The Menges Group

2013 SNP Alliance Profile and Advanced Practice Report

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A Menges Group Report Sponsored by the National Health Policy Group

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I. Introduction and Executive Summary

Congress created Special Needs Plans (SNPs), a distinct type of Medicare Advantage coordinated care plan, in 2003, to better serve poor, frail, disabled, chronically ill persons. Three broad categories of SNPs were authorized -- chronic care SNPs (C-SNPs), dual eligible SNPs (D-SNPs), and institutional SNPs (I-SNPs). The 2013 SNP Alliance Advanced Practice and Profile Report is the sixth edition of SNP performance findings for members of the SNP Alliance. The SNP Alliance is a national leadership group of 30 organizations that collectively represent more than half of current national SNP enrollment. Key findings are presented below.

The rapid growth occurring in the SNP program during 2012 continued throughout 2013.

- As of December 2013, the SNP program reached a new all-time high enrollment level of more than 1,877,346 persons.
- Double-digit percentage growth in overall SNP enrollment occurred during both 2012 and 2013.
- D-SNPs added the most new members during 2013 (over 220,000). Nationally, 15% of the nation's dual eligibles have enrolled in a SNP. In Arizona and Hawaii, more than half these states' dual eligibles have enrolled in a SNP.
- C-SNPs experienced the sharpest percentage enrollment growth (23% during 2013 and 52% from December 2011 to December 2013).
- 2013 also marks the first time in several years that I-SNP enrollment has increased, although previous declines in I-SNP enrollment were driven primarily by a recategorization of previously-enrolled persons into other SNP types (rather than by an actual loss of membership).

The SNP Alliance data provided by the survey respondents encompass an enrollment base of more than 600,000 persons.

- The data provided by these health plans includes 35% - 46% of nationwide Medicare SNP enrollees during the three-year period 2010-2012.
- 64% of these enrollees are above age 65, and 62% are female.

The SNP Alliance health plans serve a high-need population relative to the average Medicare beneficiary.

- Across the entirety of the reporting SNP Alliance plans' membership, the average (enrollment weighted mean) risk score was 1.41 during both 2011 and 2012. This figure indicates that the expected health care costs for the SNP Alliance members are roughly 41% above those of an average Medicare beneficiary.
- Average 2012 risk scores across SNP Alliance enrollees were 1.74 for C-SNPs, 1.21 for D-SNPs, 1.49 for fully integrated dual eligible SNPs (FIDESNPs), and 2.23 for I-SNPs.

SNP Alliance members have a wide variety of conditions and often have physical and behavioral health comorbidities.

- Diabetes is highly prevalent in all SNP types, being evident in 74% of C-SNP enrollees, 30% of D-SNP members, 48% of FIDESNP enrollees, and 51% of I-SNP members. Diabetes is the most prevalent health condition in each SNP type. Among FFS Medicare beneficiaries, 28% of those over 65 have diabetes and 26% of those under 65 have this condition.
- The under-65 disabled SNP population is widely distributed across numerous physical and behavioral health disorders.

Special needs individuals served by members of the SNP Alliance consistently spend fewer days in the hospital than Medicare fee for service (FFS) beneficiaries with similar needs; inpatient usage has been reduced most sharply for persons served by I-SNPs and C-SNPs.

- In 2012, Medicare beneficiaries enrolled in I-SNPs sponsored by members of the SNP Alliance spent 72% fewer days in the hospital relative to a comparable group of Medicare FFS beneficiaries.
- In 2012, Medicare beneficiaries enrolled in C-SNPs sponsored by members of the SNP Alliance spent over 50% fewer days in the hospital relative to a comparable group of people served by Medicare FFS providers.
- The annual value of the SNP Alliance plans' inpatient usage reductions is estimated to exceed $2 billion. Our tabulations also show an estimated reduction in average per enrollee inpatient costs of more than $12,000 for I-SNPs and more than $8,000 for C-SNPs during 2012.

Case studies demonstrate specific approaches used by some SNP Alliance member health plans to achieve the health status stabilization and medical cost reduction outcomes cited in this report.

Five case studies are provided at the end of the report, each describing the initiatives used by a SNP Alliance plan to coordinate care for a special needs population subgroup. These plans and initiatives are as follows:

- Brand New Day: Best Practices in Severe and Persistent Mental Illness Care
- CareMore: Best Practices in Chronic Illness Care
- Commonwealth Care Alliance: Best Practices in Care for Frail and Disabled Medicare Medicaid Enrollees
- Family Choice: Best Practices in Care for Nursing Home Residents
- SCAN: Best Practices in Care for Nursing Home Certifiable Beneficiaries at Home

II. Background on Medicare Special Needs Plan Program and the SNP Alliance

SNP Alliance

The SNP Alliance, an initiative of the National Health Policy Group (NHPG), is the only national organization exclusively dedicated to improving policy and practice for Medicare Advantage Special Needs Plans (SNPs). The SNP Alliance is a national leadership group of 30 organizations that sponsor over 250 SNPs and collectively represented 56% of national SNP enrollment as of January 2013.[1] NHPG has sponsored a survey of SNP Alliance member organizations every year since 2008.

Membership in the SNP Alliance is by invitation only, and members commit to work together to improve policy and practice in serving high-risk beneficiaries. SNP Alliance members represent all three SNP types (chronic care, dual eligible, and institutional SNPs), under a wide variety of organizational and ownership structures, in all regions of the United States. The mission of the SNP Alliance is to improve policy and practice for high-risk beneficiaries and those with complex needs.

Background on Special Needs Plans

Congress created SNPs, a distinct type of Medicare Advantage coordinated care plan, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). A major focus of the original SNP legislation was to advance the integration of Medicare and Medicaid and improve care for high-risk/high-need populations. Founding members of the SNP Alliance were identified as offering programs representative of Congressional intent.

Three broad categories of SNPs were authorized. Chronic care SNPs (C-SNPs) focus on Medicare beneficiaries with one of 15 serious chronic condition categories specified by CMS (diabetes, serious and persistent mental illness, HIV-AIDS, etc.). Dual eligible SNPs (D-SNPs) focus on persons who are covered by both the Medicaid and Medicare programs. Institutional SNPs (I-SNPs) serve beneficiaries who are either institutionalized or who reside in a community-based setting but have been determined to be nursing home eligible based on their level of care needs. D-SNPs with Medicaid contracts that offer the full array of Medicare and Medicaid benefits under capitated financing are referred to as "fully integrated dual eligible SNPs" or FIDESNPs, but they are not designated in this way in statute.

[1] This figure includes the 50 states and the District of Columbia and excludes Puerto Rico enrollment. If Puerto Rico's SNP enrollment is included, the SNP Alliance plans collectively serve 47% of all US SNP enrollees. None of the SNP Alliance plans serve Puerto Rico, which holds 16% of total SNP enrollment.

Criteria for FIDESNP designation were established by CMS by regulation. FIDE SNPs are defined as D-SNPs that: enroll special needs individuals entitled to Medicaid; provide dually-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization; have a CMS approved MIPPA compliant Medicaid contract that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing; coordinate delivery of covered Medicare and Medicaid health and long-term care services; and employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

Since 2003, Congress enacted several amendments to the original SNP statute, which raised the bar on SNPs through additional requirements. These included the following:

- As of December 2013, extended SNP authority through January 2016.
- Rescinded the "disproportionate SNP" designation, thereby requiring *exclusive* enrollment of target groups.
- Narrowed Chronic SNP eligibility to 15 specific chronic condition categories designated by CMS.
- Required SNPs to establish evidence-based Models of Care that provide to *every* beneficiary:
    - Annual comprehensive assessment of physical, functional and psychosocial health;
    - Individual care plans developed with input from beneficiaries and, if desired, families; and
    - Inter-disciplinary care teams with composition based on special needs of targeted enrollees.
- Required all SNPs to receive approval from the National Committee on Quality Assurance (NCQA) by 2012.
- Required all Institutional SNPs to validate institutional level of care equivalence by outside agency.
- Required all D-SNPs to establish a contract with their state Medicaid Agency for contract year 2013.
- Granted CMS authority as of 2011 to apply frailty adjusted payments to FIDESNPs that have PACE frailty levels, are fully integrated, and have capitated Medicaid contracts that include long term care services.
- As of 2011, required the Secretary to refine new enrollee risk factors for chronic SNPs to reflect the known risk profile and chronic health status of similar FFS individuals.

The requirements above are unique to SNPs and among the factors that differentiate SNPs from standard Medicare Advantage (MA) plans. SNPs also have additional reporting and oversight requirements, including annual reporting of SNP-specific structure and process measures and reporting of selected HEDIS measures at the plan benefit package level. In 2013, CMS proposed a number of changes to the structure of the SNP Model of Care and NCQA revised the Model of Care scoring criteria to be more consistent with the methods used to score SNP structure and process measures. These changes were initiated to clarify CMS expectations about the content of SNP Models of Care and transparency in scoring methods.

The SNP Alliance believes that many of these additional statutory requirements have influenced the outcomes discussed later in this report. For example, the Model of Care requirements, which subsequently became the basis for NCQA approval of SNPs, raised the bar on SNP clinical models and practice. We believe this has, in part, contributed to the ongoing reductions in hospital utilization. The requirement for D-SNPs to have a contract with states has increased opportunities for better coordination of Medicare and Medicaid benefits and services. And the changes to payment, while narrowly applied at present, have the potential, over time, for SNPs to improve their ability to fulfill their specialty care mandate.

Annual Report Participants and Methodology

The purpose of the SNP Alliance Profile Report series is two-fold: 1) to inform policymakers about the degree to which Special Needs Plans demonstrate added value for government and beneficiaries; and 2) to provide benchmarking opportunities for members of the SNP Alliance in seeking to improve total quality and cost performance in care of high-risk/high-need beneficiaries.

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

The data used throughout the report were provided by SNP Alliance member organizations in response to the annual survey. Much of the demographic and risk adjustment data sought in the request are derived primarily from information the SNPs already compile in their standard reports.

Respondent SNP Alliance plans also submitted a range of health care utilization statistics for a number of service categories in order to provide a more complete picture of access to care and care coordination. The survey instrument has evolved to include sections on health plan efficiency, disease prevalence, and quality of care.

Nineteen organizations responded to the annual survey. Most respondents completed the majority of the survey while others were only able to submit a portion of the requested information.

These 19 organizations and the types of plans they offer are shown in Exhibit 1**.** Six of the data-contributing organizations operate multiple SNP types. The majority of the SNP Alliance member organizations providing data for this report target dual eligible beneficiaries (17 of 19, or 89% percent). Among this group, eight organizations operate FIDESNPs; 12 organizations operate other D-SNPs. Five organizations provided C-SNP data, and seven organizations provided I-SNP data.

In this report, the dual SNPs (or D-SNPs) were divided into two groups: the Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs) and all other D-SNPs. The FIDESNPs in this

Report primarily include D-SNPs that operated under national integration demonstration authority prior to transitioning to SNP designation, plus one plan that was subsequently designated as a FIDESNP by CMS. These health plans offer the full spectrum of primary, acute and long-term care services provided under capitated Medicaid and Medicare funding using integrated methods of care and program administration. These organizations have operated highly integrated programs for dual eligible beneficiaries for many years.

The SNP Alliance health plans contributed data for calendar years 2010-2012.

Exhibit 1. SNP Alliance Data Contributors

Health Plan	C-SNP	D-SNP	FIDESNP	I-SNP
AmeriGroup		X		
ArchCare				X
Care Wisconsin			X	
CareMore	X	X		X
Commonwealth Care Alliance			X	
ElderPlan		X	X	X
Family Choice New York				X
Gateway		X		
Health Partners			X	
CIGNA-HealthSpring	X	X		X
I-Care		X		
Medica		X	X	
Molina		X		
SCAN	X	X	X	X
Senior Whole Health			X	
U Care			X	
United Healthcare	X	X	X	X
UPMC		X		
XL Health	X	X		

III. National Overview of Medicare Special Needs Plans

We are in the midst of a period of rapid growth in the SNP program, both in terms of the number of participating health plans and total SNP enrollment. Exhibit 2 presents a national overview of participating health plans by year and SNP type.

Exhibit 2. Number of Health Plans by SNP Type, 2010 - 2013

Number of Different Plans	C-SNP	D-SNP	I-SNP	Total
Dec-10	153	335	74	562
Dec-11	92	298	65	455
Dec-12	115	322	70	507
Dec-13	214	362	68	644
Percent Change in Number of Plans				
Dec '10 - Dec '11	-40%	-11%	-12%	-19%
Dec '11 - Dec '12	25%	8%	8%	11%
Dec '12 - Dec '13	86%	12%	-3%	27%

While the number of SNPs decreased from 2010 to 2011 (with the decline actually beginning in 2009), rapid growth has occurred since 2011. From December of 2011 to December of 2013, the number of SNPs increased 42%, with the sharpest growth (27%) occurring during 2013. The number of C-SNPs has grown most rapidly, more than doubling from December 2011 to December 2013 and increasing by 86% from 2012-2013 alone. There are 40 more D-SNPs in 2013 than in 2012. The number of participating I-SNPs has remained relatively stable throughout the past several years, fluctuating between 65 and 74.

The collective enrollment of the participating SNPs as of the same selected months is shown in Exhibit 3.

Exhibit 3. SNP Enrollment SNP Type, 2010 - 2013

SNP Enrollment	C-SNP	D-SNP	I-SNP	Total
Dec-10	230,612	1,047,519	94,495	1,372,626
Dec-11	196,423	1,159,077	78,209	1,433,709
Dec-12	232,530	1,303,408	49,714	1,585,652
Dec-13	297,901	1,527,676	51,769	1,877,346
Percent Change in Enrollment				
Dec '10 - Dec '11	-15%	11%	-17%	4%
Dec '11 - Dec '12	18%	12%	-36%	11%
Dec '12 - Dec '13	28%	17%	4%	18%

Key observations from the Exhibit 3 figures are summarized below:

- As of December 2013, the SNP program reached a new all-time high enrollment level of 1,877,346 persons.

- Double-digit percentage growth in overall SNP enrollment occurred during both 2012 and 2013.

- D-SNPs have added the most new members during 2013 (over 220,000).

- C-SNPs have experienced the sharpest percentage enrollment growth (28% during 2013 and 52% from December 2011 to December 2013).

- 2013 also marks the first time in several years that I-SNP enrollment has increased, although previous declines in I-SNP enrollment were driven primarily by a recategorization of previously-enrolled persons into other SNP types (rather than by an actual loss of membership).

The degree to which the SNP model has "taken hold" varies considerably by geographic market area. State level data on SNP enrollment as of September 2013 is presented in Exhibit 4. Six states had more than 100,000 SNP enrollees as of September 2013 -- California (247,197), Florida (204,890), New York (153,374), Texas (134,504), Pennsylvania (111,132) and Georgia (103,658). These six states collectively hold 62% of nationwide SNP enrollment, and 42% of the nation's dual eligibles reside in these six states.

Eight states -- Alaska, Delaware, Montana, New Hampshire, North Dakota, South Dakota, Vermont and Wyoming --had no SNP enrollment as of December 2012. This is not likely a SNP-specific issue, given that these states tend to have low levels of managed care penetration in the commercial and broader Medicare Advantage arenas.

Exhibit 4 also estimates the proportion of each state's dual eligibles who have enrolled in a Medicare SNP. We estimated that overall dual eligible enrollment in SNPs is comprised of 100% of D-SNP enrollees, plus 90% of I-SNP enrollees, plus 25% of C-SNP enrollees. Based on this algorithm, SNPs currently serve 50% or more of the dual eligibles in two states: Arizona (53%) and Hawaii (53%). SNPs serve more than 25% of dual eligibles in an additional four states: Florida (27%), Minnesota (29%), Pennsylvania (27%) and Utah (27%). Nationwide, 15% of dual eligibles are enrolled in SNPs.

It is important to point out that D-SNP growth, enrollment, and integration trends are in part influenced by plans' ability to secure a contract for coordinating with Medicaid and offering Medicaid services. As of December 2012, all D-SNPs were required to have contracts with State Medicaid agencies that met the requirements specified in MIPPA. States not only control whether plans can get state contracts for coordinating Medicare and Medicaid programs and services, but they also control the content and scope of the contracts. As the General Accounting Office pointed out in its August 2012 Report to Congress, D-SNP contracting with states historically has been constrained by limited state resources for developing and overseeing

contracts, uncertainty about whether Congress will extend D-SNPs into the future, and the impact of other integration initiatives on states and plans. Misunderstandings regarding the scope of D-SNP contract requirements were also a significant barrier in the past. CMS has helped states address many of these barriers, particularly for states participating in the Financial Alignment Demonstration, but additional resources and support are still needed to advance integration initiatives inside and outside the CMS demonstrations and using a variety of integration models. Further, while most states are using D-SNPs as a platform for integration, permanent authority for D-SNPs would increase states' comfort level with this vehicle.

Exhibit 4. SNP Enrollment by State and SNP Type, September 2013

	SNP Enrollment, September 2013					
State	Chronic or Disabling Condition	Dual-Eligible	Institutional	Total SNP Enrollment	Estimated Total Dual Eligibles	Estimated Percentage of All Duals Enrolled in SNPs
Alabama	335	40,747		41,082	190,795	21%
Alaska				-	13,464	0%
Arizona	15,713	72,294	2,480	90,487	149,014	53%
Arkansas	8,692	4,765		13,457	114,323	6%
California	31,007	209,020	7,170	247,197	1,194,733	19%
Colorado		8,778	2,317	11,095	79,939	14%
Connecticut		5,843	1,872	7,715	116,138	6%
Delaware				-	24,294	0%
District of Columbia		1,202		1,202	23,413	5%
Florida	52,175	150,111	2,604	204,890	608,733	27%
Georgia	71,165	30,391	2,102	103,658	253,288	20%
Hawaii		16,909		16,909	32,066	53%
Idaho		694		694	31,903	2%
Illinois	932	6,609	476	8,017	321,607	2%
Indiana	1,901	3,349	401	5,651	149,850	3%
Iowa	381	865		1,246	78,298	1%
Kansas			200	200	61,941	0%
Kentucky	451	1,638		1,200	171,100	1%
Louisiana	567	20,162		20,729	180,446	11%
Maine		2,497		2,497	98,019	3%
Maryland	4,065	7,274	3,327	14,666	109,307	10%
Massachusetts		26,623	321	26,944	254,521	11%
Michigan		18,387	423	18,810	251,435	7%
Minnesota	264	37,483		37,747	128,921	29%
Mississippi	786	10,359		11,145	147,514	7%
Missouri	11,341	15,402		26,743	160,732	11%
Montana				-	21,471	0%
Nebraska	267	1,244		1,511	37,479	3%
Nevada	5,981		474	6,455	39,310	5%
New Hampshire				-	28,616	0%
New Jersey	1,181	27,707	985	29,873	198,223	15%
New Mexico	1,138	7,557	227	8,922	64,439	12%
New York	1,242	140,810	11,322	153,374	749,339	20%
North Carolina	1,875	12,038	2,411	16,324	303,414	5%
North Dakota					14,145	0%
Ohio	221	13,013	3,970	17,204	295,107	6%
Oklahoma			134	134	108,947	0%
Oregon	408	20,163	627	21,198	91,639	23%
Pennsylvania	9,942	98,949	2,241	111,132	383,758	27%
Rhode Island			1,493	1,493	39,238	3%
South Carolina	11,700	7,049		18,749	144,011	7%
South Dakota				-	19,417	0%
Tennessee	213	57,355	27	57,595	244,364	24%
Texas	34,614	99,803	87	134,504	623,602	17%
Utah		8,190		8,190	30,096	27%
Vermont				-	33,553	0%
Virginia	737	972	62	1,771	167,659	1%
Washington		18,680	1,052	19,732	155,203	13%
West Virginia		143		143	76,115	0%
Wisconsin	654	15,508	1,314	17,476	204,544	8%
Wyoming				-	9,818	0%
USA Total	**269,999**	**1,220,612**	**50,134**	**1,540,745**	**9,029,304**	**15%**

Notes:

- SNP membership by state and plan type tabulated using September 2013 SNP Comprehensive Report.. A small number of health plans provided data for multi-state SNPs, mix of these plans' enrollees by state was estimated.
- Estimated total duals in SNPs adds 100% of D-SNP members, 90% of I-SNP members, and 25% of C-SNP members.
- Total number of duals derived from CMS MSIS website data for 2010, trended 1% per year to 2013. Totals derived from MSIS include persons with full and partial Medicaid coverage, and represent covered months divided by 12.
- National totals exclude Puerto Rico enrollment.

Throughout the report, we make comparisons of SNP Alliance 2010, 2011 and 2012 data in relation to 2008 fee for service (FFS) data. We continue to use the FFS comparisons obtained from an analysis of the 2008 5% sample because the 5% sample numbers were changing very little year over year. Updating the 5% sample would create considerable analytical costs but likely would not meaningfully change or improve the comparisons being made with the FFS setting.

The SNP Alliance data provided by the survey respondents encompass an enrollment base of more than 600,000 persons. As shown in Exhibit 5, the data provided by these health plans includes 35% - 46% of all Medicare SNP enrollees nationwide during the three-year period 2010-2012. The SNP Alliance plans contributing data reported CY2013 information on nearly all (94%) of the nation's I-SNP enrollees, 62% of C-SNP enrollees, 61% of FIDESNP enrollees, and 28% of D-SNP enrollees.

This data provided in this section and in the remainder of the report therefore represent a large volume of enrollees. The number of health plans contributing data to any given statistic varies is noted in each data table.

Exhibit 5. Collective Enrollment of SNP Alliance Data Contributors

	Year-End Enrollment (December)		
	2010	**2011**	**2012**
Collective Enrollment of SNP Alliance Data Contributors			
C-SNP	178,641	127,317	144,250
D-SNP	361,203	361,203	361,203
I-SNP	88,629	44,849	46,521
Total	**628,473**	**533,369**	**551,974**
Nationwide Enrollment, All SNPs			
C-SNP	230,612	196,423	232,530
D-SNP	1,047,519	1,159,077	1,303,408
I-SNP	94,495	78,209	49,714
Total	**1,372,626**	**1,433,709**	**1,585,652**
Percentage of National Enrollment in SNP Alliance Data Contributors			
C-SNP	77%	65%	62%
D-SNP	34%	31%	28%
I-SNP	94%	57%	94%
Total	**46%**	**37%**	**35%**

Demographic Mix of SNP Alliance Enrollees

The age and gender distribution of the SNP Alliance enrollees is summarized in Exhibit 6. For many SNPs, persons below age 65 constitute a large proportion (and in some cases a majority) of their enrollees. Across all non-FIDESNP D-SNPs, just under half of enrollees (48%) are under age 65. Persons under 65 also comprise 25% of C-SNP enrollment. At the high end of the age continuum, nearly half of I-SNP enrollees (47%) are age 85 or above as are 21% of FIDESNP enrollees, 6% of D-SNP enrollees, and 6% of C-SNP enrollees.

The majority of the SNP Alliance plans' enrollees are female (62%). The gender mix is closest to even among C-SNPs (57% female, 43% male) and most skewed for I-SNPs (74% female).

Exhibit 6. Age and Gender Mix of SNP Alliance Enrollees as of December 2012

	C-SNP	D-SNP	FIDESNP	I-SNP	TOTAL
Enrollees	144,250	433,182	39,157	46,521	663,110
Age Distribution					
<65	25%	46%	1%	9%	36%
65 - 84	69%	48%	77%	45%	54%
85+	6%	6%	21%	47%	10%
Gender Distribution					
Female	57%	61%	69%	74%	62%
Male	43%	39%	31%	26%	38%

IV. Risk Score Analyses

The SNP Alliance plans' average risk score information is presented in Exhibit 7. Across the entirety of the reporting SNP Alliance plans' membership, the average (enrollment weighted mean) risk score was 1.41 during both 2011 and 2012. This figure indicates that the expected health care costs for the SNP Alliance members are roughly 41% above those of an average Medicare beneficiary and demonstrates the high-need nature of the SNP populations served by these coordinated care organizations.

Exhibit 7. SNP Alliance Plans' Risk Score Overview

	Average Risk Score, All Enrollees		
	2010	**2011**	**2012**
Average (enrollment-weighted mean)			
All SNP Alliance Health Plans	1.31	1.41	1.41
C-SNP	1.31	1.70	1.74
D-SNP	1.21	1.22	1.21
FIDESNP	1.51	1.55	1.49
I-SNP	1.63	2.15	2.23
Range of Single-SNP Averages, 2013			
C-SNP			1.16 - 2.52
D-SNP			0.93 - 2.14
FIDESNP			1.37 - 2.50
I-SNP			1.77 - 2.45

Dual eligibles' average risk score in the Fee-For-Service (FFS) setting, based on programming of 5% Sample data files, was 1.26 in 2007 and 1.27 in 2008.

Institutionalized eligibles' average risk score in the FFS setting was 1.82 in 2007 and 1.84 in 2008.

Nearly all of the reporting health plans had an average risk score above 1.00 for their overall SNP membership, with the range in 2012 being 0.93 (for a D-SNP plan) to 2.50 (for a FIDESNP plan).

The average risk score across SNP Alliance C-SNP enrollees was 1.74 in 2011. While the average C-SNP risk score is almost 75% higher than the Medicare FFS average, it is not possible to closely compare SNP Alliance C-SNP enrollees with their FFS counterparts since the data from various chronic conditions were aggregated. Based on the 5% sample tabulations, the average risk score in 2008 was 1.4 for Medicare beneficiaries with diabetes and was 1.8 for those with congestive heart failure (CHF). Given that a majority of beneficiaries in the C-SNP data base were from plans serving beneficiaries with diabetes and congestive heart failure (CHF), as opposed to severe and persistent mental illness or other late stage condition, it is likely that C-SNP enrollee risk scores are at or above those for FFS beneficiaries with the same conditions.

Based on risk score analyses, the SNP Alliance D-SNPs are serving a population of dual eligibles with high needs relative to an average Medicare beneficiary, but with expected health needs slightly below the average of all FFS dual eligibles. Based on analyses of the 5% sample data files conducted previously for the SNP Alliance, dual eligibles have an average risk score of 1.26

- 1.27. The SNP Alliance D-SNP average in 2012 was 1.21 using the enrollment weighted mean, excluding FIDESNP enrollees, and 1.23 when FIDESNPs enrollees are included. Younger SNP Alliance dual eligible enrollees have a relatively low average risk score (1.08, in part, because their demographic weights are much lower than the average Medicare beneficiaries due to age). The SNP Alliance D-SNPs' average risk scores may be at or above FFS duals on an age-adjusted basis. As noted earlier, nearly half of the SNP Alliance D-SNP enrollees are below age 65.

The FIDESNPs are serving a particularly high-need group within the D-SNPs. The FIDESNP enrollees' 2012 average risk score was 1.49.

The SNP Alliance I-SNPs serve a particularly high-need subgroup with an average 2012 risk score of 2.23. The average risk score in the FFS setting for institutionalized beneficiaries is 1.84 based on tabulations using the 5% Sample data file. Thus, the SNP Alliance I-SNP plans are serving a relatively high-need subgroup even within the universe of institutionalized Medicare beneficiaries.

Exhibit 8 presents more detailed 2012 risk score information by SNP type and age cohort. This information demonstrates that within the body of C-SNP and D-SNP members, the average acuity of the enrollees increases with advanced age. However, for FIDESNP and I-SNP members, the under-65 disabled beneficiaries have the highest acuity level.

Exhibit 8. SNP Alliance Members' Average Risk Scores by Age Cohort

	Average SNP Alliance Members' Risk Score, 2012 (Enrollment-Weighted Mean)			
SNP Type	All Members	Age <65	Age 65-84	Age 85+
C-SNP	1.74	1.73	1.71	2.16
D-SNP	1.21	1.08	1.33	1.60
FIDESNP	1.49	2.21	1.41	1.74
I-SNP	2.23	2.54	2.38	2.03

Exhibit 9 presents the percentage of members by risk score group by SNP type during 2012. C-SNP enrollees are distributed fairly widely and evenly across the risk score continuum. Over half of SNP Alliance D-SNP enrollees have risk scores below 1.00, along with 41% of FIDESNP enrollees. I-SNP enrollees are concentrated at the high-end of the risk score continuum – half of these enrollees have a risk score above 2.00.

Exhibit 9. Distribution of SNP Alliance Health Plan Enrollees' Risk Scores

	Distribution of 2012 SNP Alliance Enrollee Risk Scores				
SNP Type	< 1.00	1.00 - 1.49	1.50 - 1.99	2.00+	Total
C-SNP	29%	24%	16%	32%	100%
D-SNP	54%	21%	10%	15%	100%
FIDESNP	41%	24%	13%	22%	100%
I-SNP	12%	18%	20%	50%	100%

Exhibit 10 shows the average risk scores by SNP type for enrollees new to Medicare. The bottom half of this table compares the average risk scores for those new to Medicare with the corresponding average for the full SNP Alliance membership. For example, the I-SNP score of .99 is only 45% of the average I-SNP risk score of 2.23 for all SNP Alliance I-SNP members reporting data. This could mean that I-SNPS, on average, are underpaid by 55% for new enrollees during the first year of enrollment, or until there is 12 consecutive months of data for calculating risk scores. For each SNP type, the average risk score for enrollees new to Medicare is below 1.00 and is dozens of percentage points below these health plans' average risk score for their overall membership. This creates a significant underpayment concern given that new to Medicare enrollees may not be meaningfully different from the other members in the same category of beneficiaries in terms of health needs and expected health costs – rather, they simply do not have the accumulated base of Medicare claims to depict their "true" risk score.

Exhibit 10. Risk Scores for Persons New to Medicare

	Average Risk Score, Enrollees New to Medicare		
SNP Type	2010	2011	2012
C-SNP	0.72	1.02	0.97
D-SNP	0.94	0.84	0.90
FIDESNP	1.12	1.01	0.98
I-SNP	1.04	0.95	0.99
	New Enrollees' Risk Score as % of Risk Score for All Enrollees		
SNP Type	2010	2011	2012
C-SNP	55%	60%	56%
D-SNP	78%	69%	75%
FIDESNP	74%	65%	66%
I-SNP	64%	44%	45%

During 2012, 8% of D-SNP enrollees were new to Medicare, along with 5% of FIDESNP enrollees, 4% of C-SNP enrollees, and 1% of I-SNP enrollees. These figures were closely similar for 2010 and 2011 as well.

V. Health Care Conditions

SNP Alliance members have a wide variety of conditions and often have physical and behavioral health comorbidities. The condition distribution of these plans' collective enrollee population, by SNP type, is presented in Exhibit 11.

The SNP Alliance chose to focus on this set of conditions as they were identified by the National Quality Forum (NQF) as "high-impact conditions." The National Quality Forum (NQF) defines high-impact conditions as conditions that have a high-impact on many aspects of health, such as affecting large numbers of patients and/or having a substantial impact for a smaller population; being a leading cause of morbidity/mortality; requiring high resource use (current and/or future); and relating to severity of illness and/or severity of patient/societal consequences of poor quality.

Exhibit 11. Proportion of SNP Alliance Enrollees with Various Health Conditions, CY2012

Health Condition	C-SNP	D-SNP	FIDESNP	I-SNP	Fee-For-Service
1. Major Depression	14%	19%	23%	45%	14%
2. Congestive Heart Failure	24%	11%	23%	40%	17%
3. Ischemic Heart Disease	40%	21%	30%	37%	31%
4. Diabetes	74%	34%	48%	51%	28%
5. Stroke/Transient Ischemic Attack	4%	5%	9%	19%	4%
6. Alzheimer's Disease	3%	3%	14%	29%	11%
7. Chronic Obstructive Pulmonary Disease	17%	18%	19%	26%	12%

Source of FFS data is CMS, "Chronic Conditions Among Medicare Beneficiaries: Chart Book, 2012 Edition."

Diabetes is highly prevalent in all SNP types. Within C-SNP enrollees, 74% have diabetes – a high but unsurprising statistic given that many of the C-SNPs focus on diabetes. However, the significant presence of diabetes among the other SNP types – 30% in D-SNPs, 48% in FIDESNPs, and 51% in I-SNPs – is an important finding. Essentially, all SNPs (not just diabetes C-SNPs) need to have effective care coordination programs in place to serve diabetic enrollees.

The 2013 annual survey included a focused assessment of the distribution of the disabling conditions of the SNP Alliance plans' under-65 enrollees. These tabulations, across all the reporting health plans, are presented in Exhibit 12. These figures show that the under-65 disabled SNP population is widely distributed across numerous health disorders.

Exhibit 12. Percentage of <65 Enrollees with Various Health Conditions, CY2012

Health Condition	C-SNP	D-SNP	FIDESNP	I-SNP
For Enrollees Under Age 65, How Many Have Following Characteristics?				
a) Selected Physical Disabilities				
i. HCC 161– Traumatic Amputation	4%	0%	1%	1%
ii. HCC 177 – Amputation Complications	6%	1%	4%	4%
iii. HCC 101– Cerebral Palsy and Paralytic Syndromes	3%	2%	5%	4%
iv. HCC 72 – Multiple Sclerosis	2%	1%	9%	14%
v. HCC 73 – Parkinson's and Huntington's Diseases	2%	1%	3%	9%
vi. HCC 67 – Quadriplegia and Other Extensive Paralysis	2%	1%	7%	14%
vii. HCC 68 – Paraplegia	2%	1%	5%	7%
viii. HCC 69 – Spinal Cord Disorders Injuries	6%	1%	3%	3%
ix. HCC 70 – Muscular Dystrophy	1%	0%	2%	1%
b) Behavioral Health Disabilities/Severe Mental Illness				
i. HCC 54 - Schizophrenia	1%	11%	9%	23%
ii. HCC 55 - Major Depressive, Bipolar and Other Mood Disorders	11%	23%	35%	44%
c) Intellectual or Developmental Disabilities		4%	0%	9%

VI. Utilization of Selected Services

Inpatient usage rates were tabulated across a large volume of enrollees. The CY2012 statistics are based on more than 660,000 enrollees including approximately 145,000 C-SNP enrollees, 430,000 D-SNP enrollees, 40,000 FIDESNP enrollees, and 45,000 I-SNP enrollees. Exhibit 13 presents statistics on days and admissions per 1,000 enrollees per year, and average length of stay for 2010, 2011 and 2012.

Exhibit 14 compares the inpatient days/1,000 statistics with available Medicare fee-for-service benchmarks, as derived through tabulations using the CMS 5% Sample data files as published in prior SNP Alliance Annual Profile Reports.

Exhibit 13. Inpatient Usage Statistics Across Reporting SNP Alliance Plans' Membership

	Inpatient Utilization, All Admissions		
SNP Type	**2010**	**2011**	**2012**
Days Per 1,000 Enrollees Per Year			
C-SNP	2,510	2,341	2,336
D-SNP	3,065	2,846	2,870
FIDESNP	2,489	3,478	3,080
I-SNP	1,797	2,318	2,131
Admits Per 1,000 Enrollees Per Year			
C-SNP	433	408	400
D-SNP	522	486	475
FIDESNP	478	655	589
I-SNP	340	392	359
Average Length of Stay			
C-SNP	5.8	5.7	5.8
D-SNP	5.9	5.9	6.0
FIDESNP	5.2	5.3	5.2
I-SNP	5.3	5.9	5.9

Exhibit 14. SNP Alliance Inpatient Usage Comparisons with Medicare Fee For Service

SNP Type	Inpatient Days Per 1,000 Persons Per Year		SNP Alliance Plans' Percentage Reduction in FFS Inpatient Usage
	SNP Alliance, 2012	2008 Fee-For-Service	
C-SNP			
Diabetes + CHF	2,293	5,939	61%
D-SNP	2,870	3,327	14%
FIDESNP	3,080	4,092	25%
I-SNP	2,131	7,497	72%

Direct comparison populations in the 5% Sample were available for purposes of creating D-SNP and I-SNP fee-for-service benchmarks in Exhibit 14. The FIDESNP FFS benchmark figure is estimated based on dual eligibles overall usage (3,327 days/1,000) and the FIDESNPs' average risk score being 23% higher than other D-SNPs.

The C-SNP benchmark reflects a merge of the FFS usage rate for beneficiaries with diabetes (3,744 days/1000) and with CHF (8,133 days/1,000). The 5,939 FFS benchmark figure assumes a 50%/50% mix of beneficiaries with diabetes and CHF. Against this benchmark, the C-SNPs achieved a 61% reduction in inpatient usage. If we had assumed a SNP Alliance C-SNP membership mix of 80% diabetes and 20% CHF, the inpatient savings would be 50% relative to FFS – somewhat smaller but still a massive reduction.

These comparisons show inpatient usage reductions for all SNP types, with reductions of more than half (relative to FFS) occurring in the C-SNP and I-SNP setting. The CY2012 value of these inpatient usage reductions is estimated in Exhibit 15 to be over $2 billion. The derivation of this figure, based on the usage impacts in Exhibit 14 and an assumption that the nationwide Medicare average daily payment ($2,333 in CY2011 per a MEDPAC report) represents a reasonable average amount for the SNP Alliance's avoided inpatient days, is presented in Exhibit 15. These tabulations also show an estimated reduction in average per enrollee inpatient costs of more than $12,000 for I-SNPs and more than $8,000 for C-SNPs during CY2012.

Exhibit 15. Estimated Inpatient Cost Reductions Achieved by SNP Alliance Members

SNP Type	SNP Alliance Plans' Percentage Reduction in FFS Inpatient Usage	2012 Reduction in Days/1,000 Versus FFS	Estimated Annual Savings Per Beneficiary *	2012 SNP Alliance Enrollees (Data Contributors)	Estimated Annual Inpatient Savings Created by SNP Alliance Data Contributors
C-SNP					
Diabetes + CHF	61%	3,646	$8,505	144,250	$1,226,780,461
D-SNP	14%	457	$1,066	433,182	$461,824,434
FIDESNP	25%	1,012	$2,362	39,157	$92,488,532
I-SNP	72%	5,366	$12,517	46,521	$582,319,886
TOTAL				**663,110**	**$2,363,413,313**

* Based on nationwide average Medicare inpatient payment of $2,333 per day (derived from June 2011 MEDPAC report)

Exhibit 16 assesses inpatient usage in terms of the percentage of SNP Alliance enrollees by the number of hospitalizations enrollees experienced during CY2012. In each SNP type, approximately 80% of enrollees were not hospitalized during the year. This figure is favorable to this SNP Alliance plans – it is comparable to the average across the entire Medicare fee-for-service population, despite the overall Medicare population being *much* healthier on average than the SNP enrollee population (as evidenced in the risk score comparisons provided earlier). A June 2012 MEDPAC report, "Health Care Spending and the Medicare Program – a Data Book" reported that 21.5% of beneficiaries were hospitalized during 2010 (Chart 6-10). The degree to which enrollees had three or more hospitalizations ranged from a low of 1.3% of I-SNP enrollees to a high of 3.3% of C-SNP enrollees.

Exhibit 16. Distribution of SNP Alliance Enrollees by Number of 2012 Hospitalizations

	Percent Distribution of 2012 SNP Alliance Enrollees by Number of 2012 Inpatient Admissions					
SNP Type	0 Admits	1 Admit	2 Admits	3-4 Admits	5+ Admits	Total
C-SNP	79.2%	13.2%	4.3%	2.5%	0.8%	100.0%
D-SNP	83.2%	10.6%	3.3%	1.9%	0.8%	100.0%
FIDESNP	76.5%	15.1%	5.4%	2.3%	0.7%	100.0%
I-SNP	82.9%	13.1%	2.8%	1.1%	0.2%	100.0%

VII. Case Studies of SNP Alliance Plan Best Practices

The report has been highly quantitative in nature. This final section conveys several SNP Alliance Plans' approaches to serving their enrollees, providing a largely statistical narrative description of the nature of the care coordination services being provided. Some outcome data is included within these case examples. Five health plan initiatives are provided:

A. Brand New Day: Best Practices in Severe and Persistent Mental Illness Care
B. CareMore: Best Practices in Chronic Illness Care
C. Commonwealth Care Alliance: Best Practices in Care for Frail and Disabled Medicare Medicaid Enrollees
D. Family Choice: Best Practices in Care for Nursing Home Residents
E. SCAN: Best Practices in Care for Nursing Home Certifiable Beneficiaries at Home

SNP Alliance Best Practices

October 2013

Brand New Day: Best Practices in Severe and Persistent Mental Illness Care

Brand New Day is a Medicare Advantage Prescription Drug Plan (MAPD), owned and operated by Universal Care, Inc. Brand New Day has offered a Chronic Care Special Needs Plan (C-SNP) for individuals with a severe and persistent mental illness (SPMI), since the inception of SNPs in 2005. (The industry uses the acronym SPMI to refer to either the chronic mental illness or the individual suffering from the illness.) The model of care has been implemented successfully throughout five counties in Southern California: Los Angeles; Orange; Riverside; San Bernardino; and Kern counties. To date, there are nearly 3,000 members participating, each having one or more of the following disabling conditions: Schizophrenia; Schizoaffective Disorder, Bipolar Disorder; Major Depressive Disorder; or Paranoid Disorder. The most prevalent medical conditions for this population are as follows: Alcohol or Drug abuse 60%; Smoking 90%; COPD 45%; Obesity 25%; Diabetes 20%; Hepatitis 15%; and HIV/AIDS 5-10%.

This Brand New Day C-SNP varies greatly from a standard Medicare Advantage (MA) or MAPD plan due to differences in its: (1) Objectives; (2) Model of Care; (3) Utilization Rates; and (3) Success Measurements.

Objective

The primary objective of Brand New Day is to move the member toward "recovery" to the greatest extent possible for each individual, whereas the standard MA/MAPD focuses on treatment only.

Delivery Model / Model of Care

Brand New Day is a patient-centered medical home model with a focus on integrated and coordinated care by a Care Team assigned to the member. Upon enrollment, each new enrollee is assigned to the following: Activity Center, Primary Care Physician (PCP), Primary Treating Physician (PTP psychiatrist), Clinical Pharmacist, Licensed Clinical Social Worker (LCSW), Life Coach (behavioral health specialist), Disability Care Coordinator (DCC), Medi-Medi Benefits Coordinator (MMC), and a Customer Service Center in which each representative (CSR) is trained to work with and give "Best Friend Service" to members with chronic mental illnesses. Additionally, as needed, the Care Team is expanded to include a Clinical Pharmacist, a Certified Addiction Specialist (CATC, CADC, CADE, CCS, RAS, etc.), a Complex Case Manager/RN, (CCM/RN) and a Field Intervention Nurse, LVN, (FIN) for home visits (based on referrals and under physician orders) when Home Health Agency RN level nurses are not necessary. Assigned Care Team members are scheduled to interview each new enrollee during the first 30 days to complete "intake" interviews to identify and stratify the member's risk. Intakes include: psych, alcohol or other drugs (AOD), home safety, medication adherence, health risk assessment (HRA), activities of daily living (ADLs),

and physical health needs, including the identification of preventive care needs (per HEDIS and other standards of care). All intakes take place after enrollment, but possibly before the effective date, whenever possible. Members have direct, unlimited access — with no copayments — to all of the above services. BND has removed financial and access barriers.

The delivery model of the standard MA/MAPD addresses the medical needs of the member through the Primary Care Physician (PCP) and "carves out," or separates, the psychiatric needs of the member to an outside entity, resulting in a lack of integrated, coordinated care. Most often the PCP visit is focused on treating only the presenting symptom, in hopes of a quick and non-disruptive exit by the member from the office. Little or no attention is given to preventive medical care, although most deaths for SPMIs are due to preventable or treatable physical causes, not suicide.

> ***"The higher death rate associated with mental illness has been extensively documented, but most of the attention has focused on the elevated risk of suicide, whereas most of the risk can be attributed to physical illness such as cardiovascular and respiratory diseases and cancer (80% of deaths)."***
>
> - Life Science Daily, May 31, 2013

There is no thought given by MAPDs or Original Medicare to the socialization of SPMIs which is critical to their well-being and helps quell the audio and visual hallucinations for many. MAPDs do not have supportive employment services nor do they help clients apply for financial assistance, and housing. Their members need multiple authorizations for services and do not have an assigned addiction counselor available 24-hours-a-day, 7-days-a-week. MAPDs are not aware of familial or love-relationship problems of the members. MAPDs do not keep SPMIs out of the weather and off the streets to improve health.

Reducing Unplanned ER and Hospitalization

SPMIs are frequently paranoid about seeing PCPs (they see their psychiatrists usually). For medical needs, they visit the ER and sometimes are hospitalized as a result. To reduce ER visits and unplanned hospital admissions, Brand New Day staff life coaches start working with the members upon enrollment to build a trust relationship; start the wellness and preventive care education process, assist SPMI members by scheduling wellness visits to the PCPs, and arrange for transportation (also provided by Brand New Day). When necessary, the life coach accompanies the member during appointments to the PCP (or specialist) until the member is able to trust the provider. (Providers are carefully selected.)

When a SPMI calls and is feeling suicidal and in need of hospitalization, the life coach delves into the life situation the member is currently in to identify alternative coping mechanisms. When SPMIs don't have enough rent money for the last week of the month because their disability check has been exhausted, they know they can go to an ER and say they are feeling suicidal and they will be placed on a 72-hour hold at minimum. This gives the SPMI a warm bed, three square meals, and sometimes a television to watch. MAPDs are not designed with special benefits and staff to identify or stop this pattern. The MAPD may be unaware of housing or other financial instability. They don't know if the member just broke up with a boy/girlfriend, but a Brand New Day (BND) life coach communicates frequently, keeping abreast of members' life situations.

Life coaches may enter into a behavioral contract with the member and BND will pay the rent to the facility (group home, etc.) if the member will promise to repay it. Brand New Day absorbs any losses but so far, there are savings and gain only. If BND avoids one hospital stay a year, it more than covers the rent of members who do not repay their loans, but about 50% of the loans are repaid over time and inappropriate hospitalizations are avoided. BND doesn't do this without thought and counseling and a behavioral contract with the member. Further, rental assistance is a once-in-a-lifetime offer so members don't become repeat offenders. The end result is not only cost savings but a grateful member who is more compliant with treatment plans based on the realization that BND cares about them. Most often, members respond to the offer saying, "You would do that for me? My own family wouldn't do that!" A more treatment-compliant member is a healthier member. It is a win-win situation.

Success

Brand New Day measures success by the following: Lifespan, Life Opportunities, and Lower Utilization of unplanned high-cost services.

Lifespan

Depending upon the study one reads, most national and international statistics agree that the average SPMI has a lifespan of as much as 20 years less than an average adult without a SPMI diagnosis. The average life expectancy of SPMIs is between 50 and 55 years of age. For people without a mental illness the "average life expectancy in the United States is 77.9 years." (NIMH)

> ***"The gap between life expectancy in patients with a mental illness and the general population has widened since 1985 and efforts to reduce this gap should focus on improving physical health, suggest researchers in a paper published today on bmj.com."***
>
> - British Journal of Medicine

Lifespan success is measured by calculating the average age of members continuously enrolled for 18 months or greater (those still living and those deceased). In 2011, Brand New Day joined the national SAMHSA campaign "10 By 10" to increase the life span of the mentally ill by 10 years over the next 10 years. BND members are starting to live longer with Brand New Day.

The statistics below indicate that the average age at time of death for BND members has been extended 4.7 years over the three years since adopting the 10 By 10 program. Concurrently, the average age of members still living has also increased by 0.9 years, nearly one year. (Statistics include members continuously enrolled at least 17 months prior to end of each fiscal year.)

FY	Average Age at Death
FY11	**54.2**
FY12	**55.2**
FY13	**58.9**

Report Dates	Current Ave. Age "Active" Members
6/30/2011	**48.3**
6/30/2012	**48.7**
6/30/2013	**49.2**

Life Opportunities

There is significant stigma for those with chronic, disabling mental illness. They are often shunned by family, former friends, and sadly, even by the medical community itself. Brand New Day has difficulty finding psychiatrists willing to contract to treat SPMIs. They are not "warmly welcomed" in most places. Brand New Day has established "Wellness (Activity) Centers" in each geographic community, where members can drop-in (unlimited access and no copayments) to receive individual and group therapy, health education classes, meet with their assigned licensed clinical social worker (LCSW) or their life coach, enjoy recreational activities and a monthly field trip, and, perhaps most importantly, participate in a society in which they are not judged. One individual wears a tiara every day because she believes she is a princess; one carries a stuffed animal in a pet carrier to ensure the pet has adequate shade and water throughout the day. We have very famous members whose names you might recognize: Beethoven, Jesus Christ, Elvis Presley, and other notables. Most of our members believe the FBI is after them and that their psychiatric medicines are the cause of their illness.

Idiosyncrasies are expected and accepted in Brand New Day Activity Centers. Members enjoy a life outside their home without judgment and ridicule. Members often say, "Brand New Day gave me my life back." The BND Call Center is also especially trained to give "Best Friend Service" to SPMIs by listening and helping to the greatest extent possible. The Wellness/Activity Centers have computer labs and classes to help prepare members to rejoin the work force or attend college classes. Some members have graduated from college through this program. Brand New Day has supportive employment programs through which it works to help find jobs for those who are ready. Life Opportunity Success at Brand New Day is measured by annual "Fidelity Assessments" which score each Activity Center and its care team to measure if they are offering the above opportunities and other life skills to all members.

Lower Utilization Success Measurements

BND lowers hospitalization and ER visit rates. Psychiatric hospital bed days were reduced 49.9%; Medical/surgical stays were reduced 17.5%; and ER visits were reduced 42.4% over two years of continuous enrollment. Life coaches teach members alternatives to expensive hospital services when appropriate. Fee-for-Service and MAPDs run about 2,500 bed days per thousand, while BND has reduced that by half to 1,148 bed days per thousand.

Months Enrolled	Member Months	BH Days	M/S Days	ER Visits	BH Days/ 1000	MS Days/ 1000	ER Visits/ 1000
00-06	3480	668	143	283	2303	493	976
07-12	3480	454	245	222	1566	845	766
13-18	3480	433	227	229	1493	783	790
19-24	3480	335	118	163	1155	407	562
	Reduced Bed Days/1000	333	25	120	1148	86	414
	% Reduced Bed Days/1000	49.9%	17.5%	42.4%	49.9%	17.5%	42.4%

Case Study

"Richard" joined BND and continued what had been a lifetime habit of monthly hospital admissions for alcohol intoxication with blood alcohol levels topping out over 300. When talking with Richard later, he disclosed to his life coach that he had been a chronic alcohol and methamphetamine abuser since the age of 14. Richard is in his mid-30s now. BND assigned and introduced him to an Addictions Counselor in whom he confided that he had a long history of viable suicide attempts, including overdosing on prescription medications, self-mutilation and "Suicide by Cop," which he explained was an attempt to "act so crazy and threatening that the cop had no choice but to shoot me." Richard was resistant to going into a Drug Diversion Program, due to fears of losing his apartment, fear for the welfare of his cat, and fear of change.

After multiple attempts at AA and NA, BND made arrangements to pay Richard's rent for three months on a loan basis, found appropriate housing for his cat, and paid fully for residential drug treatment. He agreed that he would stay in the Drug Rehabilitation program for at least two months. Richard successfully completed the two-month program, and requested to stay an additional month. BND extended the agreement. Richard repaid BND the loan in full and has maintained continued sobriety for four years. Richard is now living a productive life and is working in the Brand New Day Activity Center in the Snack Shack. By helping Richard with his root cause problem, BND was able to reduce ER and hospitalizations and help a man toward recovery. Richard is very happy and calls the BND corporate offices periodically to thank them for this special needs plan.

SNP Alliance Best Practices

October 2013

CareMore: Best Practices in Chronic Illness Care

About CareMore

Founded in 1993, CareMore specializes in providing a complete, proactive health care experience to people eligible for Medicare. From its origins as a medical group caring for Medicare beneficiaries, CareMore evolved into CareMore Health Plan, Inc. in 2001, when it obtained a CMS contract. The CareMore name embodies the philosophy that inspired a proactive model of care with a caring touch and focus on wellness. CareMore's mission is to:

- Provide focused and innovative health care approaches to the complex problems of aging;
- Serve members by prolonging active and independent life;
- Serve caregivers and family members by providing support, education, and access to services; and
- Protect precious financial resources of members and the Medicare Program through innovative methods of managing chronic disease, frailty, and end of life.

CareMore has historically offered a variety of Medicare Advantage products designed to meet the needs of Medicare beneficiaries. The products include MA-PD HMOs alongside a range of Special Needs Plans (SNPs) all of which are coupled with enhanced prescription drug coverage. CareMore offered its first SNP plans in 2007 in Los Angeles County and now offers 29 plans across its service area. Of the 29 plans, 25 are Special Needs Plans for individuals with chronic health conditions (C-SNP). C-SNP plans are offered by CareMore Health Plan, CareMore Health Plan of Arizona, and CareMore Health Plan of Nevada. Offerings include:

CAREMORE BREATHE for individuals with Lung Disease
CAREMORE ESRD for individuals with End Stage Renal Disease
CAREMORE HEART for individuals with Cardiovascular Disease and Congestive Heart Failure
CAREMORE DIABETES for individuals with Diabetes Mellitus

There are over 73,000 members in the existing CareMore plans with approximately 43% enrolled in a SNP plan. Unique to its plans is CareMore's model of care. Designed by physicians to address the unique needs of the frail and elderly, the model of care is focused on managing chronic diseases, such as diabetes, heart, lung, and end stage renal disease (ESRD) that, if left unmanaged, can result in decreasing functionality and ultimately higher health care costs. The model is best described as a hybrid health care system and health plan. Primary Care Physicians (PCP) are contracted to provide basic health care needs. When a member's care intensifies due to a chronic condition, CareMore clinical staff take on the management of highly complex patients in partnership with the member's PCP.

Unique Plans, Benefits and Care Programs

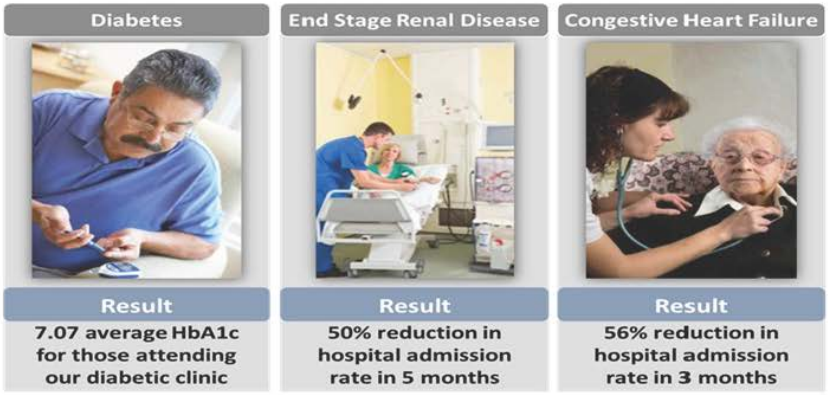
CareMore's traditional MA-PD product offers beneficiaries added value by featuring a $0 monthly premium plan in most markets and affordable cost sharing on medical services and prescription drugs. The SNP plans offered are available to Medicare beneficiaries with dual eligibility status, institutional status, or one of the following qualifying chronic conditions: diabetes, chronic lung disorders, chronic heart failure and cardiovascular disorders, or end stage renal disease (ESRD). SNP products include unique benefits and services to address the needs of the population being served. These include comprehensive disease management programs, transportation, and specialized exercise programs. Our Dual Eligible SNP has no cost sharing on Medicare-covered benefits, enhanced prescription drug coverage, dental and vision benefits. CareMore also has an Institutional SNP product, which brings health care services to beneficiaries who reside in community, assisted living, or long-term care facilities. These plans include $0 copayments on the majority of benefits and a care model that addresses the unique needs of institutional frail beneficiaries.

Benefits are aligned with our model of care and the health needs of a spectrum of Medicare beneficiaries. The majority of plans have $0 copayments for preventative and primary care, low cost skilled nursing services, transportation, exercise and strength training, electronic health monitoring, access to low-cost prescription drugs, and low or no monthly premiums — these benefit strategies are used to reduce barriers to care for our Medicare beneficiaries, which have resulted in positive clinical outcomes.

In addition, Special Need Plans (SNPs) provide enrollees coordinated care options that focus on the unique needs of this population. To support the model of care, benefits are structured to reduce financial barriers to needed care. In addition, CareMore's model provides comprehensive assessments and various heath related programs to help address the overall needs.

The CareMore Model

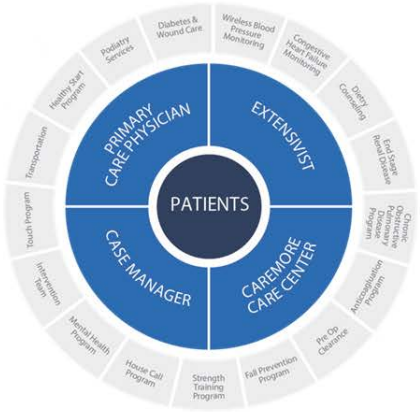
CareMore's approach to care delivery is uniquely suited to the specialized needs of patients with chronic conditions. Many of these at-risk patients have struggled in managing multiple chronic illnesses, have functional impairments and are at significantly higher risk of hospitalization and nursing home placement. Moreover, they typically have a difficult time advocating for their own needs in a complicated health care system, which exacerbates their risk of deterioration. By providing coordinated medical care and supportive services, CareMore has shown that it is possible to improve patient outcomes and satisfaction while reducing costs.



In the CareMore model, teams of non-physician health care providers, based in a CareMore Care Center, supplement primary care medical practices with hands-on disease and frailty management. Within these Care Centers, a detailed array of services are provided, which are generally too complex or costly to be provided within the primary care office. The CareMore Care Center becomes a type of "medical home" for patients with chronic conditions, where care is both delivered and coordinated, and where questions are answered. A variety of support services are provided to remove barriers that lead to patient non-compliance with care programs. These services include transportation, remote monitoring, home visits and social support services.

To support the model, CareMore employs clinicians to deliver care called "extensivists" (internists by training) who manage the complex health conditions and co-morbidities of members. Unlike traditional network managed care plans, the CareMore model uses an Extensivist/Internist to directly manage a member's care, with routine communication to the PCP. The health plan also employs other specialists and clinicians including pulmonologists, cardiologists, dermatologists, house call physicians, nutritionists, and medical assistants. Specialized Nurse Practitioners (NP) provide patient care and education as well as coordinate the many services and providers that members may need to address their co-morbidities. NPs are also used to provide care to members residing in nursing homes, assisted living facilities, or other long-term care settings. This model of care allows the plan to meet the needs of older adults as they age including end of life care. Some programs include:

- Shape Up. Levels Down™ Exercise and Strength Training
- Home Care
- Mental Health Program
- Social Services
- Podiatry
- Hospice
- Palliative Care
- Wellness Programs
- Transportation
- Diabetes-specific services
- ESRD-specific services
- COPD-specific services
- Hypertension and CHF-specific services



The CareMore Care Centers focus on proactive, integrated health care to meet the unique needs of Medicare beneficiaries, including diabetic education, wound management, a foot care program, nutritional counseling, and many other social, clinical, and para-clinical services for a high-risk frail population. The centers provide comprehensive physical examinations, called "Healthy Start" in the first year of a member's enrollment, as well as an annual health assessment called "Healthy Journey" for C-SNP members. There are currently forty-one (41) Care Centers and two (2) dedicated free-standing Mental Health Centers. As membership grows, centers are added to ensure member access and the ability to replicate the care model and outcomes. The addition of the Care Center to the continuum of health care delivery services, along with CareMore employed extensivists and case managers, allows CareMore to more effectively meet the increased demands of the chronically ill. This is not simply a better way to work with or "through" traditional health care providers, but a fundamentally new method of delivering needed services which has demonstrated superior health outcomes.

SNP Alliance Best Practices

October 2013

Commonwealth Care Alliance: Best Practices in Care for Frail and Disabled Medicare Medicaid Enrollees

Commonwealth Care Alliance is a Massachusetts-based non-profit, fully integrated, prepaid health care delivery system. It began as one of the legacy dual demonstration entities in Massachusetts, Minnesota and Wisconsin that have informed so much of the Affordable Care Act. Commonwealth Care Alliance cares for over 5,400 low-income seniors through its Senior Care Options (SCO) Program which was started in 2004. In addition, Commonwealth Care Alliance provides care for over 650 adults with severe physical and/or developmental disabilities through legacy prepaid contracts with Massachusetts Medicaid. The care of these beneficiaries is financed by over $300 million of risk-adjusted integrated Medicare and Medicaid premiums on an annualized basis, in return for the delivery of the totality of Medicare and Medicaid benefits. Its service area includes all cities and towns in Essex and Suffolk counties, and areas in Franklin, Hampden, Hampshire, Middlesex, Norfolk, and Plymouth counties.

SENIOR CARE OPTIONS PROGRAM

Target Population

The SCO program is open to Massachusetts residents aged 65 and older who are eligible for both Medicare and Medicaid, or Medicaid alone, and live in our approved service area. As of September 2013, total enrollment in our SCO program is over 5,400. Of this population, 68% of members are female and 32% are male. 62% of members speak a primary language other than English. 77% of members are functionally homebound and clinically eligible for nursing home placement but are maintained in the community through the care and services provided through the SCO program.

Our members are among the most frail and medically complex subset of Medicaid beneficiaries and they live mostly in communities that experience significant disparities in healthcare services. The average Medicare risk score for Commonwealth Care Alliance SCO membership overall is exceedingly high at 1.67. For Commonwealth Care Alliance functionally homebound members, it is 1.81, scores that are among the highest in the country for Special Needs Plans [Massachusetts Benchmark: 850,000 Medicare eligible seniors (Risk Score 1.0)].

For seniors with complex needs and homebound elders, the current organization of primary care is simply ineffective. Our SCO model of care makes the difference in achieving the objectives of improved health, independence, and quality of life for our members.

Model of Care

Our unique care model is person-centered and team-based, as well as comprehensive and flexible, and is designed to help people achieve their goals for improved quality of life. Each member is assigned a dedicated team of health care practitioners chosen to meet his or her individual needs. Core team members include the primary care provider, a primary care NP/RN and a Geriatric Support Services Coordinator (GSSC), with others, such as behavioral health practitioners, social workers, physical therapists, etc., as needed, and all working collaboratively to provide ongoing health management, early intervention, and response to episodic and urgent care.

Our clinical teams provide medical care and support services 24/7, wherever members need them, whether at home or in a doctor's office, a hospital or other location in the community. Each individualized care plan is based on an assessment and is highly individualized with care decisions made collaboratively by the clinical team and the member and the member's family or guardian. The primary care team can make and approve decisions about medical tests, medications, durable medical equipment, dental care, eyeglasses and transportation based on each member's needs — all provided at no cost to the member. For those with physical disabilities, our integrated durable medical equipment clinical assessment, management and individualized allocation bypasses the rule-based prior approval processes and months of delay associated with Fee-for-Service (FFS) programs. For those with mental illness and behavioral health needs, behavioral health clinicians are integrated into the primary care teams providing individualized care plan development and management which is a dramatic improvement over the inaccessible mental health clinics, structurally siloed from primary care, that are the norm for FFS programs.

Our members are further supported by innovative programs that educate and promote self-management of their health conditions. Our Life Choices program supports our primary care teams in ensuring that member and family wishes are central and respected when end-of-life choices must be made. Our Life Choices palliative care services allow our members to remain in the care of their SCO primary care team and receive end-of-life care that is aligned with their wishes. The results of this program are shown in the chart below:

Indicator	Pre Project Implementation Baseline Time Period	Baseline	Benchmark Performance Goal	2009	2010	2011	2012
Dying at home % members dying at home	CY 2009	19%	>45%	19%	29.6%	37%	50%
ICU days at end of life Average # ICU days per decedent in last 6 months of life	CY 2009	2.72 days	< 2 days	2.72 days	1.49 days	1.53 days	1.76 days
Advance care planning % members with evidence of advance care planning in medical record	CY 2008	CY 2008	56%	>90%	67%	59%	74%

Our Cardiovascular Disease program improves care and self-management skills of diabetics at highest-risk of developing new cardiovascular disease or complications of established cardiovascular disease. Other programs include depression care management and personal care attendant support when members need assistance. These innovative programs are available to SCO members and are designed to ensure that members receive care that contributes to better health, independence and quality of life. A good indicator of member satisfaction with our program is the low disenrollment rate, with voluntary disenrollment of 2.75% for 2012.

Other good indicators of member satisfaction are stories from our members and their families. These stories best illustrate the life-changing impact that our SCO program has on the individuals we care for. Here is a story from the daughter of one of our members:

Loretta's 80-year-old mother had been in a nursing home for three months and she wanted to come home. Loretta made the decision to care for her mother herself and began to figure out how she could make that happen.

When Loretta went to pick up her mother from the nursing home, the nurses stood by with their arms crossed. They didn't offer any advice or words of encouragement. They said to each other, "Don't worry, she'll be back."

Loretta's mother never returned.

Loretta's mother became a Commonwealth Care Alliance member and with the support of an interdisciplinary care team, Loretta was able to keep her mother in the familiar, comfortable surroundings of her own home and successfully meet her healthcare needs. The care team included a nurse practitioner (and team manager) with home visiting capabilities, a social worker, a geriatric social services coordinator from Somerville-Cambridge Elder Services (the local area agency on aging), a primary care physician, a personal care attendant/home-maker, and a visiting nurse (only for the first three months post-discharge from the nursing home). A few months later, hospice support was introduced.

Commonwealth Care Alliance empowers its primary care teams to authorize all needed services, an autonomy that enables immediate medical intervention, seamless delivery of care, and avoids unnecessary emergency department visits and hospital admissions. This ability to act quickly meant that any acute episode that Loretta's mother experienced, such as a urinary tract infection, was treated and resolved before it became a more complicated, and more expensive to treat, condition.

Twelve months after leaving the nursing home, Loretta's mother passed away peacefully in her own home, after being cared for by Loretta and Commonwealth Care Alliance for almost a year. Every day at home was a victory for Loretta and, more importantly, for her mother.

Quality and Cost Performance

Over the years, our unique model of care has been proven to improve our members' health outcomes and reduce the overall cost of care. We invest heavily in home and community-based, long-term care supports as part of individualized plans for care for our members, particularly for those who are functionally homebound. In 2011, we financed 629 personal care attendants (full-time equivalents) as a key component of individualized care plans. The enhanced financial investment into primary care infrastructure, care coordination, and home and community long-term care services is financed from savings achieved by reducing hospitalization and nursing home placements. These

strategic resource allocations are deliberate cost effective service substitutions and we know, through nine years of caring for SCO members, that they work effectively to improve health, independence and quality of life for the individuals we serve.

In 2012, Commonwealth Care Alliance invested $29.2 million above what Medicare FFS would have reimbursed our contracted primary care practice partners to fund the interdisciplinary teams and Commonwealth Care Alliance's supporting infrastructure, with the following results:

- According to a Lewin Associates study commissioned by the SNP Alliance, hospital admission and days were 56% of the risk-adjusted Medicare dual-eligible FFS experience (2009 to 2011).
- The CMS reported all-cause 30-day hospital readmission rate in 2012 was 9%, achieving a 5-star rating.
- The permanent nursing home placement rate for nursing home certifiable SCO members between 2009 and 2011 was 34% of that seen in a Nursing Home Certifiable frail elder population in FFS care.
- The seven-year annual average total medical expense increase is 3.3% and 2.8% for nursing home certifiable and ambulatory enrollees, respectively, well below the Medicare trend.
- CMS Quality Star Ratings of 4.5 Stars for performance in 2011 and 2012 placed CCA in the 87th percentile of all Medicare Advantage Plans. No SCO program in Massachusetts has a higher rating than Commonwealth Care Alliance's SCO.
- In a recent survey, 97% of physicians agreed that Commonwealth Care Alliance "helps me achieve better outcomes for my SCO patients."

From a clinical perspective, data shows:

- 67% of Commonwealth Care Alliance members have been diagnosed with diabetes and 95% of these members received a glycosylated hemoglobin test in 2012.
- 82% of Commonwealth Care Alliance members received a flu vaccine for the 2012 flu season earning a 5-star rating.
- Commonwealth Care Alliance earned a 5-star rating for performance in 2012 on all of the following measures — BMI assessment; breast cancer screening; colorectal cancer screening; glaucoma screening; diabetic eye exams; diabetic kidney disease monitoring; annual medication review; annual functional status assessment; annual pain screening; all-cause readmissions; monitoring of physical activity; reducing the risk of falling; medication adherence for diabetes; medication adherence for hypertension; and medication adherence for cholesterol. From a cost perspective, data shows the following annual rate of total medical expenditure increase:
  - Homebound (Nursing Home Certifiable) Elders (2004–2010) = 3.3%
  - Ambulatory Elders: (2005–2010*) = 2.6%*

* *Insufficient ambulatory enrollment prior to 2005*

INTEGRATED CARE PROGRAM

Massachusetts One Care: Medicaid Plus Medicare plan is part of the national duals demonstration program under the Affordable Care Act. Its purpose is to integrate financing and delivery of care for people who are eligible for both Medicare and Medicaid in Massachusetts and are eligible for Medicare due to a disability. Today, dual eligibles nationally comprise 15% of the Medicaid population, yet account for 39% of its spending. Given the complexity of this population's needs, there is great opportunity to improve the quality and cost-effectiveness of care through care coordination and integration across the continuum of Medicare and Medicaid community services. Efforts to reduce costs and provide better care for the population have generally been ineffective under the fee-for-service environment which promotes cost-shifting between programs, at the federal and state levels. One goal of the demonstration is to improve quality of care and reduce costs by aligning these two discrete systems which are often in conflict with each other.

Massachusetts will be the first state in the country to launch this program under the national initiative. There are three health plans including Commonwealth Care Alliance participating in the demonstration in Massachusetts. Commonwealth Care Alliance will launch with the broadest geographic coverage in this initial offering, covering nine counties in total. CCA's plan is available in all areas in the state in which the program will be available, and is the sole plan offered in five of the nine counties that make up the service area.

Enrollment in the program will begin through a self-selection process and be followed by a process of passive (or auto) enrollment. Enrollees will always have the option of returning to the fee-for service option if they choose. The model of care for this program is structured to integrate primary care and behavioral health care as well as long-term support services. The One Care plans receive payment from MassHealth and Medicare and are accountable for delivery and management of the care and are at risk for the cost of the services, with certain financial risk protections.

Commonwealth Care Alliance is leveraging its current experience with both the senior population under the SCO program and its experience through its clinical group, Commonwealth Community Care, caring for individuals with severe physical disabilities, in planning for the new One Care program. We recognize that there are some important differences between the populations in the SCO and One Care programs. While both programs serve individuals who are economically challenged and receiving Medicaid, there are noteworthy differences relating to the age eligibility and other characteristics of persons eligible for Medicare due to a disability. Interestingly, the vast majority of our seniors are categorized as "nursing home certifiable," and benefit from our intensive care model. The One Care membership will be much younger, and will have a smaller percentage of individuals who need the most intensive level of services. We expect approximately 25% to be in this category. In addition, a very significant percentage of the population has serious mental health issues — either as a primary condition or as a secondary diagnosis. Therefore, our model of care for the One Care program is being modified to take into account these different population characteristics.

Target Population

Approximately 90,000 people with Medicare and MassHealth Standard/CommonHealth coverage (Medicaid), who are between the ages of 21 through 64 years, are eligible for the program. Excluded from the program are people receiving services through the home and community-based service waivers. The characteristics of this population are as follows:

- 34% have serious mental illness/70% have a mental health diagnosis
- 13% have an intellectual or developmental disability
- 54% have a chronic medical diagnosis
- 14% are high users of long term services and supports
- 28% have substance use disorders

Model of Care

The program is similar to SCO in that its focus is on enhanced primary care, care coordination/management, interdisciplinary care teams, and individualized care plans. The SCO model has been adapted for this younger population with more diverse conditions, and there are basically three variations in our care model to serve this group. We have an intensive care management model for the more complex cases, and a less intensive model called supportive care management that includes a very strong behavioral health component for those who need it. The third approach is through contracted "health homes" that may be either based on a "behavioral health home" model or a "primary care health home" model. We are partnering closely with these health homes and providing clinical support as needed. In addition to intensive behavioral health services, this program has a strong focus on long term supports and services, and members will have a long-term support and services coordinator to connect them to the services they need. Our model of care integrates primary care, behavioral health care, and long-term supports and services. Clients will have an interdisciplinary care team which can include nurse practitioners, physician assistants, physicians, social workers, physical/occupational therapists, behavioral health specialists, DME coordinators, and the member. The team will deliver or arrange every type of care needed by the individual. A personal care plan will be developed with and for the individual to determine types and levels of services. Each member will have a care manager — nurse, social worker, or other individual — depending upon the needs of the individual.

The program philosophy is based on a commitment to the independent living model, as compared to the traditional medical model.

Medical Model	Independent Living Model
• "Disability" refers to problems of individual people • Solution is care, medical treatment • Health Care Provider is competent expert • Patient's role is to cooperate • Health care provider is principle decision-maker and maintains accountability • Emphasis on acute and restorative care • Goal: safety over independence	• "Disability" refers to problems of societies that fail to accommodate differences • Solution is to change social thinking, make communities accessible • Individual is knowledgeable about own care needs • Patient is a consumer and self-advocate; empowered and accountable • Emphasis on environmental change and quality of life • Goal: self-determined life

We have unique expertise in disability competent care with our clinical affiliate, Commonwealth Community Care (formerly known as Boston Community Medical Group), and we collectively bring over 30 years of experience caring for people with disabilities and complex medical needs.

SNP Alliance
Best Practices

October 2013

Family Choice: Best Practices in Care for Nursing Home Residents

Overview of Family Choice of New York I-SNP

Independent Health's Medicare Advantage Family Choice of New York (FCNY) is an Institutional Special Needs Plan (I-SNP) operating in Erie and Niagara counties in Western New York. FCNY enrolls Medicare beneficiaries who reside permanently in a nursing facility as well as those who participate in the New York State Assisted Living Program and meet the state criteria for institutional level care. Our Model of Care/ Care Management Program is specifically designed for these individuals.

Family Choice began in 2005 as a specialized care management program for about 450 Independent Health Medicare Advantage members living in nursing facilities. In 2007, FCNY became a special needs plan. Since then, our membership has averaged approximately 1,400 members per year.

Description of the Target Population

The Family Choice of New York MOC for institutionalized members is based on the principle that appropriate medical care, treatment settings, outcomes and utilization of Medicare services for the frail institutionalized elderly is significantly different than those of more robust and functional Medicare beneficiaries residing in the community. This is true for a number of reasons, including:

- Anatomical and physiological changes that occur naturally as part of the aging process require specialized assessment, diagnostic techniques, and interventions sometimes unused in younger populations.
- The diseases of aging are chronic and degenerative in nature and institutionalized elders are older on average than elders living in the community. As a result, targeted outcomes for this group must emphasize assessment, early intervention, comfort, chronic disease management, and dignity rather than cure and restoration.
- The care of institutionalized and institutional equivalent elders is a multidisciplinary process; therefore, Family Choice of New York QI program includes the measurement of indicators that have a multidisciplinary focus.
- More than one-half of institutionalized elderly are cognitively impaired, which underscores the need for specialized care management for this population.

Demographics of the Nursing Home Population

Almost half of all people who live in nursing homes are 85 years or older. Relatively few residents are younger than 65 years. Most are women (72%), many of whom are without a spouse (60% widowed) and with only a small group of family members and friends for support.

- Some type of disability or impairment with activities of daily living (ADLs) is the most common reason that older people live in nursing homes.
- Not surprisingly, people living in nursing homes generally have more disability than people living at home.
- About one-fourth (25%) of nursing-home residents need help with one or two ADLs (e.g., walking and bathing). Three-fourths (75%) need help with three or more ADLs.
- More than one-half of residents are incontinent (either bowel or bladder).
- More than one-third have difficulty with hearing or vision.
- Dementia is the most common mental problem — and affects the majority of residents.
- More than three-fourths of nursing home residents have difficulty making daily decisions, and two-thirds have problems with memory or knowing where they are.

Demographics of Assisted Living Residents

- The majority of residents living in residential care facilities are non-Hispanic white and female. More than one-half of all residents are aged 85 and over.
- Nearly two-in-10 residents are Medicaid beneficiaries, and almost six-in-10 residents under age 65 have Medicaid.
- Almost four-in-10 residents receive assistance with three or more activities of daily living, of which bathing and dressing is the most common.
- More than three-fourths of residents have had at least two of the 10 most common chronic conditions; high blood pressure and Alzheimer's disease and other dementias are the most prevalent.

Overview of the Family Choice Model of Care and Care Management Program

People who reside in nursing homes or who live in the community but require an institutional level of care, are by their very nature frail, usually disabled, have multiple chronic conditions and are frequently in the last years of life. The Family Choice Model of Care is designed specifically around the needs of these members. It recognizes the need for increased hands-on primary care with emphasis on preventative care, frequent assessment, and early intervention to maintain the highest possible functional status, quality of life, dignity and comfort.

Family Choice understands that these goals cannot be achieved without addressing not only the individual member's medical condition, but also their psychosocial and functional needs. As a result, the model is based on: (1) an interdisciplinary approach; (2) use of a comprehensive individual plan of care; and (3) an electronic health record and continually updated clinical practice guidelines tailored to the target population.

Composition /Roles and Responsibilities of the Interdisciplinary Care Team

TEAM MEMBER	ROLES / RESPONSIBILITIES
Family Choice Nurse Practitioner or Physician Assistant (for CM 1 and CMs)	• Coordinates care and services to the members assigned to them • Visits the member at least monthly or more often as their risk level requires • Makes unscheduled visits in response to changes in the member's condition • Conducts initial and annual health risk assessment • Communicates regularly with the PCP, member, family and other members of the team. • Oversees the member's Individual Plan of Care
Primary Care Physician	• Visits the member at least every 60 days and more often as needed • Responds to call from the Mid-Level Practitioner (MLP- A Nurse Practitioner or Physician Assistant) • Provides guidance and oversight of medical care provided to members
Family Choice Registered Nurse	Supports the MLP in visits to assisted living members The Transition RN supports members through the transition process
Family Choice Social Worker	• Assesses members' psychosocial needs on admission and annually • Makes regular visits to members who require psychosocial interventions • Assists members/responsible parties to document their health care wishes and advance directives • Works collaboratively with facility social service staff to identify members' needs
Care givers (Nursing Facility or Assisted Living Staff)	• Deliver care as ordered by the PCP and MLP • Notify the MLP of changes in the member's condition
Member/Family/Responsible Party (RP)	Provide input on preferences for health care delivery
Network professionals including specialty physicians; mental health professionals; pharmacists; physical, occupational and speech therapists; and others who may be asked to participate in the interdisciplinary care process based on the individual member needs identified by the Interdisciplinary Care Team.	

Individual Plan of Care and Electronic Health Record

The FCNY Individual Plan of Care is composed of the entire contents of the member's Family Choice of New York Electronic Health Record. The essential elements are: All MLP assessments; visit notes, and on-call MLP notes; communications with the member/RP and PCP; member demographic data and advance directives, social service assessments, and visit notes; and health risk assessment score and medication list. It is a living document that is continually updated as the member's needs and preferences change.

Clinical Practice Guidelines (CPGs)

Although many medical organizations have developed written and/or electronic clinical practice guidelines, none exclusively address the diseases and conditions, both chronic and acute, that are common to residents of long-term care facilities or those living in the community who require an institutional level of care. It is critical for FCNY to continually provide consistent, effective and efficient care management services that are tailored to our special member population. Our proprietary Clinical Practice Guidelines are designed specifically for the members we serve and form the basis for our Care Management Program.

The FCNY Chief Medical Officer, Medical Directors, Associate Medical Directors and a group of experienced geriatric physicians have developed the CPGs. They are updated annually and whenever FCNY physicians and physician members of the Quality Improvement Committee identify new clinical best practices in current literature.

FCNY Stakeholder Satisfaction Outcomes

Indicator	Threshold	2013 Jan-July Ave. FCNY Performance Outcomes
Satisfaction Outcomes		
Appeals	**0**	**0**
Grievances	**0**	**0**
Family Satisfaction	**90% positive**	**97.5%**
Member Satisfaction	**90% positive**	**99%**
PCP Satisfaction	**90% positive**	**97%**
NF Satisfaction	**90% positive**	**97%**

Examples of Innovative I-SNP Care Delivery Processes that Improve Member Outcomes and Resource Utilization

1. In an effort to eliminate needless hospital admissions, FCNY developed a "Treat-in-Place" program. When the member's nurse practitioner/physician assistant and/or the facility staff identifies a change in the member's condition that would otherwise result in a hospital transition, FCNY places the member on skilled level care in the nursing facility. Without changing locations or even beds, the member can receive services such as IV hydration or antibiotics, physical therapy or intensive wound care. FCNY reimburses the facility at a special Treat-in-Place rate. The result has been a significant reduction in hospital admissions and re-admissions and improved member outcomes due to the ability to treat the member in their own surroundings with clinicians especially sensitive to the needs of frail patients with complex conditions.
2. FCNY includes staff social workers on the interdisciplinary team. This has been very effective in responding to member' psychosocial needs. For example, the social worker meets with the member and family and helps them understand their treatment options and document their preferences. As a result, over 90% of our members have documented health care directives.
3. To reduce hospital readmissions within 30 days of discharge, FCNY conducts an Acute Transition Analysis Report on every hospital admission to identify the causes of the transition and determine if it could have been avoided. When a readmission within 30 day occurs, the clinical team conducts a Frequent Admission Analysis to identify possible causes and interventions. As a result, FCNY's readmission rate averages only 14%.

SNP Alliance Best Practices

October 2013

SCAN: Best Practices in Care for Nursing Home Certifiable Beneficiaries at Home

Background

SCAN Health Plan (SCAN) is the nation's fourth largest not-for-profit Medicare Advantage (MA) plan, serving nearly 145,000 members in California and Arizona. SCAN's mission is to find innovative ways to enhance seniors' health and independence and SCAN is dedicated to providing comprehensive medical coverage, prescription benefits, and support services specifically designed to meet the unique needs of seniors.

Since its founding in 1977, SCAN has provided the care needed to keep more than 50,000 seniors out of nursing homes, despite the vulnerability and frailty of its members. SCAN has demonstrated experience with the aging and long-term care populations under both the Medicare and Medicaid programs.

SCAN's I-SNP

SCAN's Institutional Special Needs Plan (I-SNP) serves members who are "institutional equivalent" — who live in the community but require an institutional level of care. Many of these members were initially part of CMS' Social HMO demonstration. When the Social HMO ended, this Plan Benefit Package (PBP) closed to any new enrollments in 2009 and 2010 and transitioned to an Institutional-Equivalent SNP. In 2011, enrollment was reopened for those meeting nursing facility level of care (NFLOC) and residing in their own home.

Currently, SCAN's I-SNP enrolls 5,068 members in Los Angeles, Orange, San Bernardino, and Riverside counties in Southern California. These members meet the state's NFLOC criteria of two or more Activities of Daily Living (ADL) impairments, are typically frail, and generally require caregiver support and assistance in managing their chronic conditions. Because of their complex health status, many members have difficulty accessing and utilizing appropriate levels of care and managing their medications.

A Member-Centric Model of Care

SCAN's I-SNP employs an integrated medical/social approach to managing vulnerable individuals. In addition to the CMS Model of Care requirements, SCAN has a suite of care management programs addressing an individual's needs at each stage of the health care continuum. SCAN's care management programs incorporate member education and coaching to enhance self-management skills, medication reconciliation across care settings, behavioral health care coordination, and referrals to community-based resources.

All I-SNP members are enrolled in a care management program, ranging in intensity from complex care management and disease management to care coordination and monthly monitoring. Care management and coordination at SCAN consists of several different programs working concomitantly in addressing needs for the frail elderly population:

- Complex Care Management (CCM) reduces acute care by emphasizing prevention, self-care, access to care, and the coordination of medical care and community services. Interventions are tailored to the member's clinical, functional, and social needs.
- Disease Management (DM) for Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).
- Care Coordination: SCAN has a variety of services and programs to help coordinate care for this population. Through targeted outreach calls, the SCAN Buddy Program helps remove barriers to accessing preventive health services, remind members to make doctors' appointments, and prompt effective doctor/patient communication.

  Some I-SNP members are also dually-eligible. Given the complexity of Medicaid eligibility, benefits, and services, SCAN developed a Personal Assistance Line (PAL) program to provide culturally sensitive and specialized expertise to access benefits from both programs.
- The SCAN Memory Program is designed for members with dementia and their caregivers, and is based on a proactive model that assesses member status and anticipates and prepares for care management issues that may arise.

Additional benefits for this SNP include:

- Transportation to medical appointments
- In-home meal delivery after hospitalizations
- Emergency-Response Systems for members at risk for falls

Successes

A primary contributor to older adults' quality of life is their ability to remain independent and at home. SCAN's entire care management team is focused on helping members with functional limitations achieve their goal of independence, remaining at home and in improved health. Data show that SCAN has achieved a high level of success. In 2012, 91% of members indicated that SCAN helped them manage their health more effectively, and 84% indicated that SCAN helped them improve their ability to live independently. In 2012, approximately 92% of SCAN I-SNP members were able to remain in their own home and avoid long-term care in a facility. In addition, SCAN's All-Cause Readmission Rate for the I-SNP is 9.83%, well below the Medicare national average of 14%[1].

[1] NCQA (2012) – www.ncqa.org/portals/0/Publications/2012%20BI_NCQA%20ReAdMi%20_Pub.pdf

Success Story

While conducting a member's annual I-SNP assessment, SCAN's care manager discovered that the member's authorization for oxygen had expired and her son had been paying privately for the equipment. To complicate matters, the member had changed PCPs since the original authorization and was unable to visit her new PCP without a portable O2 concentrator in order to obtain a needed medical evaluation to reauthorize the oxygen. The care manager diligently worked with the PCP's staff to expedite an urgent referral for a home health assessment. As a result of these efforts, the member was assessed in her home and her oxygen was delivered the very next day. The member was also referred to the physician groups' House Calls program.
During the course of the I-SNP assessment, the care manager also learned that the member's sister (who wasn't yet due for her annual reassessment) was extremely frail, at a dangerously low weight, and had not been seen by her PCP since 2011. The care manager was able to coordinate an expedited referral so that this member was assessed by the home health nurse in conjunction with her sister's visit. As a result, the member was also referred to the House Calls program.

This story demonstrates true compassion and care of members, working diligently to keep members independent and in their own homes, and demonstrates the importance of the efficiency of care coordination efforts.

Challenges

Despite these successes, membership in the ISNP is declining — this is due to death, difficulty identifying new members in the community, challenges differentiating benefits (such as no in-home support), and stricter eligibility criteria (revised state NFLOC interpretation).

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