option are among the most vulnerable in Medicare. Enhanced care can benefit them, but poorly managed care creates substantial risks.

Ideally, firms are able to modify health care use in ways that improve outcomes and satisfaction while generating savings (or at least not adding to overall costs). Alternatively, SNPs can reduce costs without adversely affecting outcomes or satisfaction. Either of these outcomes benefits all parties. All three SNP types have the potential to improve care delivery and reduce costs. However, as discussed more fully in the body of the report, their opportunities to do so may differ, as may the challenges they face in modifying care patterns in desirable ways.

CHALLENGES FOR OVERSIGHT AND MONITORING

While SNPs hold the promise of better and more coordinated care for their enrollees, they currently face very few requirements to provide care that is different from what a regular MA-PD plan would provide. All MA plans, including SNPs, have more accountability and reporting requirements than traditional Medicare, and often provide benefits not available under the traditional Medicare program. But access to providers generally is more limited in MA than in traditional Medicare, and the capitated model creates a risk for marketing abuse or denying care, particularly when the medical consequences of such denials are in the distant future.

Monitoring Information Needs

Much of the information needed to determine the ways in which SNPs may be special is not publicly available at this point. Particular areas for development, and public reporting of information that could prove valuable in allowing SNP performance to be monitored, are set out below:

- ***CAHPS and HEDIS Quality Data Do Not Yet Include Measures Specifically Designed to Assess SNP Performance.*** CMS uses Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) indicators to monitor quality within the traditional MA program, and a number of these measures are included on the CMS "Medicare Options Compare" web site. A limitation of these data is that they are captured at the contract level, which is appropriate for general MA monitoring but not sufficient for monitoring SNPs, unless SNP enrollees constitute all or most of the enrollment under the contract. Because they were constructed for a general beneficiary population, these sources also do not necessarily include the kinds of quality measures that may be most sensitive to SNP performance. CMS currently is working with the NCQA to develop SNP-specific quality and performance measures. SNPs will be required to submit HEDIS data to NCQA by June 30, 2008; NCQA will provide SNP performance data to CMS by September 30, 2008.

- ***Model of Care Information Could Be Made Public.*** As part of their 2008 applications, CMS required current and future SNP applicants to describe their model of care for specific special needs populations and how it would be implemented, including the relevant clinical expertise of its network providers. CMS has not said whether any information from these models will be made public, but doing so would provide another method of accountability and source of information to help enrollees determine whether a particular SNP would be a good fit for them.

- ***Data on Use of Pharmacy Benefits Not Publicly Available.*** While MA contractors are not required to report either claims or encounter data to CMS for Part A and B benefits (hospital and physician services), such data are required of all Part D plans, including Medicare Advantage prescription drug plans. There are pending CMS regulations that would provide guidelines on how such claims data could be used. It would be beneficial to provide CMS with the broadest authority, consistent with patient privacy concerns, to use these data to better monitor quality of care across the traditional Medicare program, regular MA, and SNPs.

Further information is essential for assessing the value of specific types of SNPs to Medicare beneficiaries and to the program, including information on coordination with Medicaid for dual eligible SNPs, trends and variations in enrollee risk scores for chronic condition SNPs, and nursing facility care quality of care and hospital utilization for enrollees in institutional SNPs.

CONCLUSIONS

All three SNP types have the potential to add value for beneficiaries, compared to traditional fee-for-service Medicare or other MA plan types. With the extra year of SNP authorization, CMS could do more to make information on SNP performance available, and SNPs themselves could be held to higher standards than they have been thus far. Industry will argue that there are limits on how much SNPs can be expected to do beyond what is required of other MA-PD plans, as long as SNPs are paid no more than these other plans for comparable enrollees. Yet policymakers and others might argue that, if there are benefits from specialization and a focus on populations with special needs, SNPs should be able to achieve greater efficiencies in providing this care than other less specialized plans, and to add measurable value beyond what other plan types can achieve. If they cannot do so within a reasonable period of time, it may be appropriate to consider whether their authority to specialize in this way should be continued. In making this decision, the actual and potential benefits of SNPs must be weighed against any additional costs or adverse consequences that may result from continuation of this authority to specialize. At this point, the weight of the evidence on both sides of the scale is far from certain.

INTRODUCTION

Medicare Advantage Special Needs Plans (SNPs) were authorized in the Medicare Prescription Drug Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, Section 231), which allowed for a new type of Medicare Advantage (MA) managed care plan that specializes in serving specified subgroups of Medicare beneficiaries. SNPs can target any of three categories of beneficiaries:

1. those dually enrolled in state Medicaid programs,
2. residents of nursing facilities or similar institutions,[3] or
3. beneficiaries with severe or disabling chronic conditions (for simplicity, we will refer to these as "chronic condition" SNPs).[4]

SNP authority represents the first time Congress has authorized private plans to limit enrollment to specific types of beneficiaries. This authority was originally scheduled to expire at the end of 2008, but in December 2007, Congress extended it through 2009, accompanied by a one-year moratorium on new SNPs.[5]

Why the Interest in SNPs?

The number of SNPs approved by the Centers for Medicare & Medicaid Services (CMS) has increased sharply, rising from 276 in 2006 to 477 in 2007 and 772 for 2008.[6] Enrollment has also increased substantially, rising from 531,507 in July of 2006 to 1,080,593 in November 2007 (Appendix Table C-1).

This increase in the number of SNPs and in SNP enrollment raises three related questions:

- Why are companies establishing SNPs?
- What are the opportunities and risks of SNPs for beneficiaries?
- How can policymakers determine whether SNPs are "special"?

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[3] Eligible long-term-care institutions include skilled nursing facilities, intermediate care facilities, and inpatient psychiatric facilities. Institutional SNPs can also enroll those living in the community, but who require a level of care equivalent to those residing in a long-term-care facility.

[4] SNPs may also be approved if they "disproportionately serve" any of these populations.

[5] Medicare, Medicaid, and SCHIP Extension Act of 2007 (S. 2499, Section 108).

[6] The latest CMS information (December 2007) on the number of SNPs approved for 2008 is available on the Web at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage [Accessed December 24, 2007].

This paper addresses each of these issues. It provides background information on how SNPs fit into the larger Medicare context and into the MA marketplace. It distinguishes among the three different SNP types (dual eligible, institutional, and chronic condition), since each type raises different issues for plan sponsors, beneficiaries, and Medicare policymakers. The paper concludes with a number of options for how SNP reporting and monitoring can be improved in order to better determine whether or not SNPs are special, and whether they are adding value to the Medicare program. The fact that SNPs are focused on many of the most vulnerable Medicare beneficiaries—whether because of illness, disability, low income, or other reasons—makes SNPs particularly relevant from a public policy perspective.[7]

Data Sources and Methods

The paper is based on Mathematica Policy Research (MPR) tracking of SNPs and other MA plans from 2005 to 2007, and interviews and discussions during this period with health plans, state and federal officials, and consumer advocates. The lead author also has participated in more than ten industry conferences on SNPs during this time, and has worked with multiple states on Medicare and Medicaid integration through the Center for Health Care Strategies. While many questions about SNPs and their performance cannot yet be answered, enough is now known to formulate the questions that should be asked, and consider what kind of system may be needed in the future to monitor SNP performance effectively.

KEY INDICATORS OF SNP ROLE IN THE MARKET

Current indicators highlight the growth of SNPs and the influence they are beginning to have in the marketplace. What this will mean in the long term is not clear. Substantial segments of current SNP enrollees are part of these plans for reasons that are unique and unlikely to be relevant in the future. The ability of SNPs to attract enrollment, particularly from beneficiaries now served by traditional Medicare, likely will determine their long-range role and influence. In brief, the key facts include the following:

- ***Large numbers of SNP plans are being offered***, and that number is growing annually. In 2008, 722 plans will be offered, up from 477 in 2007 and 276 in 2006.
- ***The number of SNP contracts is smaller*** (254), since many companies offer one or more SNPs within larger MA contracts that may also include non-SNP products. In mid-2007, there were 88 SNP-only contracts, and 166 in which SNPs were included with other MA plans. About 27 percent of SNP enrollment was in SNP-only contracts and 73 percent in contracts that included other MA offerings. In larger multi-state MA companies like UnitedHealthcare, Humana, and Kaiser, SNP enrollment averaged about 5 percent of total MA enrollment in mid-2007, while the SNP percentage was larger in many newer, smaller, and/or more specialized plans.

[7] The MMA requires CMS to report to Congress by December 31, 2007 on the impact of SNPs on "the cost and quality of services provided to enrollees" and the "costs and savings to the Medicare program" resulting from the SNP authorization. While CMS has contracted with Mathematica Policy Research to assist with this report to Congress, this paper is completely separate from that effort and does not rely on any of the data or analyses prepared by Mathematica for CMS.

- ***Many firms are offering SNP products.*** In 2008, over 150 companies will be offering 439 dual eligible SNPs, and 20 will be offering 89 institutional SNPs. Over 40 companies will be offering 244 chronic condition SNPs, and they will be available in all but six states.[8]

- ***SNP enrollment has been growing,*** doubling between mid-2006 and mid-2007 from just over 500,000 to over one million. SNPs accounted for 12 percent of all MA enrollment in November 2007—with almost 1.1 million enrollees in such plans (Figure 1). Only about a fifth of Medicare beneficiaries are in MA, however, so the traditional Medicare program remains the dominant way in which beneficiaries receive Medicare benefits.

- ***While dual eligible SNPs continue to dominate SNP enrollment, the market share of other types of SNPs is growing*** (Figure 2). November 2007 data show dual eligible SNPs accounting for 70 percent of the SNP enrollment, down from 83 percent in July 2006, while the market share has grown to 17 percent for chronic care SNPs and 13 percent for institutional SNPs (Figure 3).

- ***A sizeable number of SNP enrollees entered the program because of unique circumstances unlikely to occur again.*** For example, the heavy enrollment of dual eligibles in SNPs was facilitated in late 2005 by the passive enrollment into dual eligible SNPs of approximately 200,000 dual eligibles already in state Medicaid managed care plans. SNP enrollment increased by more than 100,000 in early 2007 when CMS transitioned five Social HMOs (SHMOs, owned by SCAN and Elderplan) to SNP status. More than 240,000 enrollees are in plans in Puerto Rico, which has a unique payment environment.[9] Because most beneficiaries still are in traditional Medicare, future growth potential is heavily linked to attracting beneficiaries who previously have not sought to enroll in an MA plan.[10]

- ***A large number of SNPs have very few enrollees***, which means that a market shakeout may be likely. Of the 477 SNPs operating in November 2007, over half of them (249) had fewer than 500 enrollees, 27 percent had fewer than 100 enrollees, and 13 percent had fewer than 10.

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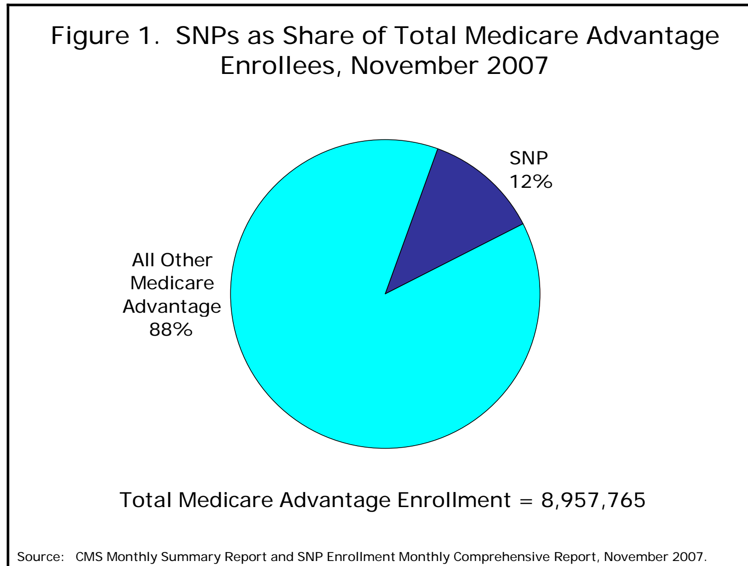
[8] For purposes of this tally, companies with more than one contract for a specific SNP type were counted only once, so the count of companies is lower than the count of contracts.

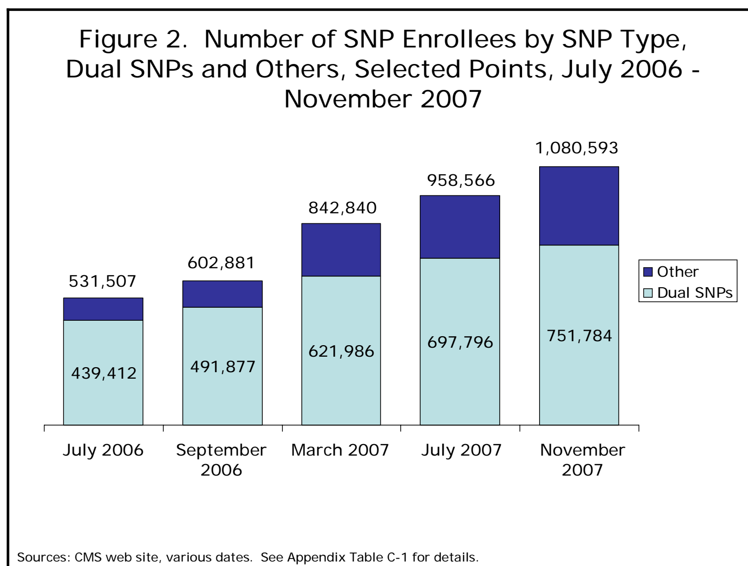
[9] MA payment rates are substantially above traditional Medicare fee-for-service rates in Puerto Rico, and the federal match rate for Medicaid is only 50 percent, which makes serving dual eligibles in SNPs and other MA plans financially attractive for plans.

[10] Among dual eligibles, over 90 percent are in traditional Medicare and receive their Part D prescription drug coverage through stand-alone PDPs in which they were auto-enrolled at the beginning of 2006. CMS, "Medicare Beneficiaries With Creditable Prescription Drug Coverage by Type, As of January 16, 2007" available at: http://www.statehealthfacts.org/comparetable.jsp?ind=307&cat=6 (accessed November 5, 2007).

HOW DO SNPs FIT INTO MEDICARE?

SNPs fall within the Medicare Advantage managed care program. Contractors within MA that wish to offer a SNP must do so through one of the authorized coordinated care contract





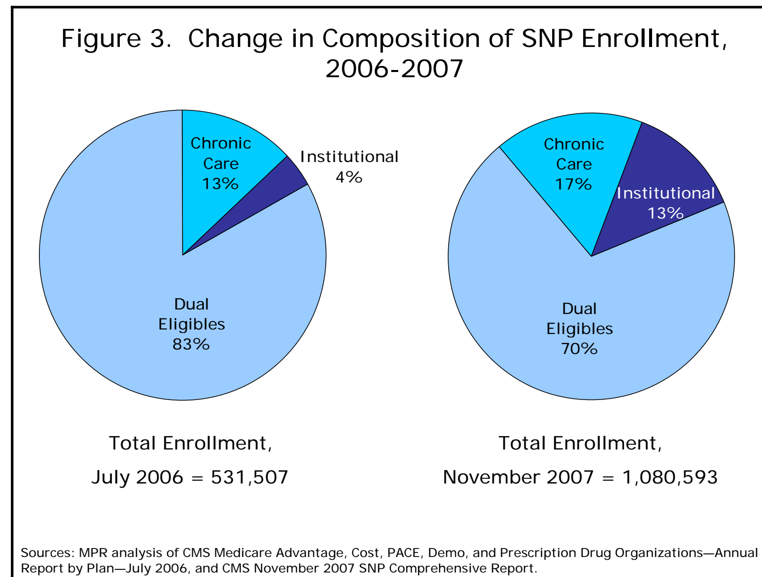


Figure 3. Change in Composition of SNP Enrollment, 2006-2007

Sources: MPR analysis of CMS Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Organizations—Annual Report by Plan—July 2006, and CMS November 2007 SNP Comprehensive Report.

options; contracts that include SNPs also are required to incorporate the Part D prescription drug benefits into those plans (MA-PDs).[11] To date, the main difference between SNP MA-PDs and other MA-PDs involving coordinated care plans is that SNPs may limit enrollment to specific categories of "special needs" beneficiaries. SNPs are paid in the same way as other MA-PD plans, and generally are subject to the same CMS requirements. For 2008, CMS began requiring additional information from SNPs on how they propose to operate as part of the MA application process. CMS also is developing additional quality and performance monitoring measures for SNPs, and is now requiring more information on how SNPs propose to coordinate with state Medicaid programs.

Table 1 (see Appendix A for more detail) compares traditional fee-for-service (FFS) Medicare (with prescription drug coverage from a stand-alone prescription drug plan [PDP]), MA-PD plans generally, and SNPs in a number of areas, including payment and risk adjustment, risk pooling and sharing, availability and use of funds for extra benefits, network and marketing requirements, care management infrastructure, beneficiary protections, quality and performance monitoring, and incentives to contract and coordinate with Medicaid.

[11] In effect, this allows local health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs), as well as regional PPOs to offer a SNP. SNP plans may not be offered under a private fee-for-service contract (PFFS), nor may they be offered as a Medical Savings Account. Some SNPs, for historical reasons, are classified as "demonstration" contracts.

Table 1. Summary Comparison of Key Requirements Across Traditional Medicare, MA-PD, and SNP Options

	Traditional Medicare				
	Part A and B	Part D	MA-PD Coordinated Care (Part C and D)	SNP (Part C and D)	Comments on SNP
Payment	Services or bundles	Capitated with risk adjustment	Capitated with risk adjustment	Same as MA-PD	
Risk-Bearing Entity	Medicare	Contractor with some Medicare sharing	Contractor with some Medicare sharing	Same as MA-PD	Plan filings should take into account dual eligibility in allocating use of savings
Extra Benefits/Use of Savings	None	None	75 percent of any A/B savings available	Same, but benefits can be tailored	"Risk-pool" share of savings is targeted on SNP subgroup
Network Requirements	None	Pharmacy access	Access requirements and pharmacy access	Same as MA-PD, but in 2008 need to show needed "clinical expertise"	Institutionalized SNP must have LTC contracts
Marketing Requirements	Not applicable	Marketing guidelines and approval of materials	Marketing guidelines and approval of materials	Same as MA-PD	Issues exist regarding how to show relationships to state Medicaid for duals
Care Management	Not required	Drug utilization and review, quality assurance, and drug management	Must assure continuance of care; most plans have systems; same Part D requirements	Same as MA-PD, but in 2008 must describe model of care	May be subject to additional future requirements
Beneficiary Protection and Quality Monitoring	A/B appeal procedures	Grievance procedures	Required benefits and beneficiary protection, grievances	Same as MA-PD	Customized SNP measures being developed by CMS

Source: MPR analysis of CMS requirements for the Kaiser Family Foundation. (See Appendix A for more details.)

Traditional Medicare versus Medicare Advantage

All Medicare beneficiaries are eligible for the traditional Medicare program. Indeed, enrollment in such a program remains the default option for almost all Medicare beneficiaries. In limited instances where dual eligible beneficiaries were enrolled passively in MA SNPs, the traditional Medicare option remains available, and continuing enrollment in MA is voluntary.

Traditional Medicare does not impose any limits as to which Medicare providers beneficiaries may see. (Providers may decide not to participate, although historically most have.) The traditional program also does not include the kinds of care coordination or disease management features that MA coordinated care plans may offer, although selected beneficiaries may have access to pilot or demonstration programs of this type.

Whereas providers in the traditional program typically are paid for individual services or narrowly defined components of care episodes, MA plans are paid on a capitated basis per person per month; if MA plans can provide benefits for less than that payment, they are required to give 25 percent of the savings to Medicare and to use the rest to enhance benefits or reduce costs for Medicare beneficiaries. Historically, such savings have been used to offset Medicare's cost sharing or offer additional benefits (vision, dental, hearing, transportation). Because current payments to MA plans exceed costs under the traditional program,[12] MA plans have an advantage in being able to fund such benefits (Gold 2005; 2007b).

The situation is different for prescription drug benefits (Part D). MA-PD plans and stand-alone PDPs, which provide Part D drug benefits to enrollees in traditional Medicare, essentially have the same requirements. However, the fact that pharmacy benefits are provided as part of an integrated package of coverage through coordinated care likely makes it easier for MA-PDs to coordinate care and use pharmacy claims to enhance quality improvement programs than it is for traditional Medicare providers.[13] MA-PD plans, unlike stand-alone PDPs, also have the capacity to use savings from delivering Part A and B benefits to reduce the costs of Part D coverage or enhance the benefits provided. Improved coordination of Medicare benefits could be valuable to beneficiaries potentially eligible for SNPs, whether they are in regular MA or SNP plans. Enhanced benefits will be most valuable to those without other forms of supplemental coverage, such as Medicaid.

Regular MA-PD Plans versus SNPs

With a few minor exceptions, regular MA-PD plans and SNPs are paid in the same way.[14] Marketing requirements are the same for SNPs and other MA-PD plans, and beneficiary protections essentially are too. While network requirement and care management infrastructures

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[12] See Medicare Payment Advisory Commission, *Report to the Congress*, March 2007 and June 2007.

[13] For an analysis of payment and a description of how this may be done, see Draper, Cook, and Gold (2003).

[14] Certain dual eligible demonstration plans in Minnesota, Wisconsin, and Massachusetts, and SHMOs in California and New York, will receive a portion of their capitated payments through a pre-existing "frailty adjuster" system through the end of CY 2010, so their payments will be somewhat different from those of other MA-PD plans during that period.

for SNPs and other MA-PD plans also are generally the same, SNP applicants for 2008 must describe how their networks will have the "clinical expertise" to meet the special needs of the individuals they enroll. For 2008, CMS also has required applicants to describe their "model of care" for the special populations they serve.

In the future, more differences may emerge in the requirements placed on SNPs versus MA-PDs. The CMS 2008 Call Letter says that CMS has included a section in its MA Audit Guide specifically designed to review critical aspects of SNPs, and that it is developing SNP-specific measures of health outcomes (clinical, functional, and patient experiences).[15]

Current MA-PD quality and performance measures—largely based on HEDIS, CAHPS, and the Health Outcomes Study (HOS)—are reported at the contract rather than the plan level, so performance for SNPs that are part of a larger MA contract is not separately measured through this system. However, CMS stated in a July 19, 2006 "Quality 'How To' Guide for SNPs" that MA organizations having other plans in addition to SNPs must begin to separate out their SNP reporting in 2007 (p. 5).[16]

CMS has been working with NCQA to develop SNP-specific quality and performance measures. NCQA and CMS announced on December 14, 2007 that SNPs with contracts in FY 2007 must submit data to NCQA on 13 existing HEDIS measures and several proposed structure and process measures for each SNP benefit package by June 30, 2008. NCQA will assess and validate the SNP submissions, and deliver the SNP performance measures to CMS by September 30, 2008.[17]

Variation Across SNP Types

Requirements generally are the same for each type of SNP, although their practical applications and impact are likely to vary across the three types of plans because of unique features of the populations each serves.

One difference relates to requirements for SNPs based in institutions versus those that generally serve members in the community. CMS requires that institutional SNPs have contracts with each nursing facility in which they have enrollment, and the care models most institutional SNPs use depend heavily on nursing facility cooperation, so their enrollment outside of those cooperative facilities is unlikely. Within facilities, SNPs must recruit resident-by-resident, since CMS rules prevent nursing facilities from steering residents to a particular Part D plan.[18] Dual eligible and chronic condition SNPs typically serve community members, and do not have to deal with such issues.

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[15] CMS 2008 Combined Call Letter, issued April 19, 2007, pp. 50-51, available on the Web at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf (accessed November 5, 2007).

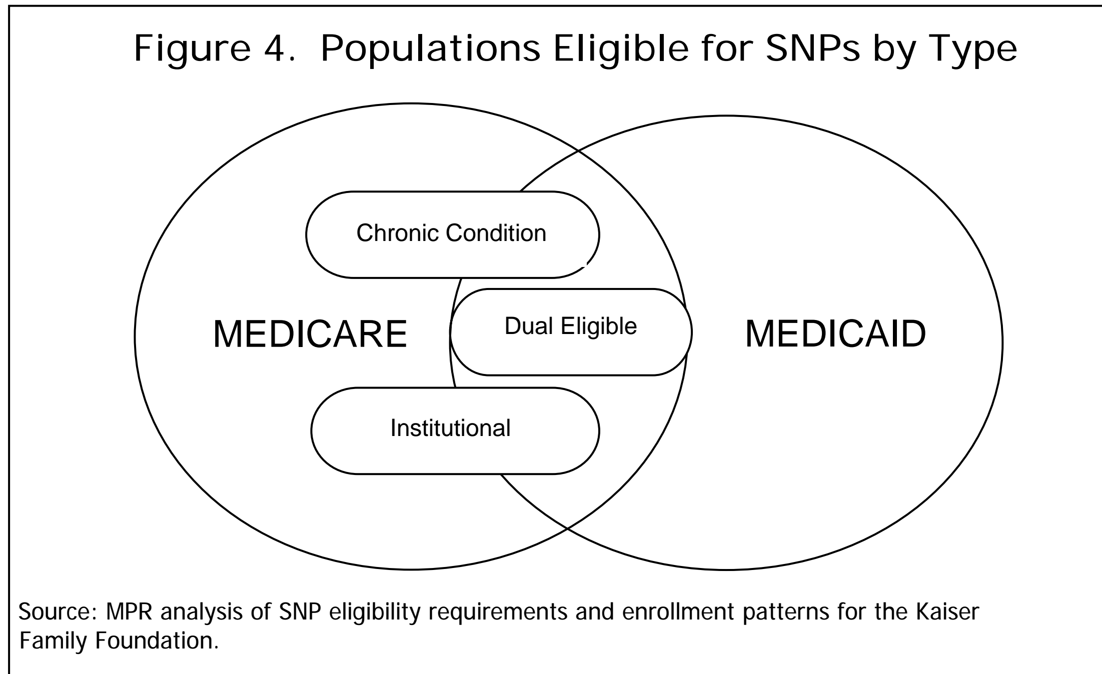
[16] Available on the web at: http://www.cms.hhs.gov/IntegratedCareInt/Downloads/Quality_How_To.pdf (accessed November 5, 2007).

[17] For more detail, see http://web.ncqa.org/tabid/625/Default.aspx (accessed January 2, 2008).

[18] United (Evercare) accounted for more than 20 percent of total institutional SNP enrollment in November 2007, and five converted Social HMOs (owned by SCAN and Elderplan) accounted for another 74 percent. Most SCAN and Elderplan enrollees are living in the community, rather than in institutions.

The other major difference across SNPs relates to the role of dual eligibles in their target population, and what this implies for their operations. As Figure 4 shows, dual eligible SNPs almost exclusively serve those eligible jointly for both Medicare and Medicaid, but approximately half of enrollees in chronic condition and institutional SNPs are also dual eligibles.

Figure 4. Populations Eligible for SNPs by Type



Source: MPR analysis of SNP eligibility requirements and enrollment patterns for the Kaiser Family Foundation.

Before the MMA, dual eligibles were not likely to be enrolled in MA plans. Indeed, the SNP option was motivated in part by a desire to have plans better coordinate benefits across Medicare and Medicaid to meet the needs of those who are dually eligible. Joint eligibility for Medicare and Medicaid has two major implications for how SNPs operate. First, it influences, or should influence, the design of SNP benefit packages, since dually eligible beneficiaries receive many of the extra benefits and reduced cost sharing typically provided in MA through Medicaid, and so do not benefit from having these included under the SNP. Second, enrollment of dual eligibles creates opportunities to incorporate Medicaid benefits to better integrate care. However, including two programs in one plan also adds the challenge of how best to coordinate requirements across them.

Relationship to Medicaid

SNPs—especially dual eligible SNPs—have more incentives to contract and coordinate with Medicaid than other MA-PD plans, since their dual eligible enrollees continue to receive significant amounts of care from Medicaid, especially nursing facility and community-based long-term care. Dual eligible SNPs that "passively enrolled" members from Medicaid managed care plans in 2005 and 2006 generally contract with Medicaid agencies for some Medicaid benefits (except in Pennsylvania). Plans in dual eligible demonstrations in Minnesota, Wisconsin, and Massachusetts also contract with Medicaid. Except for a few plans in Arizona and Wisconsin, chronic condition and institutional SNPs have so far not contracted with Medicaid.

Most chronic condition SNPs focus primarily on conditions that require acute medical care, rather than long-term care in nursing facilities or in the community. Since Medicaid covers few acute care services for dual eligibles, and since many enrollees in chronic condition SNPs are not dual eligibles, the absence of Medicaid services may not leave a major gap in chronic condition SNP benefit packages. Similarly, institutional SNPs can operate successfully if they can reduce Medicare hospitalizations, although including Medicaid nursing facility and home- and community-based services could increase their potential substantially. For dual eligible SNPs, however, a major underpinning for their business case is likely to turn on their ability to better coordinate Medicare and Medicaid services for their beneficiaries. If they are unable to do that, it is not clear what value they can add beyond what a regular MA-PD could provide.

The interest states have in contracting with a Medicare SNP is likely to vary with their managed care history and future interests. States that have already invested in getting dual eligibles into their Medicaid managed care plans prior to 2006 have an existing infrastructure for rate-setting and contracting that can be used to contract with Medicare plans. Also, those already covering Medicaid long-term care in managed care arrangements, or who have plans to do so in the reasonably near future, are likely to find the SNP contracting option attractive. Because Medicaid has only limited responsibility for paying for acute care for dual eligibles now that the Medicare drug benefit is in place, states that are not in these situations may find that their costs for contracting with SNPs are likely to exceed the benefits, at least in the short term.

There are at least 20 states in which dual eligibles and/or long-term-care services have been covered in Medicaid managed care, and that either already contract with SNPs, or may be interested in doing so.[19] As of November 2007, almost 83 percent of total SNP enrollment (outside of Puerto Rico) was in those 20 states, so SNPs appear to be focusing their efforts on states where the prospects of contracting with Medicaid may be most promising. States with current contracts with SNPs or with other indicators of potential interest in contracting with SNPs are shown in Table 2, along with the total number of dual eligible SNPs in each state.[20]

WHY ARE COMPANIES ESTABLISHING SNPS?

Understanding why companies establish SNPs can help policymakers assess the potential impact of company incentives on Medicare beneficiaries and the Medicare program. It can also help in assessing how various policy changes might affect those incentives. This section provides an overview of why companies are establishing SNPs. The next section then looks more closely at the "business case" for different SNP types and the major factors that can affect that business case from the company perspective.

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[19] The 20 states are those with a "Yes" in at least one column in Table 2. For a more detailed discussion of why states may want to contract with SNPs, see Verdier 2006 and Saucier and Burwell 2007.

[20] MedPAC voted in December 2007 to recommend that Congress require dual eligible SNPs to contract with states within three years to coordinate Medicaid benefits.

Table 2. Indicators of Current or Potential Interest State Interest in Contracting With SNPs

State	Number of Dual Eligible SNP Plans	State Currently Contracts With Some SNPs	State Covers Some Dual Eligibles in Comprehensive Medicaid Managed Care Plans	Medicaid Managed Care Includes Some Long-Term-Care Benefits
Total	**320**	**13 States**	**20 States**	**9 States**
Alaska	0	No	No	No
Alabama	3	No	No	No
Arkansas	10	No	No	No
Arizona	11	Yes	Yes	Yes
California	27	Yes	Yes, in some counties	Yes, in some counties
Colorado	4	Yes	Yes	No
Connecticut	6	No	No	No
District of Columbia	1	No	Yes	No
Delaware	1	No	No	No
Florida	56	No	Yes	Yes, in some small demos
Georgia	8	No	No	No
Hawaii	3	No	No	No
Iowa	2	No	Yes	No
Idaho	1	Yes	No	No
Illinois	8	No	No	No
Indiana	1	No	No	No
Kansas	1	No	No	No
Kentucky	1	Yes	Yes	Yes
Louisiana	3	No	No	No
Maine	2	No	No	No
Maryland	3	No	No	No
Massachusetts	6	Yes	Yes	Yes
Michigan	2	No	No	No
Minnesota	13	Yes	Yes	Yes
Mississippi	2	No	No	No
Missouri	1	No	No	No
Montana	0	No	No	No

Table 2 *(continue)*

State	Number of Dual Eligible SNP Plans	State Currently Contracts With Some SNPs	State Covers Some Dual Eligibles in Comprehensive Medicaid Managed Care Plans	Medicaid Managed Care Includes Some Long-Term-Care Benefits
Nebraska	0	No	No	No
Nevada	2	No	No	No
New Hampshire	0	No	No	No
New Mexico	2	No	No	No
New Jersey	1	No	Yes	No
New York	45	Yes	Yes, in small pilots	Yes, in small pilots
North Carolina	1	No	Yes	No
North Dakota	0	No	No	No
Ohio	3	No	No	No
Oklahoma	1	No	No	No
Oregon	8	Yes	Yes	No
Pennsylvania	11	No	Yes	No
Rhode Island	2	No	No	No
South Carolina	1	No	No	No
South Dakota	1	No	No	No
Tennessee	7	No	Yes	No
Texas	19	Yes	Yes	Yes
Utah	2	Yes	Yes	No
Vermont	0	No	Yes	No
Virginia	1	No	No	No
Washington	3	Yes, in a small pilot	Yes	No
West Virginia	0	No	No	No
Wisconsin	4	Yes	Yes	Yes
Wyoming	0	No	No	No

Sources: CMS SNP Comprehensive Report, November 2007, CMS 2007b, Saucier and Burwell 2007, Saucier and Fox-Grage 2005, and MPR analysis for the Kaiser Family Foundation.

Note: State SNP plan counts do not sum to total because some plans span multiple states. SNPs that operate in both Maryland and the District of Columbia, Illinois and Missouri, and New Mexico and Texas are counted in both states. The 320 total is an unduplicated count of plans.

Since SNPs are paid in the same way as other MA-PD plans, the opportunity to obtain higher capitated payments from Medicare may not be a major factor in company decisions to establish SNPs, as opposed to other MA plan types.[21] There may be some aspects of the CMS risk adjustment system that make some SNP types more or less attractive financially, but there is little firm evidence of that so far.[22] Other reasons to offer SNPs include: the potential to add new markets; the relative ease of establishing SNPs, especially for the initial 2006 and 2007 contract years; the opportunity for companies that have expertise in disease management, institutional care, and Medicaid to focus on populations they are experienced in serving; the opportunity to tailor benefit packages to fit the needs of specific populations, and to target marketing; and the opportunity to market to dual eligible beneficiaries year-round, since they can change plans at any time during the year.

New Markets

Most Medicare beneficiaries are in the traditional Medicare program, and significant subgroups (dual eligibles, institutionalized) historically have been served by traditional Medicare rather than MA or its predecessor private plan programs. The MMA spurred companies to become much more interested in Medicare because its beneficiaries, particular aged ones, are a growing population that account for a substantial share of health expenses. At the same-time, the phase-in of risk-adjusted payment to MA plans (completed in 2007) made higher-cost enrollees more attractive for plans. Also, the Part D drug benefit established by the MMA provided a major new opportunity for private plans (see Gold and Peterson 2006). In enacting the MMA, Congress substantially expanded the potential scope of private plans in Medicare. For industry, SNPs in this environment were a new option that had the potential to provide access to populations previously served mainly through public systems. Historically, different plans have operated in Medicare and Medicaid (Felt-Lisk et al. 2001). For plans involved with Medicaid, SNPs offered a way of also participating in Medicare, by using the Medicaid base to enter the Medicare market.

Ease of Establishing SNPs

For most MA companies, establishing a SNP is relatively easy. If a company is already in the MA business and has the staff, infrastructure, networks, and experience needed to operate that business in specific geographic areas, the additional incremental expense and effort needed to establish a SNP can be relatively modest. This was especially true for the 2006 and 2007 contract years, when the SNP application process did not require large amounts of information beyond what was required for any other type of MA plan. Even if a firm was unsure of its future strategy for SNPs, it may have viewed SNPs as valuable slack capacity or a hedge that expanded the firm's future options. In contrast, entry costs are higher for new companies, or for existing companies seeking to serve new markets. Many of the Medicaid managed care companies that

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[21] MedPAC staff estimated in a December 6, 2007 presentation to the Commission that SNPs (outside of Puerto Rico) will be paid 109 percent of FFS in 2008, compared to 112 percent for all HMOs and regional PPOs.

[22] The increase in chronic condition SNPs from 73 in 2007 to 244 for 2008 warrants further analysis. It could be that some of these plans are structured in ways that take advantage of particular aspects of the risk adjustment system.

became dual eligible SNPs in 2005, for example, were new to Medicare. Such companies need to learn how to link with Medicare and may have to create new networks for the Medicare product. The time needed for such expansion could explain why post-MMA SNP growth lagged behind that of some other forms of MA (especially PFFS) that are much easier to establish. Specialized SNP requirements may add to the costs of entry in the future; so far, however, the new requirements in place for 2008 do not appear to have slowed the growth of offerings in the SNP sector.

Building on Existing Expertise and Experience

While there is no comprehensive and systematic information on which SNPs have had prior experience in disease management, institutional care, Medicaid, or Medicare, a sizable share of SNP enrollment is concentrated in plans that have this kind of experience (United/Evercare had over 14 percent of total SNP enrollment in November 2007, for example, and Kaiser had about 6 percent). One category of new entrant comprises the Medicaid managed care plans long specializing in this population, which accounted for about 200,000 of the initial SNP enrollment in 2005-2006. For example, in California, the Orange County Organized Health System that covers both acute and some long-term care had a longstanding interest in integrating Medicare coverage; SNP authority allowed them to do so. Arizona strongly encouraged existing Medicaid managed care organizations to become SNPs, and most did so in 2005. The ability to leverage existing experience also appears to underlie decisions by some new entrants, such as the SHMOs in California and New York. Another example is Care Improvement Plus, a disease management company that previously did not participate extensively in MA but has been a major participant in CMS's legislatively mandated Medicare Health Support program, which provides some beneficiaries in the traditional Medicare programs with enhanced care coordination services. Care Improvement Plus operates in MA through a regional Preferred Provider Organization (PPO) structure. In 2006, it had fewer than 300 enrollees in one state; by November 2007, the firm had almost 80,000 enrollees in six states, with an exclusive focus on chronic condition SNPs. The model employed by the organization is markedly similar to that piloted in its previous work in traditional Medicare. For the most part, the firm operates without networks, paying providers Medicare rates and overlaying the firm's care management infrastructure on top of this system.

Tailoring Benefit Packages

SNPs that serve populations with distinctive, or at least more homogeneous needs than the general Medicare population, gain the opportunity of tailoring benefit packages to this population by offering this type of plan, thus perhaps increasing plan attractiveness to potential enrollees. For example, compared to the regular MA-PD plan offering, SNP plans might cover more of the prescription drugs these populations need, with fewer restrictions on access. They might provide more care coordination, or nurse practitioner, mental health, or other specialized services. Their provider networks might include more of the kinds of specialists that such beneficiaries need. MA-PD plans that cannot restrict their enrollment in the way that SNPs can might be concerned that they would not be able to adequately target and control the use of such extra benefits if they were broadly available to all their members. Without such targeting, the financial savings from reductions in hospitalizations and other costly services that can help to finance extra preventive care may be limited. SNP beneficiaries may gain from such targeting if

it allows firms to use the savings in ways that result in a better match of services to enrollee needs than occurs in a regular MA plan.

The ability to target may be less meaningful to firms seeking to enroll dual eligibles, or to dual eligible beneficiaries themselves. Most of the acute care benefits a regular MA-PD might offer as supplements to its overall benefit package already are provided through Medicaid. More care coordination, with a special focus on helping enrollees learn about and access Medicaid services, is certainly one option. This kind of coordination with Medicaid is, of course, easier to accomplish if a SNP has a contract with the state to provide some Medicaid services, or at least some sort of cooperative arrangement with the state Medicaid agency. Some Medicaid services (mental health, home health, transportation, excluded Part D drugs) also may help to reduce Medicare expenditures for hospitalizations and short-term post-acute nursing facility care, giving SNPs a financial incentive to facilitate use of such services by their dual eligible members.

Marketing

Tailoring their benefit packages to particular populations should assist SNPs with marketing to those populations, although some benefits, such as care coordination, can be hard to explain in the abstract, especially when marketing to populations who have not experienced such benefits in the past. Another potential advantage of SNPs from the perspective of some companies is the ability to market to dual eligibles all year, as opposed to only during the November 15 to December 31 annual election period.[23] This can help to keep marketing staffs and agents busy throughout the year. Almost all potential enrollees in dual eligible SNPs are dual eligibles, as are about half of those who may enroll in chronic condition and institutional SNPs. However, while dual eligibles and nursing facility residents can change plans at any time, most available evidence indicates that they do not actually do so.[24] In addition, as noted earlier, current and accurate contact information for duals generally is not available to SNPs and other MA plans. As a result, the benefits to SNPs of year-around marketing to dual eligibles may be more theoretical than real for most plans.

FACTORS THAT AFFECT THE BUSINESS CASE FOR DIFFERENT SNP TYPES

Companies establishing SNPs must consider how such plans can add enough value for enrollees and plan owners to justify whatever costs are incurred in establishing and operating them. The business case for SNPs turns on the plans' ability to (1) obtain enrollment; (2) assure that diagnoses are properly recorded so that Medicare's risk-adjusted capitated payments adequately reflect enrollees' predicted costs; and (3) modify care patterns so that unnecessary use of costly Medicare services (emergency room, inpatient hospital, prescription drugs) is

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[23] In December 2007, MedPAC voted to recommend that Congress eliminate dual eligibles' ability to enroll in MA plans outside of open enrollment, except for SNPs with state contracts. Under the recommendation, dual eligibles would continue to be able to disenroll and return to FFS Medicare at any time during the year.

[24] Almost all the dual eligibles auto-enrolled in stand-alone PDPs in early 2006 were still in such plans in early 2007. In a January 30, 2007 press release, CMS reported that only 7 percent of all Part D enrollees chose to change plans during the 2006 open enrollment period (http://www.cms.hhs.gov/apps/media/press_releases.asp [Accessed December 24, 2007]). Earlier research on Medicare managed care also found that Medicare beneficiaries are reluctant to change plans once they enroll. See, for example, Gold, Achman, Brown 2003 and Stevens 2003. -

minimized. These factors play out differently for each SNP type. How they evolve also affects what benefits or risks SNPs may create for Medicare and for beneficiaries. We review these three issues below.

Reaching Scale and Enrollment Goals

An underlying premise of SNPs is that specialization will allow plans to gain scale to do things they could not otherwise do in delivering care to those with special needs. For this and other reasons, enrollment potential is critical to how firms view the market. Ultimately, the role SNPs play in the market may depend both on how many and what kind of beneficiaries they reach. In most markets, a larger market share means more impact. However, SNPs treat high-cost and high-need subgroups of beneficiaries. As a result, reaching this subgroup and caring for them effectively could have an impact on Medicare, even if the total enrollment is small. The issue of enrollment and scale differs for each type of SNP.

For chronic condition SNPs, the definition of chronic conditions will influence both the potential pool of enrollees who may be recruited and the share of costs incurred by these enrollees. Because eligibility is based on health conditions, chronic condition SNPs seeking enrollment may benefit from their established networks of physicians, hospitals, and other providers for referral of potential enrollees who have the conditions focused on by these SNPs. Such SNPs say they often rely on these local providers to identify beneficiaries who have certain kinds of chronic conditions, and the potential enrollees themselves generally consult with their providers before deciding to enroll. If a chronic condition SNP does not have an established reputation in the community, this route to enrollment may be difficult for them.[25] Chronic condition SNPs that are part of larger MA organizations also can benefit from their regular MA membership, which can serve as a source of enrollment in a more specialized chronic condition SNP. For SNP-only chronic condition SNPs, enrollment may be easier to obtain if they have broad, but loose, provider networks with few restrictions on which providers enrollees may use; this appears to be the case in some SNP-only chronic condition plans.

Dual eligible SNPs face a different situation than chronic condition SNPs. Because the MMA makes stand-alone PDPs the default plan, more than 90 percent of full dual eligibles (6.1 million out of 6.6 million) were enrolled in stand-alone PDPs in January 2006 in order to ensure continuation of their prescription drug coverage after Medicaid coverage ended in December 2005. Dual eligible SNPs face the challenge of persuading these auto-enrolled duals to switch plans. While duals can change Part D plans at any time, they must make an affirmative decision to do so, and then take whatever steps are necessary to disenroll from one plan and enroll in another. For firms, the challenge is reaching these beneficiaries. For beneficiaries, the issue is understanding whether the product being offered is truly "special," and what advantages or disadvantages it may have relative to what they currently have.

[25] Care Improvement Plus was the only chronic condition SNP with significant enrollment growth between 2006 and 2007. It accounted for 27 percent of total chronic condition SNP enrollment in July 2007, and 66 percent of growth between July 2006 and July 2007. Another 51 percent of July 2007 chronic condition SNP enrollment was accounted for by a single plan in Puerto Rico (MMM Healthcare). Its July 2007 enrollment was down 13 percent, compared to July 2006.

Firms face challenges in marketing to these dually eligible beneficiaries. Generally, there are no readily available lists of dual eligibles with addresses and telephone numbers that dual eligible SNPs can use for outreach and marketing. Potential enrollees must be contacted one at a time. Dual eligibles often have low education and literacy levels (more than 60 percent have not graduated from high school) and limited community and workplace ties (more than half live alone or in institutions, and only 1 percent have employer-provided health insurance).[26] For Medicare and its beneficiaries, such characteristics also create concerns over potential marketing abuse, as well as the ability of a dually eligible beneficiary to make an informed choice.

Some companies have advantages relative to others in marketing to duals. In particular, companies that operate both PDPs and MA plans, such as UnitedHealthcare, WellCare, and Humana, have contact information for the duals who have been auto-enrolled in their PDPs, and can market directly to them as long as they follow CMS marketing guidelines.[27] State Medicaid agencies also have contact information for dual eligibles, and can inform duals of SNP and other MA-PD opportunities, as long as they do not favor one plan over another.[28] Those opportunities are relatively limited for most dual eligible SNPs, however.

Institutional SNPs face perhaps the greatest challenges in obtaining enrollment. To obtain enrollment, institutional SNPs must first secure a contract with each relevant nursing facility, and then enroll residents one at a time, with no steering by the nursing facility. Apart from the converted SHMO demos in California and New York, total institutional SNP enrollment in November 2007 was only 38,881, and almost 80 percent of that was in Evercare, which has been operating institutional SNPs as part of CMS demonstrations for more than a decade.

Obtaining Complete and Accurate Diagnostic Data

An important premise underlying SNPs is that plans serving individuals with special needs will be rewarded with more funding to manage their care because risk adjustment ties payment to needs. The MA risk-adjusted payment system is based on use of diagnostic data for each plan enrollee from the prior year. Those data are submitted by plans to CMS and used by CMS to calculate risk scores and capitated payments for the current year.

The prospective feature is particularly important to policymakers because it limits the ability to "game" the system, but prior-year diagnostic data may not always be available. When they are

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[26] MedPAC. "New Approaches to Medicare." Report to the Congress, June 2004, p. 76.

[27] UnitedHealthcare and Humana stand to lose hundreds of thousands of dual eligibles enrolled in their stand-alone PDPs in 2008, since they bid below the Part D benchmark in a large share of the regions in which they operate. In that situation, CMS reassigns duals to other PDPs, unless they choose to stay in their current PDPs and pay the amount by which their subsidized part D premium exceeds the benchmark. Analysts put the potential enrollment losses for UnitedHealthcare at 650,000 and for Humana at 400,000. See Vesely 2007. In addition, WellCare may face difficulties in gaining and retaining enrollment as a result of a search of its Tampa headquarters by armed federal and state law enforcement officials on October 24, 2007 and potential ramifications from that event.

[28] For details, see CMS, "Marketing 'How to" Guide for Special Needs Plans," July 19, 2006, available on the Web at: http://www.cms.hhs.gov/IntegratedCareInt/Downloads/Marketing_How_To.pdf. [Accessed November 28, 2007.

not, plans enrolling these individuals may receive risk scores and MA payments that are below the likely costs of their care. The link between diagnostic data and payment adds to the pressure on the risk adjustment system to minimize opportunities for gaming through use of techniques such as "upcoding," or selective focus on financially more attractive patients within given risk categories. Such practices can add to Medicare costs and serve to detract from the goals of a risk-based payment system.

While the issue of available diagnostic data is an issue for all types of SNPs, some may have an easier time obtaining such data than others.[29] For example, obtaining diagnostic data generally is not a problem for institutionalized SNPs, since diagnoses and other care needs for nursing facility residents are usually well documented. In addition, the Medicare risk-adjusted health plan payment system adjusts payments upward for institutionalized enrollees, in addition to the diagnosis-based payment adjustments.

Because CMS's risk adjustment system was being phased in during a slow growth period for MA plans, the issue of diagnostic data for new enrollees may have received less attention than it may merit in the future, especially for SNPs. When beneficiaries first join Medicare, they are automatically assumed, in effect, to have "average" health-based risk the first year.[30] In open enrollment models, this generally has not been an issue, as few become eligible each year. The more important issue involves what is done when an enrollee is not new to Medicare itself, but to a particular MA plan. If the beneficiary came from traditional Medicare, there is the potential to get the data from Medicare fee-for-service claims data. However, these claims—especially those submitted by physicians—often do not include complete and accurate recording of diagnoses. For dual eligibles, there is also the potential to obtain claims data from state Medicaid programs, though this may be administratively challenging, especially if the SNP does not have a contract with the state.

Obtaining reasonably complete and accurate diagnostic information from the year before enrollment is especially important for chronic condition SNPs, since most of their enrollees are likely to have high costs that may not be covered fully if their diagnoses are not reflected adequately in the plan's risk-adjusted payments. Again, companies that are able to shift enrollment from their existing MA plans into a chronic condition SNP are likely to have less difficulty in assuring that diagnostic information is adequate to support higher risk scores.

While most SNP beneficiaries can be expected to have above-average risk scores, some SNPs have been approved where this may not be the case. If low risk scores are due to the lack of diagnostic data for enrollees with high-cost conditions, the result could be underpayments.

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[29] In theory, SNPs in general might be in a better position than less specialized MA plans to persuade physicians, hospitals, and other providers to document more completely and accurately the diagnoses that provide the basis for the risk-adjusted payments that all MA plans receive from CMS, since SNPs may have closer relationships with these providers. If SNPs were successful in documenting enrollee diagnoses more fully and completely than other MA plans, the per-beneficiary risk-adjusted payments for SNP enrollees could be higher than they would be for the same enrollee in an MA plan that was less successful in its documentation. However, there is no current evidence that SNPs are systematically more successful than other MA plans in documenting diagnoses.

[30] For new enrollees lacking 12 months of Medicare Part B eligibility in the prior year, the risk score is based solely on demographic factors (age and sex), Medicaid status, and the original reason for Medicare entitlement (disability or age).

Some argue that, because of the rationale for chronic condition SNPs, the beneficiaries served should have an average score above the norm.[31] However, it could be that some beneficiaries, particularly those under 65 and disabled, whether dually eligible for Medicaid or not, may have special needs related to their functional status (e.g., physical accessibility, communication) that do not necessarily result in above-average medical costs.

Modifying Care Patterns

A SNP's ability to modify care patterns is essential to the firm's being able to operate well in an environment in which the plan is at risk for the cost of services. We do not yet know whether this will be possible, and if so, how. The answer is important, not just to firms but to beneficiaries and the Medicare program overall. Ideally, firms are able to modify use in ways that improve outcomes and satisfaction while generating savings (or at least not adding to total net costs). Alternatively, SNPs could reduce costs without adversely affecting outcomes or satisfaction. Either of these outcomes benefits all parties. Quality and performance measures are important because they provide additional information to help in assessing trade-offs, and can help policymakers learn about the net benefits of SNPs. All three SNP models have the potential to improve care delivery and reduce costs, although their opportunities may differ as may the challenges they face in modifying care patterns in desirable ways.

Dual eligible SNPs have the potential to provide care coordination and management services better tailored to the unique needs of duals, including consideration of their generally lower levels of education and literacy, their use of languages other than English, and their limited family and community ties. In addition, duals face unique care coordination and access challenges growing out of their reliance on Medicaid for many services not covered by Medicare, including mental health, substance abuse, and long-term-care services. Dual eligible SNPs can assist their enrollees in navigating the Medicaid system, which could result in lower use of emergency rooms and inpatient hospital services, thereby reducing Medicare costs the SNP would otherwise have to pay. However, doing so requires knowledge of Medicaid and effective strategies for the target population, as well as an ability to maximize the gains through coordination with Medicaid.

Chronic condition SNPs should be in a position to modify care patterns because they generally are allowed to choose the conditions in which they wish to specialize based on the likelihood that costly services such as hospitalization can be reduced if those conditions are treated properly. It also may be that more of their enrollment represents an affirmative informed choice by enrollees. That could mean that those who enroll in chronic condition SNPs are more likely to be motivated and able to participate effectively in their own care.

However, many chronic care plans are focused on multiple, often diverse, conditions; this could limit their ability to specialize and thereby generate the gains that are theoretically possible. Further, gains from specialization may be more likely in some kinds of chronic condition SNPs than others, based on how specialized the current needs of the population are and

[31] Section 431 of H.R. 3162, the Children's Health and Medicare Protection Act of 2007, as passed by the U.S. House of Representatives in August 2007, would require chronic condition SNPs to have an average risk score of 1.35 or higher, beginning in 2009.

how well served they are under the current system. For example, potential gains from treating Alzheimer's patients whose special needs may be ignored in the current system could be greater than for those treating relatively low-risk patients with hypertension or high cholesterol, who may get the same care in other MA programs or in Medicare through a coordinated care demonstration.[32]

Institutional SNPs have substantial potential to modify care patterns because they are at risk for all the hospitalization costs that their enrollees may incur, as well as for their Medicare nursing facility and prescription drug costs. Institutional SNPs are able to use savings from reducing hospitalization to provide or pay the nursing facility for services that may help keep nursing facility residents out of the hospital, including on-site nurse practitioner services, wound care, consulting pharmacist services to improve use of prescription drugs, and more intensive on-site services to treat conditions that might otherwise require hospitalization. Institutional SNPs also may be able to transition nursing facility residents out of the facility and into the community, where many of the services they need may be covered by Medicaid home- and community-based service (HCBS) waiver programs rather than by the SNP. If an institutional SNP contracts with Medicaid to cover Medicaid nursing facility and HCBS waiver services, as is done in Arizona and some other states, the incentives and opportunities for SNPs to transition nursing facility residents into the community may be even greater.

It may prove challenging, however, to create effective new partnerships between institutional SNPs and nursing facilities, because each may be suspicious of the other's motives. Further, managing the care of very sick and institutionalized patients requires firms to confront one of the biggest historical weaknesses of the care system—a focus on acute care delivery, with incentives for short-term intervention, rather than long-term stabilization and management to improve quality of life.

HOW DO SNPs FIT INTO THE OVERALL MA PROGRAM?

While policymakers have tended to focus their attention on the number of SNP plans, knowing how many contracts offer these plans is important, because it is a better indicator of the number of unique sponsors that might be offering one or more SNP plans in particular markets. When more than one SNP is offered under the same contract, they are most likely to differ only in benefits, cost sharing, and premiums. Some companies also obtain a separate plan number under the same contract for each county within a state. Care management is likely to be handled the same in a particular contract (at least within a type of SNP). We review here some of the characteristics of SNPs and their enrollment as viewed through the contracts in which the SNPs are offered.

MA Contracts with SNPs

SNPs are pervasive within MA, at least on paper. In July 2007, there were 551 MA Contracts (Table 3). Almost half of these—254, or 46 percent—included at least one SNP plan

[32] MedPAC voted to recommend in December 2007 that chronic condition SNPs be required to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.

Table 3. Contract Availability by Contract Type, July 2007

			SNP Contracts		
	Total MA Contracts	Regular MA (Non-SNP) Contracts	Total SNP Contracts	Contracts with Some SNPs	SNP-Only Contracts
Total	**551**	**297**	**254**	**166**	**88**
Local HMO	291	100	191	138	53
Local PPO	119	93	26	15	11
PFFS	47	47	0	0	0
RPPO	14	8	6	3	3
Demo	38	7	31	10	21
Other	42	42	0	0	0

Source: MPR analysis of CMS Monthly data from the MA contacts file and SNP Comprehensive Report, July 2007.

within their offerings. Sixty-five percent of these 254 contracts (166) offered SNPs along with regular MA plans. The rest (88, or 35 percent) offered SNP plans only. For the most part, SNPs that were offered were handled through HMO contracts, although some were under PPOs (mostly local, but some regional PPOs) or demonstration contracts. Sixty-six percent of HMOs offer at least one SNP contract. Dual eligible plans are more likely to be offered under MA contacts than any other type of SNP (Figure 5). Thirty-seven percent of contracts offer such a plan, whereas only 12 percent and 8 percent offer institutional or chronic care SNPs, respectively. (Some offer more than one type of SNP plan.)

SNP Market Share

As of mid-year 2007, SNPs accounted for 11 percent of all enrollees in MA plans and 13 percent of HMO enrollees (Table 4). SNPs represent a disproportionate share of the still small, though growing, regional PPO (RPPO) enrollment, with approximately 38,000 of 167,000 enrollees, or 22 percent. SNPs currently represent 71 percent of enrollment in demonstration plans.

SNP Enrollment by Contract Types

As with contract counts, HMOs dominate SNP enrollment (Figure 6). Just over three-quarters of SNP enrollees are in HMOs, and another 16 percent are under demonstration contacts, which also are likely to be based on an HMO model. In comparison to HMOs, PPOs historically have had less emphasis on care management, although they allow enrollees more

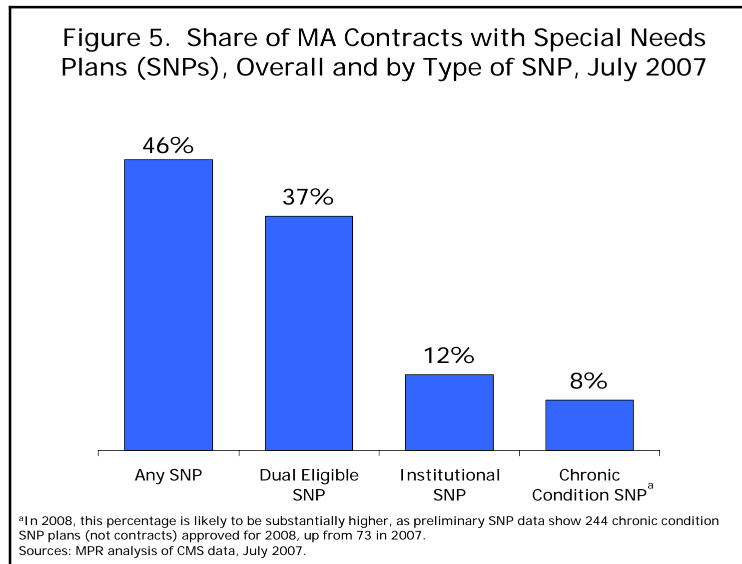

Table 4. Contract Enrollment by Contract Type, July 2007

	Total MA Enrollment	Total SNP Enrollment in MA Contracts	Total SNP Enrollment in MA Contracts Offering SNP and Other MA Plans	Total SNP Enrollment in SNP-Only MA Contracts	Total SNP Enrollment as Percentage of Total MA Enrollment
Total	**8,645,970**	**957,553**	**695,101**	**262,452**	**11%**
Local HMO	5,743,022	724,830	582,401	142,429	13%
Local PPO	480,223	42,495	12,761	29,734	9%
PFFS	1,650,435	0	0	0	0%
RPPO	167,481	37,626	8,370	29,256	22%
Demo	216,344	152,602	91,569	61,033	71%
Other	388,465	0	0	0	0%

Source: MPR analysis of CMS Monthly data from the MA contacts file and SNP Comprehensive Report, July 2007.

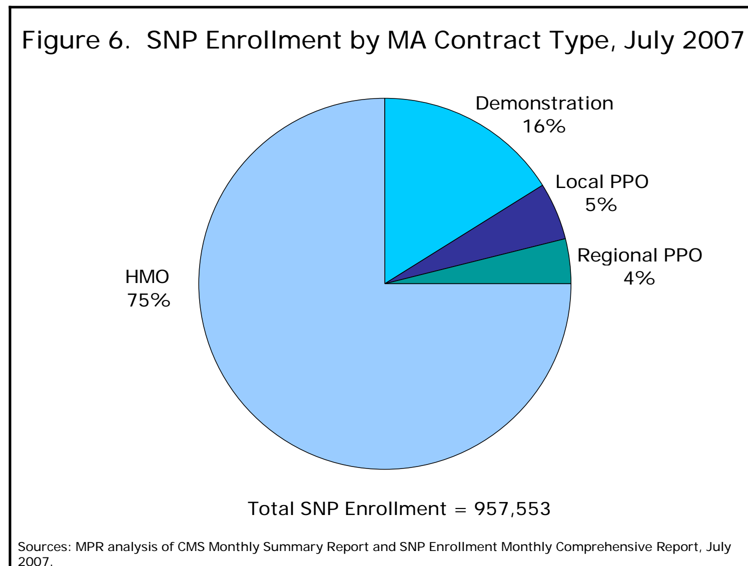

Figure 6. SNP Enrollment by MA Contract Type, July 2007

Sources: MPR analysis of CMS Monthly Summary Report and SNP Enrollment Monthly Comprehensive Report, July 2007.

flexibility in provider access, since enrollees can go out of network if they are willing to absorb the (often substantial) cost (Gold, Cupples Hudson, and Davis 2006). About 8 percent of SNP enrollees are in a PPO, either local or regional.

Regional PPOs have not been strong within the MA marketplace, in part because they have a difficult time in developing provider networks over large areas of the country (Gold 2007b). For this reason, their use as a base for a SNP plan offering is somewhat surprising. Of about 38,000 SNP enrollees in regional PPOs, approximately 29,000 of them are in chronic care SNPs operated by Care Improvement Plus.[33] We understand that Care Improvement Plus SNPs operate less as network-based than as fee-for-service products upon which care management is overlaid. The other SNP enrollees are under UnitedHealthcare contracts serving dual eligibles. UnitedHealthcare also accounts for almost all (41,206 of 42,495) of SNP enrollees in local PPOs. (In other work, we have discussed UnitedHealthcare's strategy of offering a diversified MA product line. See Gold 2006a).

SNP Activity within Major MA Firms

Historically, a small number of firms have dominated the MA marketplace (Gold 2001; 2006). This continues to be the case today, although MA growth and diversification of products has led to somewhat lower rates of concentration than in the past. These major firms are less dominant in the SNP market, however.

In mid-year 2007, three firms cumulatively accounted for 38 percent of all MA enrollment: UnitedHealthcare (15%), Humana (13%), and Kaiser Permanente (10%) (Table 5). Another

[33] More specifically, there are 37,626 SNP enrollees in regional PPOs, of whom 8,370 are dual eligibles SNPs, none are in institutional SNPs, and 29,256 are in chronic condition SNPs. All of the former (duals) are in UnitedHealthcare regional contracts and all of the latter are in Care Improvement Plus.

15% were enrolled in firms that are affiliated with BC/BS.[34] Each of these has a distinctive pattern with respect to SNPs though together they are much less dominant within the SNP line of business, at least to date, than in MA more generally. (For additional information on firms, see appendix B.)

- ***UnitedHealthcare.*** Among major MA firms, UnitedHealthcare has been most active in the SNP market. Consistent with their strategy of broad offerings, UnitedHealthcare has a SNP plan option in most of their contracts (Table 6). The firm, now integrated with PacifiCare, has 79 contracts spanning all contract lines, 67 of which have a SNP plan option. The firm offers all three types of SNPs; of the 67 MA contracts with SNP plans, 45 have plans for dual eligibles, 37 for institutionalized beneficiaries, and 19 for subgroups needing chronic care. Eight percent of total MA enrollment within the firm is in SNPs. UnitedHealthcare makes more use of PPOs as a vehicle for SNP enrollment than any other large firm. (Care Improvement Plus—a new entrant—is the only other firm using this option in 2007.)
- ***Humana.*** While Humana has more than 1 million enrollees in MA, more than 600,000 of them are in PFFS or other contracts not eligible to offer SNPs. In 2007, all of Humana's SNP offerings were within its (limited number of) HMO contracts—4 of 7 total HMO contracts. It did not offer SNPs through regional PPOs, although its RPPO contract covers most of the country. SNPs account for only 2 percent of Humana's 2007 MA enrollment. The entire enrollment is in SNPs geared to dual eligibles through HMO contracts. The firm does not offer any other kind of SNP, although it has a limited enrollment in local and regional PPOs under 14 different contracts.
- ***Kaiser Permanente.*** Among MA firms, Kaiser is unique in its consistent emphasis on HMO products, or fairly similar products paid under cost or Health Care Prepayment Plan (HCPP) authority. As a result, its enrollment has been relatively stable, without the recent dramatic growth experienced by some companies. In 2007, Kaiser offered SNPs in 3 of its 11 geographically specific contracts. All were focused on dual eligibles. SNP enrollment accounts for about 6 percent of the firm's total MA enrollment. It is our understanding that these individuals are not new to the firm but rather are enrollees previously served through MA plans that have been converted to SNPs.

[34] With mergers, Wellpoint now owns many companies that previously had separate BC/BS licenses. Within the MA market however, it does not dominate Blues-licensed MA business, with only 57,000 enrollees in Blues branded products. Another 116,000 enrollees are served through non-Blues branded products (e.g., UniCare).

Table 5. SNP Enrollment by Selected MA Firms, By Overall Size of MA Enrollment, July 2007

	Total MA Enrollment		SNP Enrollment	
Firm Name of Affiliation	N	%	N	%
Total Enrollment	**8,645,970**	**100%**	**957,553**	**100%**
Blue Cross/Blue Shield Affiliate	1,328,396	15.4	55,975	5.8
UnitedHealthcare	1,320,543	15.3	110,370	11.5
Humana	1,083,761	12.5	23,680	2.4
Kaiser Permanente	874,100	10.1	56,148	5.9
Health Net	220,735	2.5	8,746	1.0
Aetna	187,176	2.2	0	0
Wellcare	154,635	1.8	23,087	2.4
Other	3,476,624	40.2	679,547	71.0

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007, SNP Comprehensive Report, July 2007.

Note: Numbers may not be identical to standard SNP reports because of the challenges in merging and discrepancies between general MA and SNP data.

Table 6. Role of SNPs in UnitedHealthcare Medicare Advantage Market, July 2007

	Total Contracts	Contracts with SNP Plans	MA Enrollment	SNP Enrollment	SNP Enrollment as Share of Total MA
All	79	67	1,320,543	110,370	8%
HMO	41	34	1,102,970	57,707	5%
Local PPO	19	18	60,337	41,206	68%
Regional PPO	3	3	42,850	8,370	19%
Demonstration	12	12	4,503	3,095	69%
All Other (PFFS, Cost HCPP	4	0	109,783	0	0%

Source: MPR analysis from CMS data on MA contracts and enrollment and SNP plans; firm coding based on MPR data, July 2007.

Note: Includes contracts previously offered by PacifiCare. In the marketplace, UnitedHealthcare MA plans often are offered through the "Secure Horizons" brand.

- ***BC/BS Affiliated Companies.*** These are separate companies that offer products under a license from the national Blue Cross and Blue Shield (BC/BS) organization. A key requirement of such a license is that products, in most though not all instances, serve defined service areas (often states) and not compete geographically with another Blues- licensed company's products. Only 16 of the 68 BC/BS affiliated company MA contracts offer an SNP plan, and each of these focuses solely on the dual eligibles through either HMO or demonstration contracts. Overall, SNPs account for just under 6 percent of total MA enrollment. However, the companies vary substantially in their role in the MA market, and activity likely is focused on a subset of companies.

Extent to Which SNP Sponsors Are Unique

Whether because the SNP market is new and has not yet had an opportunity to "shake out," or because it has unique features, somewhat different firms currently dominate SNP enrollment than dominate overall MA enrollment; some are new to MA, although UnitedHealthcare is the leader in both markets.

Of the 254 contracts that include a SNP plan, 90 have gone to one of the four firms or affiliates noted above. This 35 percent share is relatively the same as within MA generally, although UnitedHealthcare is even more dominant within the SNP market. In terms of enrollment, however, these four firms or affiliates account for only 26 percent of the SNP market, whereas they constitute double that, 53 percent, of the MA market generally.

What accounts for the difference? While we are not entirely sure, it seems that several factors may be at work.

- ***Irrelevance of PFFS to SNP Market.*** PFFS plans, which cannot be SNPs, accounted for just under a fifth of all MA enrollees in mid 2007; this enrollment was particularly relevant to Humana, which had more than 600,000 enrollees in such products.

- ***Local Focus of Care Coordination.*** Because SNPs involve coordinated care, they are less likely to benefit from national economies of scale. This allows locally relevant plans to operate in the market, although they still require sufficient scale to learn how to work with CMS in a way that keeps their administrative costs reasonable.

- ***Influence of Puerto Rico.*** Puerto Rico accounted for over 240,000, or 25 percent, of total SNP enrollment in mid 2007. In July 2007, Puerto Rico also accounted for more than 60,000 of the enrollees in chronic care SNPs, or 52 percent of the total enrollment in such plans. The Puerto Rico market has unique features and many of their SNP enrollees are in local plans based in Puerto Rico only. (MMM Healthcare had over 94,000 enrollees in July 2007, MCS Life Insurance Company had 47,500 enrollees, and Preferred Medicare Choice had over 39,000.)

- ***New Entrants Spurred by SNP Opportunities.*** As discussed previously, the MMA, and its drug benefit and enhanced MA program—and the SNP option more specifically—opened up new Medicare markets that had the potential to attract new

> entrants if they could overcome the hurdles of learning to work with Medicare. Firms such as Care Improvement Plus used this opportunity to parlay their care management experience, whereas others such as Wellcare used their Medicaid experience to leverage broader participation in the Medicare market. Some of these (Care Improvement Plus) are entirely SNP enrollment products. Others (Wellcare) have both SNP and general MA enrollment.

So far there has not been a concerted effort to fully reconcile SNP reported names with underlying firm ownership. However, work to date suggests that, while concentration within SNPs may be less than in MA and still evolving, the top 10 SNP companies account for almost 60 percent of all enrollment (Table 7).

Geographic Variation by State in the SNP Market

As shown in Table 8, both MA and Medicaid managed care traditionally have been more prominent in some states than others; the same is true to an even greater extent with SNPs. Eighty-six percent of total July 2007 SNP enrollment was concentrated in Puerto Rico and nine states. In contrast, these states account for 42 percent of all Medicare beneficiaries and 60 percent of all MA enrollees.

Table 9 shows total MA and total SNP enrollment by state. High enrollment levels obviously are influenced by the size of the beneficiary population, whereas penetration rates reflect not just SNP enrollment but how it relates to other MA enrollment. Nationwide, total SNP enrollment was only 11 percent of total MA enrollment in July 2007, but the percentage was substantially higher in a number of states, including South Dakota (36 percent), Maryland (22 percent), Delaware (19 percent), Arizona (17 percent), Minnesota (17 percent), and Tennessee (17 percent). For the most part, these are states that have a history of Medicaid managed care or efforts to integrate Medicare with Medicaid. Some also have had problems getting more mainstream MA enrollment, so SNP enrollment represents a large share of total MA enrollment. South Dakota, for example, shows up only because of the small number of total MA enrollees (around 7,000) and Maryland's MA penetration has been low since the departure of a number of firms in the early 2000s.

The last two columns on the right in Table 9 show the total number of dual eligibles in each state in mid-2006 (the latest data available) and July 2007 enrollment in all SNP types as a percent of all dual eligibles in the state. This is only a rough measure of the SNP-eligible population that SNPs have enrolled in a state, since dual eligible SNPs do not have to limit their enrollment exclusively to dual eligibles, and chronic condition and institutional SNPs are not limited to dual eligibles, although approximately half of their current enrollment appears to be dual eligibles.

Table 7. Top 10 SNP Companies, By Enrollment, July 2007

Company	Enrollment
UnitedHealthcare	110,370 (multiple states)
MMM Healthcare, Inc.	94,482 (PR)
SCAN Health Plan	91,712 (CA, AZ)
Kaiser Foundation Health Plan	56,148 (CA, CO, GA)
MCS Life Insurance Company	47,504 (PR)
Preferred Medicare Choice, Inc.	39,822 (PR)
Care Improvement Plus	31,652 (multiple states)
Managed Health, Inc.	27,887 (NY)
Keystone Health Plan	25,421 (PA)
Gateway Health Plan, Inc.	24,925 (PA)
Total	**549,923 (57.4% of total SNP enrollment)**

Source: CMS July 2007 SNP Comprehensive Report

Table 8. Top 10 States, By SNP Enrollment, July 2007

	SNP Contracts		SNP Enrollees		Medicare Beneficiaries		MA Enrollees	
	N	%	N	%	N	%	N	%
Total	**254**	**100%**	**957,553**	**100%**	**44,067,816**	**100%**	**8,645,970**	**100%**
PR	13	5.1	241,088	25.2	620,287	1.4	346,505	4.0
CA	24	9.4	182,939	19.1	4,386,037	10.0	1,451,163	16.8
PA	12	4.7	102,490	10.7	2,189,492	5.0	707,167	8.2
NY	24	9.4	72,735	7.6	2,879,429	6.5	679,956	7.9
AZ	15	5.9	50,175	5.2	818,639	1.8	288,705	3.3
TX	16	6.3	46,439	4.8	2,641,789	6.0	385,801	4.5
FL	23	9.1	45,692	4.8	3,135,438	7.1	769,426	8.9
MN	13	5.1	35,813	3.7	471,940	1.0	214,321	2.5
TN	9	3.5	28,307	3.0	955,071	2.2	166,871	1.9
OR	9	3.5	17,469	1.8	557,166	1.2	218,747	2.5
All Others	96	37.8	134,406	14.0	25,412,033	57.7	3,417,308	39.5

Source: State SNP and MA enrollment counts are from MPR analysis of the CMS MA Monthly State/County Contract file, July 2007; CMS July 2007 SNP Comprehensive Report, and CMS 2007 Plan Finder. National SNP and MA enrollment totals are from author analysis of the CMS Monthly MA Contract file, July 2007 and the July 2007 SNP Comprehensive Report. Medicare beneficiary totals are from author analysis of CMS State/County Market Penetration file, December 2005, the most recent data available.

Table 9. Total MA and Total SNP Enrollment by State, July 2007

State	Number of SNPs[a] (July 2007)	SNP Enrollment (July 2007)	Total MA Enrollment[b] (July 2007)	Total July 2007 SNP Enrollment as a Percent of Total July MA Enrollment	Total Number of Full and Partial Dual Eligibles (June 2006)[c]	Total July 2007 SNP Enrollment as a Percent of Total June 2006 Dual Eligibles[d]
National	**254**	**957,553**	**8,645,970**	**11.1%**	**7,530,654**	**12.7%**
Alaska	0	0	63	0.0%	11,622	0.0%
Alabama	4	17,132	114,732	14.9%	185,526	9.2%
Arkansas	4	5,780	45,556	13.8%	100,237	6.3%
Arizona	15	50,175	288,705	17.4%	119,872	41.9%
California	24	182,939	1451163	12.6%	843,121	21.7%
Colorado	5	8,633	165,581	5.2%	62,898	13.7%
Connecticut	6	3,716	54,789	6.8%	64,510	5.8%
District of Columbia	2	419	6,470	7.9%	13,910	3.7%
Delaware	2	315	3,302	19.2%	20,459	3.1%
Florida	23	45,692	769,426	5.9%	476,829	9.6%
Georgia	9	14,907	109,152	13.7%	223,211	6.7%
Hawaii	3	1,013	67,813	1.5%	26,119	3.9%
Iowa	2	40	55,175	0.1%	67,570	0.1%
Idaho	1	410	40,661	1.0%	24,782	1.7%
Illinois	9	5,023	139,137	3.7%	271,997	1.9%
Indiana	1	381	88,332	0.4%	99,944	0.4%
Kansas	1	0	29,510	0.0%	48,320	0.0%
Kentucky	1	9,652	76,660	12.6%	142,518	6.8%
Louisiana	2	1,908	109,712	1.7%	157,327	1.2%
Massachusetts	9	13,968	169,845	8.2%	216,932	6.4%
Maryland	6	9,028	41,341	21.8%	88,285	10.2%
Maine	3	181	5,499	3.3%	90,991	0.2%
Michigan	5	1,445	225,692	0.6%	195,115	0.7%
Minnesota	13	35,813	214,321	16.7%	108,806	32.9%
Missouri	3	3,585	149,902	2.3%	161,462	2.2%
Mississippi	3	1,144	32,102	5.4%	134,208	1.3%
Montana	0	0	17,847	0.0%	17,728	0.0%
North Carolina	2	4,611	185,886	2.5%	270,543	1.7%
North Dakota	1	56	6,269	0.9%	12,972	0.4%

Table 9 *(continued)*

State	Number of SNPs[a] (July 2007)	SNP Enrollment (July 2007)	Total MA Enrollment[b] (July 2007)	Total July 2007 SNP Enrollment as a Percent of Total July MA Enrollment	Total Number of Full and Partial Dual Eligibles (June 2006)[c]	Total July 2007 SNP Enrollment as a Percent of Total June 2006 Dual Eligibles[d]
Nebraska	2	156	24,099	0.6%	33,422	0.5%
New Hampshire	0	0	4,123	0.0%	22,280	0.0%
New Jersey	5	2,379	115,212	2.1%	147,184	1.6%
New Mexico	2	681	59,542	1.1%	51,494	1.3%
Nevada	3	69	93,430	0.1%	31,599	0.2%
New York	24	72,735	679,956	10.7%	585,237	12.4%
Ohio	4	5,228	314,963	1.7%	231,710	2.3%
Oklahoma	3	480	66,132	0.7%	79,236	0.6%
Oregon	9	17,469	218,747	8.0%	63,612	27.5%
Pennsylvania	12	102,490	707,167	14.5%	305,949	33.5%
Puerto Rico	13	241,088	346,505	69.5%	194,763	123.7%
Rhode Island	4	3,808	60,917	6.3%	34,433	11.1%
South Carolina	2	6,626	64,836	10.2%	123,800	5.4%
South Dakota	1	2,581	7,110	36.3%	17,137	15.1%
Tennessee	9	28,307	166,871	16.6%	248,508	11.2%
Texas	16	46,439	385,801	12.0%	506,841	9.2%
Utah	2	2,021	47,023	4.3%	24,497	8.2%
Virginia	2	155	96,739	0.2%	150,019	0.1%
Vermont	0	0	1,272	0.0%	27,166	0.0%
Washington	3	1,652	168,291	1.0%	121,462	1.4%
Wisconsin	8	5,224	168,207	3.1%	200,761	2.6%
West Virginia	0	0	71,332	0.0%	63,326	0.0%
Wyoming	0	0	2781	0.0%	8,404	0.0%

Source: State SNP and MA enrollment counts are from MPR analysis of the CMS MA Monthly State County Contract file, July 2007; CMS July 2007 SNP Comprehensive Report; and CMS 2007 Plan Finder. National SNP and MA enrollment totals are from MPR analysis of the CMS Monthly MA Contract file, July 2007 and the CMS July 2007 SNP Comprehensive Report.

[a]Contract totals across states will not sum to the national total because some contracts span multiple states.

[b]State MA enrollment totals will not sum to the national total. State breakdowns were derived from the CMS State County Contract file. MA enrollment counts at the county level do not include counties with enrollments of less than 11 because of HIPAA. The national totals include all MA enrollees and are higher than the sum of the state totals.

[c]CMS, "2006 Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2006," p. 11. Available on the web at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf.

[d]This is only a rough measure of the percentage of the SNP-eligible population that SNPs have enrolled in a state, since dual eligible SNPs do not have to limit their enrollment exclusively to dual eligibles, and chronic condition and institutional SNPs enroll many non-duals.

Table 10 *(continued)*

Table 10 shows the variation in dual eligible enrollment by state and selected multi-state firms. In 29 states, UnitedHealthcare had dual eligible SNPs that were part of broader MA plans, but in only 12 of those was the dual eligible SNP enrollment more than 5 percent of its total MA enrollment. In 5 states, Health Net had dual eligible SNPs that were part of its larger array of MA plans, and the dual SNP enrollment was more than 5 percent of its total MA enrollment in 2 of those states. In 6 states, WellCare had dual eligible SNPs that were part of other MA offerings, with the dual SNP percentage of the total MA enrollment ranging from 17 percent in Florida to 38 percent in New York. In three states and Puerto Rico, Humana had dual eligible SNPs that were part of other MA offerings, but the dual SNP enrollment was more than one percent of the total MA enrollment only in Florida (1.5 percent) and in Puerto Rico, where the dual eligible SNPs represented 100 percent of its total MA enrollment.

OPPORTUNITIES AND RISKS OF SNPS FOR BENEFICIARIES AND MEDICARE

While SNPs hold the promise of better and more coordinated care for their enrollees, they currently face very few requirements or specific incentives to provide care that is different from what a regular MA-PD plan would provide. All MA plans, including SNPs, have more accountability and reporting requirements than traditional Medicare. They also often provide benefits not available under that program, but access to providers generally is more limited in MA plans than in traditional Medicare.

There are thus two related questions for beneficiaries: (1) would an MA plan meet their needs better than traditional Medicare; and (2) if so, would a SNP be better than a regular MA plan? Since MA and SNP enrollment is voluntary, beneficiaries generally will not choose to enroll unless they think those managed care options are better than traditional Medicare, at least with the kind of supplement they are able to purchase (or have available through Medicaid or other sources). If they learn that this is not the case, dual eligibles can disenroll from SNP or other MA plans at any time, while non-dual enrollees generally must wait until the next open enrollment period to switch out.

SNP Marketing

To enable beneficiaries to make these choices effectively, it is important that SNP marketing efforts include clear and full disclosure of the pros and cons of SNP enrollment. Beneficiaries who have been successful in developing relationships with the providers they need in the traditional Medicare program, and who are able to navigate the Medicare and Medicaid systems on their own, are not likely to benefit from enrollment in SNPs or other MA plans. For others, however, the potential availability of assistance with care coordination and navigation of the system may outweigh the loss of a wide choice of providers, especially if they have not been successful in obtaining access to needed providers in the traditional Medicare system. Whether the benefits that SNPs may offer to such beneficiaries will actually materialize, however, may not be possible for them to assess fully until they actually enroll, at least until CMS is more successful in developing and reporting SNP-specific performance and quality measures.

Table 10. Dual Eligible SNP Share of Total MA Enrollment for MA Companies, by State, July 2007

State	Company	Dual Eligible SNP Enrollment as a Percent of Total Company State MA Enrollment
Alabama	UnitedHealthcare	9.6%
	Blue Cross/Blue Shield	1.7%
	HealthSpring	44.4%
Arkansas	UnitedHealthcare	4.0%
	Other	8.4%
Arizona	UnitedHealthcare	7.6%
	Blue Cross/Blue Shield	48.9%
	Cigna	5.3%
	Health Net	6.1%
	Other	52.2%
California	UnitedHealthcare	1.7%
	Blue Cross/Blue Shield	1.2%
	Health Net	4.5%
	Kaiser Foundation Health Plan	8.1%
	Other	6.8%
Colorado	UnitedHealthcare	2.2%
	Kaiser Foundation Health Plan	2.7%
	Other	11.6%
Connecticut	Health Net	0.7%
	WellCare	34.3%
District of Columbia	Elder Health	5.3%
Florida	UnitedHealthcare	10.4%
	Humana	1.5%
	WellCare	16.5%
	Other	4.0%
Georgia	UnitedHealthcare	11.5%
	WellCare	18.5%
	Kaiser Foundation Health Plan	7.4%
	Other	0.0%
Hawaii	UnitedHealthcare	11.7%
	Other	1.8%
Iowa	UnitedHealthcare	0.1%
Idaho	UnitedHealthcare	11.8%

Table 10 *(continued)*

State	Company	Dual Eligible SNP Enrollment as a Percent of Total Company State MA Enrollment
Illinois	UnitedHealthcare	1.2%
	HealthSpring	31.1%
	Humana	0.1%
	WellCare	21.8%
Indiana	UnitedHealthcare	4.6%
Kentucky	Other	44.2%
Louisiana	WellCare	20.0%
	Other	2.2%
Massachusetts	UnitedHealthcare	11.7%
	Other	0.7%
Maryland	Elder Health	52.5%
	Other	0.7%
Maine	Other	5.6%
Michigan	Other	1.6%
Minnesota	Blue Cross/Blue Shield	49.5%
	Other	16.1%
Missouri	UnitedHealthcare	1.9%
Mississippi	HealthSpring	33.3%
	Other	23.0%
New Jersey	Other	36.3%
North Carolina	UnitedHealthcare	6.7%
Nebraska	UnitedHealthcare	0.6%
New Mexico	UnitedHealthcare	11.9%
Nevada	Health Net	2.8%
New York	UnitedHealthcare	3.9%
	Blue Cross/Blue Shield	0.1%
	Health Net	6.8%
	WellCare	38.1%
	Other	10.4%
Ohio	UnitedHealthcare	4.7%
	Other	0.3%
Oklahoma	UnitedHealthcare	1.3%
	Other	0.2%
Oregon	UnitedHealthcare	0.6%

Table 10 *(continued)*

State	Company	Dual Eligible SNP Enrollment as a Percent of Total Company State MA Enrollment
	Other	15.2%
Pennsylvania	UnitedHealthcare	18.5%
	Blue Cross/Blue Shield	6.3%
	Elder Health	37.6%
	Other	32.2%
Puerto Rico	Humana	100%
	Blue Cross/Blue Shield	48.7%
	Other	48.9%
Rhode Island	UnitedHealthcare	1.1%
	Blue Cross/Blue Shield	6.3%
South Carolina	Other	1.6%
Tennessee	UnitedHealthcare	2.2%
	HealthSpring	16.6%
	Other	30.3%
Texas	UnitedHealthcare	14.0%
	Humana	0.5%
	Elder Health	49.7%
	HealthSpring	11.2%
	Other	9.3%
Utah	UnitedHealthcare	5.7%
	Other	11.8%
Virginia	UnitedHealthcare	1.2%
Washington	UnitedHealthcare	1.2%
	Other	0.7%
Wisconsin	UnitedHealthcare	2.0%
	Other	1.9%

Source: State SNP and MA enrollment counts are from MPR analysis of the CMS MA Monthly State County Contract file, July 2007; CMS July 2007 SNP Comprehensive Report; and CMS 2007 Plan Finder. National SNP and MA enrollment totals are from MPR analysis of the CMS Monthly MA Contract file, July 2007; and the CMS July 2007 SNP Comprehensive Report.

Complaints and Grievances

Most SNPs with substantial enrollment are likely to invest significant resources in making sure that current enrollees are satisfied, since it is usually more costly to obtain new enrollees than to retain current ones. If some enrollees turn out to be much more costly to care for than anticipated, however, and if the CMS risk-adjusted payment system does not appear to the firm to be adequate to cover those costs, its incentives to retain such enrollees may well decline. This is a risk to SNP enrollees. The CMS complaint and grievance system that applies to all MA plans is designed to make sure that the benefits promised to enrollees actually are provided, so enrollees who are not satisfied with their treatment can use this system to deal with their concerns. This is especially applicable in situations where disenrollment is not a satisfactory alternative, as when the issue is provision of or payment for care currently needed or already provided. However, the complaint and grievance system can be complicated and time-consuming to use, so in many cases it may not provide adequate and timely relief.

SNP Exits

There is also the possibility that SNPs will choose or be forced to go out of business, especially if they are unable to obtain sufficient enrollment, or if other assumptions in their business plans turn out to be unrealistic. If Congress reduces current levels of MA payment, that could also have an impact on SNP business decisions. The consequences from any SNP exits for current SNP enrollees will depend on their alternatives. If the departing SNP was offered by a company with other MA-PD options in the same geographic area, the SNP's enrollees may be able to shift to one of those, or to similar SNP or MA-PD options offered by other companies in the area. SNP enrollees also have the option of returning to traditional Medicare, and obtaining stand-alone PDP coverage for their prescription drug needs. In that case, they would lose whatever care coordination and care management benefits they may have had in the SNP, along with whatever extra Medicare benefits the SNP may have offered. They would also have to expend the time and effort needed to choose alternative Medicare coverage, and take the risk that their choice may not meet their needs as well as the SNP in which they were enrolled previously.

CHALLENGES FOR OVERSIGHT AND MARKETING

How to Tell Whether SNPs Are Special?

Much of the information needed to determine the ways in which SNPs may be special is not publicly available at this point. In this section, we discuss some ways in which SNPs could be monitored and evaluated by using new or already available information. We start with questions that apply to all SNPs, and then look at some issues most relevant to particular SNP types.[35]

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[35] In December 2007, MedPAC voted to recommend that Congress require CMS to establish additional tailored performance measures for SNPs, and that CMS provide beneficiaries and their counselors with information that compares SNPs to other MA plans and traditional Medicare.

Beneficiary Perspectives

CAHPS Satisfaction Surveys. The CAHPS surveys are designed to assess beneficiary satisfaction, but surveys currently are designed to operate at the contract level. That is, they obtain beneficiary feedback and use sampling frames designed to give reasonably representative estimates for the "average" enrollee in that MA contract. When a contract offers only SNPs (which the majority do not), the estimates will provide information on SNP beneficiary perspectives, at least in the areas covered by the survey. Because most SNP enrollees participate in contracts that have other kinds of plans as well, the estimates for those contracts do not provide specific feedback on how SNP enrollees perceive the plan, as opposed to others' perceptions. Although CMS could separately report SNP versus other MA responses, the sampling frame might not yield representative data for the SNP subsector of enrollment (which in any case, it was not designed to do). Further, and probably even more significant, there likely will not be enough SNP enrollees sampled to provide robust estimates of their distinct experience under that contract. In addition, standard CAHPS questions may not provide information on areas particularly relevant to SNP enrollees. To the extent that these problems can be overcome through modification to CAHPS and the way data are reported, CAHPS can be a good source of information on SNP enrollee satisfaction.

HEDIS Clinical Measures. Most of the HEDIS measures CMS currently collects are not focused on chronic or institutional care or on specific needs of dual eligibles, and they are collected and reported at the contract level rather than the plan level. As noted earlier, however, CMS is working with NCQA to develop SNP-specific quality and performance measures.

Enrollment and Disenrollment. Since dual eligibles can change plans at any time, and all SNP enrollees can change plans during the annual open enrollment period, enrollment and disenrollment trends can provide insights into enrollee satisfaction or dissatisfaction.

Complaints and Grievances. CMS currently reports Part D prescription drug plan enrollee complaint information at the contract level. While there are concerns about the current adequacy of this system (Center for Medicare Advocacy 2007), it could be expanded to cover complaints about MA plan services in addition to prescription drugs.

Content and Implementation of SNP "Models of Care"

As noted earlier, SNP applicants for 2008 were required to describe the "models of care" they proposed to use in their SNPs. CMS has said that both new and existing SNPs will be audited on how they implement these care models (CMS 2007). CMS has not said whether any information from these models of care will be made public, but doing so would provide another means of accountability, and could help potential enrollees determine whether a particular SNP would be a good fit for them.

Data on Service Use

MA plans do not report claims or encounter data to CMS for services provided under Parts A or B, so CMS cannot monitor or report on the utilization of these services in MA plans. MA-

PDs, SNPs, and PDPs must submit extensive claims-level data on the use of Part D drugs to CMS on a monthly basis.[36] Those data could be used to compare measures of prescription use across MA-PD plans, SNPs, and PDPs. Since similar Medicaid claims-level drug data soon will be available through 2005, analyses of drug use by dual eligibles in any form of SNP could be conducted to examine how, if at all, drug use was different for dual eligibles in Medicaid in 2005 versus MA in 2006.

Dual Eligible SNP Monitoring

Dual SNP Use of Rebate Dollars. Most things for which regular MA-PD plans use savings or rebate dollars (reduced Medicare cost sharing, extra benefits not covered by Medicare) already are covered for duals by Medicaid. Proposed uses of rebate dollars by SNPs could be analyzed to determine the extent to which they propose to use these dollars for services such as care coordination, which may be especially useful for dual eligibles, as opposed to vision, dental, hearing, and transportation services, which dual eligibles commonly receive, at least to some extent, from Medicaid. However, the bids that MA plans submit include only limited information on these supplemental benefits. Any additional care coordination activities that plans propose to fund with rebate dollars, for example, would be in the general category of "health and education" services not otherwise covered by Medicare, with no detail provided beyond the amount of dollars proposed. It is also worth noting that the amount of rebate dollars available to plans in the future may decline if Congress reduces MA reimbursement.

Coordination with State Medicaid Programs. As noted earlier, contracting with states to cover Medicaid services, or at least coordinating Medicare and Medicaid services more effectively, is something SNPs could do that clearly would make them "special." This is particularly important for dual eligible SNPs.

SNP applicants for 2008 were required to (1) identify any contracts with states for Medicaid services, as well as the populations served under those contracts; (2) describe how Medicare and Medicaid services will be coordinated; and (3) if the applicant does not have such a contract, describe how the applicant intends to work with state Medicaid agencies to help SNP enrollees access Medicaid services and coordinate Medicare and Medicaid services.

CMS reporting of this information would help states, beneficiaries, and plans to better understand the extent and content of the relationships between SNPs and states. For example, do contracts cover just Medicare cost sharing and "wrap-around" Medicaid acute care services, or do they also cover Medicaid long-term-care services (nursing facility, home health, and home- and community-based waiver services)? What are SNPs doing specifically to coordinate Medicare and Medicaid services?

Chronic Condition SNP Monitoring

Almost all MA-PD plans have some kind of disease management program. What do chronic condition SNPs do that is different? Does their independence and assumption of risk for all

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[36] For a description of the Part D data that must be submitted, see CMS 2006.

services make a difference? If so, is that difference positive or negative for chronic condition SNPs and their enrollees? While CMS generally does not collect and report plan-level data on services used or outcomes in MA plans, there may be companies willing to provide such data for demonstrations or evaluations that could help to illuminate these issues.

CMS also might consider requiring firms to justify the care management potential of SNPs they want to offer before approving them. Specific guidance also could be issued to define allowable SNPs rather than CMS's current policy of approval on a case-by-case basis.

Trends and Patterns in Risk Scores. Since chronic condition SNPs are supposed to be serving beneficiaries with "severe or disabling" chronic conditions, CMS could track and report trends and patterns in enrollee risk scores in chronic condition SNPs to help determine the extent to which SNPs are serving enrollees with higher needs than those served in other MA plans. Such reporting would also show how chronic condition SNPs vary among themselves in terms of risk scores. If confidentiality concerns preclude SNP-specific reporting of risk scores, CMS could report broader patterns among types of chronic condition SNPs.

Institutional SNP Monitoring

Since institutional SNPs assume risk for all Medicare services, including hospitalization, they potentially can use savings from reduced hospitalization to improve nursing facility services. If they contract with Medicaid for Medicaid long-term-care services, they also may have incentives to achieve savings and improve care by helping people remain in or return to the community, rather than using nursing facilities. There are a number of ways in which the impact of institutional SNPs could be measured.

Hospital Utilization. Do institutional SNPs reduce unnecessary hospitalizations for nursing facility residents? CMS can monitor and report on hospitalization rates for nursing facility residents in fee-for-service Medicare by using Medicare hospital and nursing facility claims data. CMS could require institutional SNPs to report data on hospitalizations for their enrollees, and compare them to hospitalization rates for fee-for-service Medicare nursing facility residents. CMS also could define certain types of hospitalizations of nursing facility residents as "potentially avoidable," and use that as a measure of SNP performance, rather than use the incidence of all hospitalizations as a benchmark.[37]

Nursing Facility Quality of Care. Do institutional SNP enrollees have a better or worse quality of care than other Medicare skilled nursing facility residents, based on nursing facility Minimum Data Set (MDS) measures? (The CMS Medicare Managed Care Manual says CMS is considering using MDS to measure quality and performance in institutional SNPs.[38] [Chapter 5, Section 30]).

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[37] In its June 2007 *Report to the Congress*, MedPAC suggested that CMS use potentially avoidable re-hospitalization rates as a measure of quality in Medicare skilled nursing facilities (pp. 212-216).

[38] Available on the web at: http://www.cms.hhs.gov/manuals/downloads/mc86c05.pdf [Accessed November 5, 2007].

Prescription Drug Use in Nursing Facilities. Do institutional SNPs improve prescription drug utilization in nursing facilities? SNPs and other MA-PD and PDP plans currently must report detailed Part D drug information to CMS on a monthly basis. Drug use by institutional SNP enrollees could be compared to use by those enrolled in other MA-PD plans, and in stand-alone PDPs.

CONCLUSIONS

All three SNP types have the potential to add value for both plans and beneficiaries, compared to traditional Medicare or other MA plan types. The business case for each SNP type is different, however, as are the potential risks and benefits for enrollees. At this point, most SNPs have not been operating long enough to determine whether their potential will be realized either for the plans or beneficiaries they are intended to serve.

With the SNP authorization now scheduled to expire at the end of 2009 rather than 2008, and with a one-year moratorium on new SNPs, there will be more time to evaluate SNP performance and assess the extent to which they are adding value to the Medicare program. MedPAC voted in December 2007 to recommend that Congress require CMS to establish additional, tailored performance measures for SNPs, and that CMS provide beneficiaries with more information comparing SNPs to other MA plans and traditional Medicare.

There are a number of additional steps CMS could take to make more information on SNP performance available, and SNPs themselves could be held to higher standards than they have been thus far. There may be limits on how much SNPs can be expected to do beyond what is required of other MA-PD plans as long as SNPs are paid no more than these other plans for comparable enrollees. Nonetheless, if there are benefits from specialization and a focus on populations with special needs, SNPs should be able to achieve greater efficiencies in providing this care than less specialized plans, and add measurable value beyond what other plans can achieve. If they cannot do so within a reasonable period of time, it is appropriate to consider whether the authority of MA-PD plans to specialize in this way should be continued.

In making this decision, the actual and potential benefits of SNPs must be weighed against any additional costs or adverse consequences that may result from continuation of this authority to specialize. At this point, the weight of the evidence on both sides of the scale is far from certain.

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APPENDIX A

COMPARISON OF REQUIREMENTS ACROSS PROGRAMS

Table A-1 *(continued)*

Table A-1. Comparison of Key Features of Medicare Fee-for-Service (FFS), Prescription Drug Plans (PDPs), Medicare Advantage Prescription Drug Plans (MA-PDs), and Special Needs Plans (SNPs)

	Medicare FFS and Part D Stand-Alone PDPs	Non-SNP MA-PDs	Dual Eligible SNPs	Chronic Condition SNPs	Institutional SNPs
Medicare Payment System and Risk Adjustment	• Parts A and B o Medicare FFS payments to providers • Part D o Medicare payments to plans based on plan bids o Risk adjustment - RxHCC system based on diagnoses - 8% more for duals - 21% more for institutionalized o Risk sharing - Shared risk corridors for 2008-2011 - Plans pay/keep 100% if losses/gains are within 5% of target amount (first corridor), 50% of amounts in next 5% corridor, and 20% of amounts beyond 10% of target (third corridor)	• Part C o Medicare payments to plans based on plan bids o Risk adjustment - CMS-HCC system based on diagnoses - Extra payment for dual eligibles and institutionalized • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs
Risk Pooling, Sharing, and Spreading	• Parts A and B o Government fully at risk, shared across program • Part D o Government and plans share risk	• Parts A and B o Plans fully at risk - Gov't shares risk with RPPOs • Part D o Government and plans share risk	• Same as non-SNP MA-PDs • Plan ability to spread risk internally across high- and low-cost enrollees may be less than non-SNP plans, especially if dual eligible SNP has high enrollment of high-cost under-65 disabled dual eligibles	• Same as non-SNP MA-PDs • Very limited plan ability to spread risk internally across enrollees, since almost all have predictably high costs	• Same as non-SNP MA-PDs • Somewhat more plan ability to spread risk internally than chronic condition SNPs, since some institutionalized enrollees have predictably low costs, but less ability to spread risk than dual eligible SNPs

Table A-1 *(continued)*

	Medicare FFS and Part D Stand-Alone PDPs	Non-SNP MA-PDs	Dual Eligible SNPs	Chronic Condition SNPs	Institutional SNPs
Availability of Medicare Funds for Extra Benefits	• Parts A and B o None • Part D o If plans expect costs to be below Medicare payments, can propose lower beneficiary premiums and/or enhanced benefits in their bids	• If plan has "savings" from bidding below benchmark, 75% (called a "rebate") must be used for extra benefits and 25% goes to CMS • Rebate dollars can be used to: o Reduce Part A and B cost sharing o Reduce Part B premiums o Add benefits Medicare does not cover (vision, dental, hearing, transportation) o Reduce Part D premiums o Enhance Part D benefits	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs

Table A-1 *(continued)*

	Medicare FFS and Part D Stand-Alone PDPs	Non-SNP MA-PDs	Dual Eligible SNPs	Chronic Condition SNPs	Institutional SNPs
Uses of Extra Medicare Funds	• Part D o Reductions in enrollee premiums o Enhancement of Part D benefits (lower deductibles and coinsurance, donut hole coverage)	• For 2006, plans allocated o 65% of rebate dollars to reduce Part A and B cost sharing o 14% to add benefits not covered by Medicare o 11% to reduce the Part D premium o 5% to enhance Part D benefits o 4% to reduce Part B premium (MedPAC, June 2006)	• Less likely to use rebate dollars to reduce Medicare premiums and cost sharing, since Medicaid covers most of these costs for dual eligibles • Less likely to use rebate to add Medicare benefits, since Medicaid covers many of these benefits for dual eligibles • Less likely to use rebate to enhance Part D benefit, since dual eligibles have no Part D deductibles, coinsurance, or donut hole, and limited co-pays • May use rebate to cover services especially needed by dual eligibles, such as care coordination	• Same as dual eligible SNPs, except only about half of enrollees are dual eligibles • May use rebate to cover services especially needed by beneficiaries with chronic conditions, such as disease management	• Same as dual eligible SNPs, except only about half of enrollees are dual eligibles • Institutionalized dual eligible beneficiaries do not pay any Part D co-pays • May use rebate to cover services needed to help avoid institutionalization (for those living in the community) or hospitalization (for those in nursing facilities)
Network Requirements	• Medicare FFS o Not applicable • Part D o Pharmacy access requirements at 42 CFR sec. 423.120	• Access to services requirements at 42 CFR sec. 422.112 • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs • As part of applications for 2008, must describe how networks will have the “clinical expertise” to meet the special needs of dual eligibles	• Same as non-SNP MA-PDs • As part of applications for 2008, must describe how networks will have the “clinical expertise” to meet the special needs of individuals with severe or disabling conditions	• Same as non-SNP MA-PDs • Must have contracts with long-term-care institutions in which enrollees reside • As part of applications for 2008, must describe how networks will have the “clinical expertise” to meet the special needs of the institutionalized population

Table A-1 *(continued)*

	Medicare FFS and Part D Stand-Alone PDPs	Non-SNP MA-PDs	Dual Eligible SNPs	Chronic Condition SNPs	Institutional SNPs
Marketing Requirements	• Medicare FFS o Not applicable • Part D o CMS "Medicare Marketing Guidelines" for PDPs o CMS approval of marketing materials (42 CFR sec. 423.50)	• CMS "Medicare Marketing Guidelines" for MA-PDs • CMS approval of marketing materials (42 CFR sec. 422.80)	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs	• Same as non-SNP MA-PDs
Care Management Infrastructure	• Medicare FFS o Not applicable • Part D o PDPs must have drug utilization management, quality assurance, and medication therapy management programs (42 CFR sec. 423.153)	• Most plans provide some care management, care coordination, and disease management of Medicare acute care and post-acute services • Plans are required to "ensure continuity of care and integration of services," including "coordination of plan services with community and social services" (42 CFR sec. 422.112(b)) o Usually funded out of administrative dollars • Plans can use rebate dollars to fund caregiver resource services and electronic monitoring of beneficiaries as "supplemental" Medicare benefits • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs, but may devote more resources to care coordination • All SNP applicants for 2008 must describe their "model of care" for the special populations they serve, and specifically address how it applies to frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries who are near the end of life • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs, but may devote more resources to disease management • For 2008 applications, must describe their "model of care" • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs, but may devote more resources to reducing institutionalization and hospitalization • For 2008 applications, must describe their "model of care" • Part D o Same as stand-alone PDPs

Table A-1 *(continued)*

	Medicare FFS and Part D Stand-Alone PDPs	Non-SNP MA-PDs	Dual Eligible SNPs	Chronic Condition SNPs	Institutional SNPs
Beneficiary Protections and Quality/Performance Monitoring	• Medicare FFS o Part A and Part B appeals procedures at 42 CFR (secs. 405.701 and 405.801) • Part D o Provisions for grievances, coverage determinations, and appeals at 42 CFR sec. 423.562	• Medicare Advantage program provisions for benefits and beneficiary protections at 42 CFR (sec. 422.100 *et seq)*, quality improvement at 42 CFR. 152 *et seq*., and grievances and appeals at 42 CFR (sec. 422.560 *et seq*.) • Part D o Same as stand-alone PDPs	• Same as non-SNP MA-PDs • CMS is working with NCQA to identify and develop customized quality and performance measures for SNPs (CMS Quality "How To" Guide for SNPs, July 19, 2006)	• Same as non-SNP MA-PDs • CMS is developing customized SNP quality and performance measures	• Same as non-SNP MA-PDs • CMS is developing customized SNP quality and performance measures
Incentives to Contract and Coordinate With Medicaid	• Medicare FFS o CMS oversees Medicaid responsibility to pay Medicare low-income beneficiary cost sharing • Part D o PDPs may be able to obtain Medicaid prescription drug utilization data for new enrollees who previously obtained drug coverage from Medicaid	• May be more efficient for plan and state to contract for up-front capitated payments from Medicaid for Medicare cost sharing and "wrap-around" Medicaid-covered benefits o Requires state to devote resources to setting rates and negotiating contracts	• Same as non-SNP MA-PDs for acute care services, but Medicaid coverage of care coordination is more extensive than Medicare • Major potential advantage is opportunity to include and coordinate Medicaid long-term care (LTC) services, home health, home- and community based services (HCBS), and nursing facility care o Usually only possible when Medicaid covers LTC services in capitated Medicaid managed care, or plans to do so	• Same as for dual eligible SNPs, but chronic care SNP enrollees may have less need for LTC services, limiting potential advantages of contracting with Medicaid for these services	• Same as for dual eligible SNPs, but more potential for coordinating Medicare and Medicaid nursing facility payments and services, and more opportunity to cover home health and HCBS, where Medicare coverage is much more limited than Medicaid

Source: MPR analysis of CMS requirements for the Kaiser Family Foundation

APPENDIX B

ADDITIONAL DATA ON SNPs IN MA MARKET CONTEXT

Table B-1. Overview of Firm Offerings and Enrollment, July 2007

	Number of Total MA Contracts	Contracts without SNPs	Total SNP Contracts	Contracts with Some SNPs	SNP Only Contracts	Contracts by SNP Type: Dual	Contracts by SNP Type: Institutional	Contracts by SNP Type: Chronic	Total MA Enrollment	Non-SNP Enrollment	Total SNP Enrollment	SNP Enrollment as a Percentage of All MA Enrollment	SNP Enrollment by SNP Type: Dual	SNP Enrollment by SNP Type: Institutional	SNP Enrollment by SNP Type: Chronic
Total Contracts	**551**	**297**	**254**	**166**	**88**	**205**	**65**	**43**	**8,645,970**	**7,688,417**	**957,553**	**11%**	**697,706**	**143,406**	**116,441**
Major MA Contractors (Historically)															
Subtotal	**210**	**97**	**95**	**72**	**23**	**73**	**37**	**21**	**5,071,588**	**4,815,009**	**256,579**	**5%**	**213,845**	**29,778**	**12,956**
UnitedHealthcare	76	9	67	48	19	45	37	19	1,320,543	1,210,165	110,378	8%	68,091	29,778	12,509
Humana	27	23	4	4	0	4	0	0	1,083,761	1,060,081	23,680	2%	23,680	0	0
Kaiser Permanente	11	8	3	3	0	3	0	0	874,100	817,952	56,148	6%	56,148	0	0
Blue Cross/Blue Shield	55	21	16	12	4	16	0	0	1,328,396	1,272,421	55,975	4%	55,975	0	0
Aetna	31	31	0	0	0	0	0	0	187,176	187,176	0	0%	0	0	0
Health Net	8	4	4	4	0	4	0	2	220,735	211,989	8,746	4%	8,299	0	447
CIGNA	2	1	1	1	0	1	0	0	56,877	55,225	1,652	3%	1,652	0	0
Selected Other (Typically Newer) Contracts															
Subtotal	**19**	**7**	**12**	**7**	**5**	**6**	**1**	**6**	**228,853**	**172,506**	**56,347**	**25%**	**23,087**	**0**	**33,260**
Care Improvement Plus	4	0	4	0	4	0	0	4	31,652	0	31,652	100%	0	0	31,652
Coventry	5	4	1	1	0	0	0	1	42,386	40,958	1,428	3%	0	0	1,428
QMED	1	0	1	0	1	0	0	1	180	0	180	100%	0	0	180
Wellcare	9	3	6	6	0	6	1	0	154,635	131,548	23,087	15%	23,087	0	0
All Other Contracts	**322**	**193**	**147**	**87**	**60**	**126**	**27**	**16**	**3,345,529**	**2,700,902**	**644,627**	**19%**	**460,774**	**113,628**	**70,225**

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007; SNP Comprehensive Report, July 2007.

Table B-2 *(continued)*

Table B-2. Firm Offerings by Contract Type, July 2007

	Number of Total MA Contracts	Contracts without SNPs	Total SNP Contracts	Contracts with Some SNPs	SNP Only Contracts	Contracts by SNP Type		
						Dual	Institutional	Chronic
Total Contracts	**551**	**297**	**254**	**166**	**88**	**205**	**65**	**43**
UnitedHealthcare	79	12	67	48	19	45	37	19
Humana	27	23	4	4	0	4	0	0
Kaiser Permanente	11	8	3	3	0	3	0	0
Blue Cross/Blue Shield	68	52	16	12	4	16	0	0
Aetna	31	31	0	0	0	0	0	0
Health Net	8	4	4	4	0	4	0	2
Cigna	2	1	1	1	0	1	0	0
Care Improvement Plus	4	0	4	0	4	0	0	4
Coventry	5	4	1	1	0	0	0	1
Qmed	1	0	1	0	1	0	0	1
Wellcare	9	3	6	6	0	6	1	0
Other	306	159	147	87	60	126	27	16
Total HMO	**291**	**100**	**191**	**138**	**53**	**168**	**41**	**22**
UnitedHealthcare	41	7	34	27	7	28	20	2
Humana	7	3	4	4	0	4	0	0
Kaiser Permanente	5	2	3	3	0	3	0	0
Blue Cross/Blue Shield	26	14	12	10	2	12	0	0
Aetna	17	17	0	0	0	0	0	0
Health Net	4	0	4	4	0	4	0	2
Cigna	2	1	1	1	0	1	0	0
Care Improvement Plus	1	0	1	0	1	0	0	1
Coventry	3	2	1	1	0	0	0	1
Omed	1	0	1	0	1	0	0	1
Wellcare	6	0	6	6	0	6	1	0
Other	178	54	124	82	42	110	20	15
Total LPPO/POS	**119**	**93**	**26**	**15**	**11**	**21**	**13**	**6**
UnitedHealthcare	19	1	18	9	9	13	12	6
Humana	13	13	0	0	0	0	0	0
Blue Cross/Blue Shield	24	22	2	2	0	2	0	0
Aetna	12	12	0	0	0	0	0	0

Table B-2 *(continued)*

	Number of Total MA Contracts	Contracts without SNPs	Total SNP Contracts	Contracts with Some SNPs	SNP Only Contracts	Contracts by SNP Type		
						Dual	Institutional	Chronic
Health Net	2	2	0	0	0	0	0	0
Coventry	2	2	0	0	0	0	0	0
Other	47	41	6	4	2	6	1	0
Regional PPO	**14**	**8**	**6**	**3**	**3**	**3**	**0**	**3**
UnitedHealthcare	3	0	3	3	0	3	0	0
Humana	1	1	0	0	0	0	0	0
Blue Cross/Blue Shield	1	1	0	0	0	0	0	0
Aetna	1	1	0	0	0	0	0	0
Health Net	1	1	0	0	0	0	0	0
Care Improvement Plus	3	0	3	0	3	0	0	3
Other	4	4	0	0	0	0	0	0
Demo	**38**	**7**	**31**	**10**	**21**	**13**	**11**	**12**
UnitedHealthcare	12	0	12	9	3	1	5	11
Kaiser Permanente	1	1	0	0	0	0	0	0
Blue Cross/Blue Shield	2	0	2	0	2	2	0	0
Other	23	6	17	1	16	10	6	1
All Other (Cost, HCPP, PFFS)	**89**	**89**	**0**	**0**	**0**	**0**	**0**	**0**
UnitedHealthcare	4	4	0	0	0	0	0	0
Humana	6	6	0	0	0	0	0	0
Kaiser Permanente	5	5	0	0	0	0	0	0
Blue Cross/Blue Shield	15	15	0	0	0	0	0	0
Aetna	1	1	0	0	0	0	0	0
Health Net	1	1	0	0	0	0	0	0
Wellcare	3	3	0	0	0	0	0	0
Other	54	54	0	0	0	0	0	0

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007; SNP Comprehensive Report, July 2007.

Table B-3 *(continued)*

Table B-3. Firm Enrollment by Contract Type, July 2007

	Total MA Enrollment	Total SNP Enrollment	SNP Enrollment as a Percentage of All MA Enrollment	SNP Enrollment by SNP Type		
				Dual	Institutional	Chronic
Total Contracts	**8,645,970**	**957,553**	**11%**	**697,706**	**143,406**	**116,441**
UnitedHealthcare	1,320,543	110,378	**8%**	68,091	29,778	12,509
Humana	1,083,761	23,680	**2%**	23,680	0	0
Kaiser Permanente	874,100	56,148	**6%**	56,148	0	0
Blue Cross/Blue Shield	1,328,396	55,975	4%	55,975	0	0
Aetna	187,176	0	0%	0	0	0
Cigna	56,877	1,652	3%	1,652	0	0
Health Net	220,735	8,746	4%	8,299	0	447
Care Improvement Plus	31,652	31,652	100%	0	0	31,652
Coventry	42,386	1,428	3%	0	0	1,428
Omed	180	180	100%	0	0	180
Wellcare	154,635	23,087	15%	23,087	0	0
Other	3,345,529	644,627	19%	460,774	113,628	70,225
Total HMO	**5,743,022**	**724,830**	**13%**	**636,905**	**12,035**	**75,890**
UnitedHealthcare	1,102,970	57,707	5%	47,892	8,221	1,594
Humana	402,098	23,680	6%	23,680	0	0
Kaiser Permanente	807,137	56,148	7%	56,148	0	0
Blue Cross/Blue Shield	849,251	45,036	5%	45,036	0	0
Aetna	114,902	0	0%	0	0	0
Health Net	196,036	8,746	4%	8,299	0	447
Cigna	56,877	1,652	3%	1,652	0	0
Care Improvement Plus	2,396	2,396	100%	0	0	2,396
Coventry	33,212	1,428	4%	0	0	1,428
Omed	180	180	100%	0	0	180
Wellcare	103,795	23,087	22%	23,087	0	0
Other	2,074,168	504,770	24%	431,111	3,814	69,845
Aetna	21,159	0	0%	0	0	0
Health Net	19,768	0	0%	0	0	0
Coventry	9,174	0	0%	0	0	0

Table B-3 *(continued)*

	Total MA Enrollment	Total SNP Enrollment	SNP Enrollment as a Percentage of All MA Enrollment	SNP Enrollment by SNP Type		
				Dual	Institutional	Chronic
Other	187,656	1,167	1%	1,167	0	0
Regional PPO	**167,481**	**37,626**	**22%**	**8,370**	**0**	**29,256**
UnitedHealthcare	42,950	8,370	19%	8,370	0	0
Humana	37,720	0	0%	0	0	0
Blue Cross/Blue Shield	49,928	0	0%	0	0	0
Aetna	1,178	0	0%	0	0	0
Health Net	3,030	0	0%	0	0	0
Care Improvement Plus	29,256	29,256	100%	0	0	29,256
Other	3,419	0	0%	0	0	0
Demo	**216,344**	**152,602**	**71%**	**41,698**	**109,982**	**922**
UnitedHealthcare	4,503	3,095	69%	2,385	168	542
Kaiser Permanente	4,007	0	0%	0	0	0
Blue Cross/Blue Shield	10,817	10,817	100%	10,817	0	0
Other	197,017	138,690	70%	28,496	109,814	380
All Other (Cost, HCPP, PFFS)	**2,038,900**	**0**	**0%**	**0**	**0**	**0**
UnitedHealthcare	109,783	0	0%	0	0	0
Humana	617,825	0	0%	0	0	0
Kaiser Permanente	62,956	0	0%	0	0	0
Blue Cross/Blue Shield	262,389	0	0%	0	0	0
Aetna	49,937	0	0%	0	0	0
Health Net	1,901	0	0%	0	0	0
Wellcare	50,840	0	0%	0	0	0
Other	883,269	0	0%	0	0	0

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007; SNP Comprehensive Report, July 2007.

Table B-4. SNP Contract Availability by SNP Type, July 2007

	Dual Eligible					Institutional					Chronic or Disabling Condition				
	Total SNP Contracts	Contracts with Some SNPs	Contracts with Some SNPs as Percentage of Total SNP Contracts	SNP-Only Contracts	SNP-Only Contracts as Percentage of Total SNP Contracts	Total Contracts	Contracts with Some SNPs	Contracts with Some SNPs as Percentage of Total SNP Contracts	SNP-Only Contracts	SNP-Only Contracts as Percentage of Total SNP Contracts	Total Contracts	Contracts with Some SNPs	Contracts with Some SNPs as Percentage of Total SNP Contracts	SNP-Only Contracts	SNP-Only Contracts as Percentage of Total SNP Contracts
Total	**205**	**141**	**69%**	**64**	**31%**	**65**	**44**	**68%**	**21**	**32%**	**43**	**26**	**60%**	**17**	**40%**
Local HMO	168	125	74%	43	26%	41	34	83%	7	17%	22	15	68%	7	32%
Local PPO	21	13	62%	8	38%	13	4	31%	9	69%	6	2	33%	4	67%
PFFS	0	0	--	0	--	0	0	--	0	--	0	0	--	0	--
RPPO	3	3	100%	0	0%	0	0	--	0	--	3	0	0%	3	100%
Demo	13	0	0%	13	100%	11	6	55%	5	45%	12	9	75%	3	25%
Other	0	0	--	0	--	0	0	--	0	--	0	0	--	0	--

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007; SNP Comprehensive Report, July 2007.

Table B-5. SNP Contract Enrollment by SNP Type, July 2007

	Dual Eligible					Institutional					Chronic or Disabling Condition				
	Total SNP Enrollment	SNP Enrollment in Contracts with Some SNPs	SNP Enrollment in Contracts with Some SNPs as Percentage of Total SNP Enrollment	SNP Enrollment in SNP-Only Contracts	SNP Enrollment in SNP-Only Contracts as Percentage of Total SNP Enrollment	Total SNP Enrollment	SNP Enrollment in Contracts with Some SNPs	SNP Enrollment in Contracts with Some SNPs as Percentage of Total SNP Enrollment	SNP Enrollment in SNP-Only Contracts	SNP Enrollment in SNP-Only Contracts as Percentage of Total SNP Enrollment	Total SNP Enrollment	SNP Enrollment in Contracts with Some SNPs	SNP Enrollment in Contracts with Some SNPs as Percentage of Total SNP Enrollment	SNP Enrollment in SNP-Only Contracts	SNP Enrollment in SNP-Only Contracts as Percentage of Total SNP Enrollment
Total	**697,706**	**513,618**	**74%**	**184,088**	**26%**	**143,466**	**104,210**	**73%**	**39,196**	**27%**	**116,441**	**77,273**	**66%**	**39,168**	**34%**
Local HMO	636,905	502,378	**79%**	134,527	**21%**	12,095	10,823	89%	1,212	10%	75,890	69,200	91%	6,690	9%
Local PPO	10,733	2,870	**27%**	7,863	**73%**	21,389	2,190	10%	19,199	90%	10,373	7,701	74%	2,672	26%
PFFS	0	0	**--**	0	**--**		0	--	0	--		0	--	0	--
RPPO	8,370	8,370	**100%**	0	**0%**		0	--	0	--	29,256	0	0%	29,256	100%
Demo	41,698	0	**0%**	41,698	**100%**	109,982	91,197	83%	18,785	17%		372	40%	550	60%
Other	0	0	**--**	0	**--**		0	--	0	--			--	0	--

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007; SNP Comprehensive Report, July 2007.

APPENDIX C

ADDITIONAL SNP TABLES

Table C-1. SNP Enrollment Growth Between July 2006 and November 2007

SNP Enrollment	July 2006	September 2006	March 2007	May 2007	June 2007	July 2007	Growth July 2006-July 2007	Major Contributors to July 2006-July 2007 Enrollment Growth	August 2007	September 2007	October 2007	November 2007
Total	**531,507**	**602,881**	**842,840**	**906,857**	**930,013**	**958,566**	**427,059**		**989,112**	**1,021,800**	**1,050,635**	**1,080,593**
Dual Eligible	439,412	491,877	621,986	670,499	684,143	697,796	258,384	Kaiser Foundation HP (CA, CO, and GA) 2006 Enrollment – 0 2007 Enrollment – 56,148	709,665	722,286	737,125	751,784
Chronic Condition	69,939	71,635	81,093	93,346	102,913	117,327	47,388	Care Improvement Plus 2006 Enrollment – 277 2007 Enrollment – 31,652	135,903	155,609	168,762	183,881
Institutional	22,156	39,323	139,761	143,012	142,957	143,443	121,287	SCAN (CA) 2006 Enrollment – 0 2007 Enrollment – 91,029 Elderplan (NY) 2006 Enrollment – 0 2007 Enrollment – 16,808	143,544	143,905	144,748	144,928

Source: CMS website, various dates. The months shown in the table above are the only months for which CMS has released plan-by-plan SNP enrollment data between January 2005 and November 2007.

Table C-2. Special Needs Plan Enrollment Summary– November 2007

Total SNP Enrollment	**1,080,593**
Dual Eligible	751,784
Chronic or Disabling Condition	183,881 (59,999 in PR and 78,631 in Care Improvement Plus)
Institutional	144,928 (90,379 in SCAN and 30,018 in UnitedHealth)

Total Number of SNP Plans	**477**
Dual Eligible	320
Chronic or Disabling Condition	73
Institutional	84

Top 10 States, By SNP Enrollment (Number of SNP Plans in Parentheses)

PR	247,752 (37)
CA	189,871 (38)
PA	102,152 (15)
NY	78,777 (55)
FL	66,708 (65)
TX	64,100 (35)
AZ	53,572 (16)
MN	36,133 (13)
TN	26,205 (11)
AL	19,674 (6)
Total	*884,944 (81.9% of total national SNP enrollment)*

Top 13 SNP Companies, By Enrollment

UnitedHealth	155,882 (Multiple states)
SCAN Health Plan	91,235 (CA, AZ)
MMM Healthcare, Inc.	90,791 (PR)
Care Improvement Plus	78,631 (Multiple states)
Kaiser Foundation Health Plan	56,910 (CA, CO, GA)
MCS Life Insurance Company	52,243 (PR)
Preferred Medicare Choice, Inc.	33,384 (PR)
Managed Health, Inc.	30,907 (NY)
HealthSpring	25,535 (AL, TN)
Keystone Health Plan	25,180 (PA)
Gateway Health Plan, Inc.	24,562 (PA)
WellCare	24,140 (Multiple states)
Humana	23,092 (FL, PR, TX)
Total	*712,492 (65.9% of total SNP enrollment)*

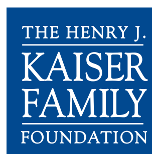
Number of SNPs With Fewer Than:

10 enrollees	62
100 enrollees	129
500 enrollees	249

Number of Contracts With Fewer Than:

10 enrollees	17
100 enrollees	37
500 enrollees	98

SOURCE: CMS November 2007 SNP Comprehensive Report (http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage)



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