SNP Alliance

The National Voice for Special Needs and Medicare-Medicaid Plans

A National Nonprofit Leadership Organization

Annual SNP Alliance Member Survey

Selected Findings & Implications

WEDNESDAY, APRIL 22, 2020 – VIRTUAL SESSION – MEMBERS ONLY

SESSION FOCUS: SNP & MMP SURVEY INFO

- *This session will provide highlights from the 2019 SNP Alliance member survey.*
- *We will offer summary information about observed differences by plan type and insights on quality measurement priorities and social determinants of health and provide comment/comparisons.*
- *We will discuss how plans and the SNP Alliance have been responding to these issues.*

Speaker: *Deborah Paone, DrPH, MHSA, Performance Evaluation Lead & Policy Consultant, SNP Alliance, DC; dpaone@snpalliance.org*

MEMBER SURVEY

Part 1:
Enrollment
Utilization
Conditions

Part 2:
Quality measurement
SDOH

Background: Total Medicare Advantage enrollment = 22 million individuals in 2019 (34% of all Medicare beneficiaries); SNP enrollment is about 14% of all MA enrollment; SNP Alliance represents about 2/3 of all SNPs.

Sources: Kaiser Family Foundation, "A Dozen Facts about Medicare Advantage in 2019", June 2019; CMS monthly reports; SNPA Data

Thank you *to these participating member health plans!* *(N=21 Plans Responding in 2019)*

2019 Survey, *ALL* Respondents N=21 (88%)

Thank you to participating health plan members who completed either Part 1 (Quantitative) or Part 2(Qualitative) or both parts of our 2019 survey:

*AIDs Healthcare Foundation***	*Independent Care Health Plan*
*Brand New Day***	*LA Care Health Plan*
Blue Plus MN (HMO Minnesota)	*Medica*
CareMore/Anthem	*Molina*
*Care Oregon***	*SCAN Health Plan*
Care Wisconsin	*Senior Whole Health/Magellan*
Commonwealth Care Alliance	*UCare*
ElderPlan	*United***
Gateway	*UPMC*
HealthPartners	*WellCare/Centene*
HCSC	

**** Responded to only one portion of the survey**

2019 reporting of CY2018 data

Respondents – Quantitative Portion Only (Part 1)

SNP type	***# of Orgs.***
C-SNPs	4
D-SNPs	11
FIDE-SNPs	12
I-SNP	4
MMPs	8

Selected Findings on:
Enrollment Characteristics & Utilization

Part 1 of
Annual Survey

Methods:
Excel Spreadsheet

Plan Team Respondents:
Data Analytics,
Population health
Gov't Programs

Age of Enrolled Member

	D-SNP = 11 *Approx. 302,000 members*	C-SNP = 4 *Approx. 62,000 members*	I-SNP = 4 *Approx. 9,200 members*	MMP = 8 *Approx. 137,000 members*	FIDE-SNP = 12 *Approx. 83,700 members*	*Nat'l Data: Medicare-only beneficiaries (1)*	*Nat'l Data: Dual Eligible Beneficiaries (2)*
< Age 65	47%	22%	17%	47%	3%	10%	39%
65-84	48%	70%	39%	46%	78%	79%	50%
85+	5%	8%	44%	7%	19%	11%	11%

Highlights:

- ***I-SNPs have the highest proportion of members of advanced age (44% at 85+)***
- ***FIDE-SNPs have the greatest proportion of members age 65+ (97%)***
- ***MMPs and D-SNPs have similar member profiles in terms of age distribution, with almost 50% of membership under age 65***

Sources for National Data: (1) MedPAC, ***Report to Congress***, June 2019 (Chapter 4)
(2) CMS, MMCO ***Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006-2018***, September 2019

Selected Conditions

	D-SNP = 11 *Approx. 302,000 members*	C-SNP = 4 *Approx. 62,000 members*	I-SNP = 4 *Approx. 9,200 members*	MMP = 8 *Approx. 137,000 members*	FIDE-SNP = 12 *Approx. 83,700 members*	*All MA Plans* (includes SNPs)
Diabetes w/Complications	29%	57%	26%	14%	35%	20%
COPD	24%	20%	23%	18%	18%	14%
Vascular, Thrombosis	23%	35%	63%	18%	28%	19%
CHF	16%	17%	26%	13%	18%	12%

Highlights:

- ***C-SNPs have the highest percentage of members with Diabetes (some C-SNPs specialize in this disease)***
- ***SNP populations have greater prevalence of these chronic conditions as compared to average in all MA plans***
- ***I-SNP populations have much higher prevalence of vascular disease/thrombosis***
- ***MMP populations are similar to MA average for these chronic conditions***

Sources for National Data: (1) MedPAC, *Report to Congress*, June 2019 (Chapter 4)
(2) CMS, MMCO, *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006-2018*, September 2019
(3) MedPAC, Health Care Spending and the Medicare Program, Data Book, June 2019

Selected Conditions

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Major Depression, BiPolar	**25%**	**25%**	**41%**	**22%**	**26%**	**12%**
Drug, Alcohol Dependence	**11%**	**17%**	**22%**	**9%**	**7%**	**4%**

Highlights:

- ***All SNPs and MMPs have a higher percentage of members with major depression/bipolar disorder than the MA average***
  - ***I-SNPs percentage is over 3X MA average***
- ***All SNPs and MMPs have a higher percentage of members with drug/alcohol dependence than the MA average***

Sources for National Data: (1) MedPAC, *Report to Congress*, June 2019 (Chapter 4)
(2) CMS, MMCO *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006-2018*, September 2019
(3) MedPAC, Health Care Spending and the Medicare Program, Data Book, June 2019

Selected Utilization

Enrollment- weighted mean was used to aggregate and report

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% w/ Hosp Admission	15%	14%	16%	19%	19%	14%
% w/ ER visits	40%	28%	27%	36%	33%	29%
% w/ Observation stays	6%	6%	9%	7%	7%	Not reported
%/ Medicare Skilled Home Health visits*	17%*	6%*	**	8%*	19%*	Not reported

NOTES: * We found wide variation across these plans (even within plan type) for proportion of members ***receiving home health visits***. This may indicate area for greater data capture--MedPAC's analysis of encounter data revealed more frequent gaps--plans had incomplete data reporting or capture -- around home health care visits (MedPAC *Report to Congress*, June 2019)

** Not enough data to report

Source for MA data: MedPAC Report to Congress, March 2019 (reporting 2016 data)

Focus on the Dually-Eligible

	D-SNP = 11	C-SNP = 4	I-SNP = 4	MMP = 8	FIDE-SNP = 12	*All MA Portion DE*
Duals as a Proportion of Enrollment	***10 plans out of 11 had 90-100% duals*** **96%***	***Among these plans most enrollees were not dually eligible*** **35%**	***Among these plans less than half of enrollees were dually eligible*** **41%**	6 plans with sufficient data to report ***All had 97-100% duals*** **99.7%***	***11 plans out of 12 had 88-100% duals*** **98%***	**14%**
% Full Benefit Duals out of all Duals	**6 out of 11 had above 90% of duals as Full Benefit** (smaller plans) **Weighted avg: 73%**	**Of the members who were duals, 80% were full benefit**	**Of the members who were duals, 94% were full benefit**	**Of the members who were duals, 98.4% were full benefit**	**Of the members who were duals, 100% were full benefit**	
% Partial Benefit Duals	**5 out of 11 had between 10-40% partial duals** (larger plans) **Weighted avg: 27%**	**20% were partial duals** (of the members who are dually eligible)	**6% were partial duals** (of the members who were dually eligible)	**1.6% were partial duals** (of the members who were dually eligible)		

*Temporary loss of Medicaid eligibility within the course of the calendar year suppresses this being at 100%.

Sources for National Data: (1) MedPAC, *Report to Congress*, June 2019 (Chapter 4)
(2) CMS, MMCO *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006-2018*, September 2019
(3) CMS, MMCO, *People Dually Eligible for Medicare and Medicaid,* Fact Sheet, March, 2020

Focus on the Dually-Eligible

FY 2019 Report to Congress

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Dual population growing slightly faster than Medicare only population

Between 2006 and 2018, the total number of dually eligible beneficiaries increased at an average annual rate of 2.9% to 12.2 million, whereas Medicare-only beneficiaries increased at an annual rate of 2.7% to 50.7 million.

Disability status is much higher among dually eligible beneficiaries

- In ***2018***, 38.6 % of dually eligible beneficiaries had disability as their current Medicare status, compared to only 8.4 percent of Medicare-only beneficiaries

Dual eligible population has a higher prevalence of chronic conditions

- 70% of dually eligible individuals have three or more chronic conditions (vs. 52% of Medicare-only beneficiaries)
- 41% have at least one mental health diagnosis (vs. 16% of Medicare-only beneficiaries)

This report and other analytic products can be accessed at the CMS Medicare-Medicaid Coordination Office analytics webpage: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-MedicaidCoordination-Office/Analytics.html.

MEDICARE-MEDICAID COORDINATION OFFICE
Centers for Medicare & Medicaid Services
FACT SHEET – MARCH 2020

People Dually Eligible for Medicare and Medicaid

FIGURE 2
Share of Medicaid and Medicare Enrollment and Costs Associated with Dually Eligible Individuals[6]

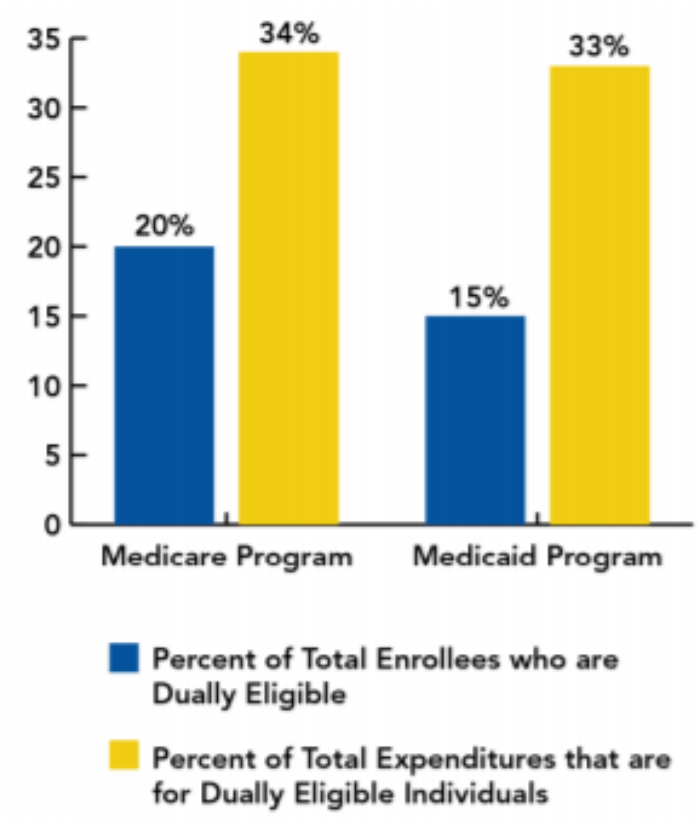
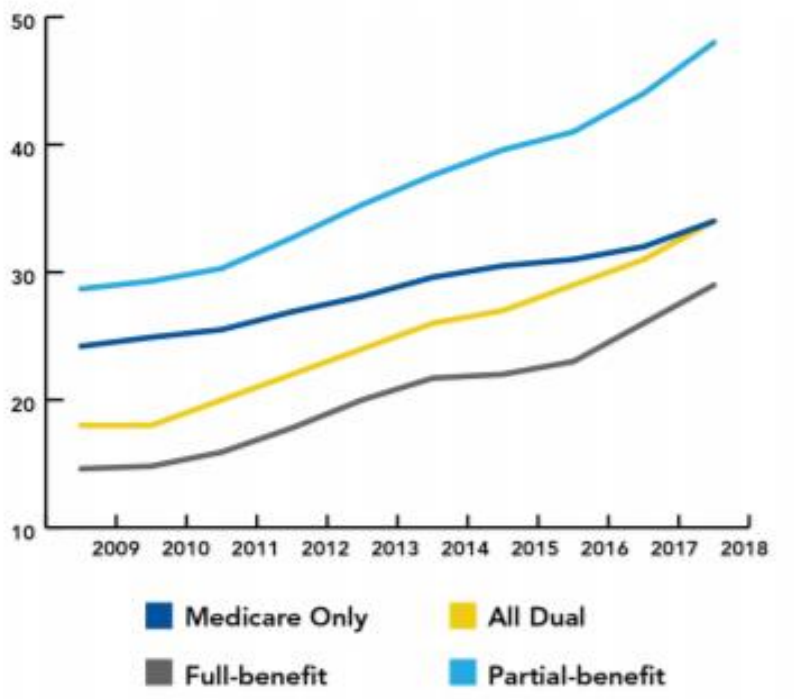


FIGURE 4
Medicare Managed Care[8]

Among dually eligible individuals (full- and partial-benefit) 37 percent were enrolled in Medicare managed care in 2018, up from 18 percent in 2009.



Questions?

Executive Summary

- ***Special Needs Plans and Medicare and Medicaid Plans are different from general Medicare Advantage plans.***

AND

- ***All Special Needs Plans and Medicare Medicaid Plans are NOT the same . . . they have significant differences by SNP or MMP type in population characteristics, including:***
  - ***Age distribution***
  - ***Number and type of chronic disease and behavioral health conditions***
  - ***Dual status***

Selected Findings on:
Quality Measurement, Care Models, Social Determinants

Part 2
of Annual Survey

Methods:
E-survey

Plan Team Respondents:
Quality Leads, Clinical & Care management Services, Compliance, & Population health

Examining Aspects of Models of Care

Focus on: *Health Risk Assessment*

1. ***Improving Health Risk Assessment Completion Rate*** is a priority ("Most Important" 12/18)
2. *Having a **better system/data capabilities for mining, analyzing, aggregating sharing and acting on HRA** information across plan and with providers* ("Most Important" 11/18)
3. *Changing HRA processes, methods to **improve member responsiveness*** ("Most important" 8/18)
4. *Reducing the **time/costs** of HRA* ("Most important" 8/18)
5. *Making our HRA **more comprehensive*** ("Already done" 14/18)
6. ***Having a connected approach between HRA and complex care management approach*** *(*"Already done" 10/18)

Examining Aspects of Models of Care

Insights & Issues around: *Health Risk Assessment*

1. ***Member refusal or avoidance*** (multiple attempts to reach, leave messages, send letters, texts, emails, but no response) is high—individuals already inundated with requests for information. Plans also report that cultural issues, health beliefs, language/wording issues and other diversity issues play a part in resistance to HRA.
2. ***HRAs are not standardized*** (nationally); States that also require HRA having specific tools, domains, or processes required—very hard when working across States. Also definition of "completion" differs; all of this variation makes it hard to ensure even comparisons and to analyze.
3. Plan vs. Delegate Care Coordinator ***conducting HRA*** –advantages, disadvantages, challenges
4. Lack of common/shared and integrated data platform/I.T. an issue; a barrier to ***integrated outreach, care response, reporting***

Medicare Quality Measures – Top Concerns

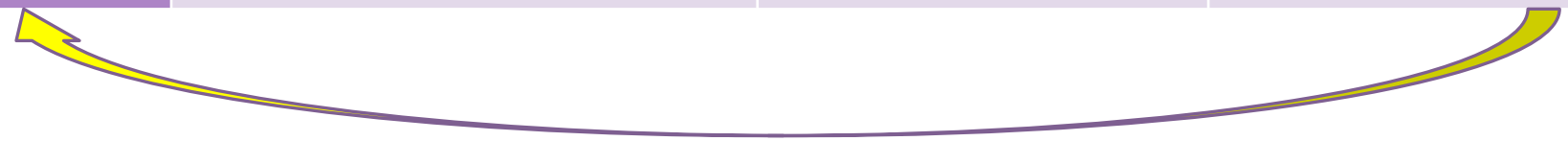
What are your <u>top concerns</u> with regard to Medicare quality measures? *(weighted 1 through 5, with 1 being of utmost importance, having quality and financial implications)*

1. **HOS derived measures** – *HOS self-report survey, measures, methods do not accommodate the SNP/MMP population* (15/18 ranked 1 or 2 top concern)
2. **Cut points** – *Star measure cut points vary year to year, little difference between 3, 4, and 5 star thresh holds or are topped out* (12/18 ranked 1 or 2 top concern)
3. **SDOH** - *Measures are not adequately risk adjusted for social risk/SES factors which are prevalent in our SNP population* (12/18 ranked 1 or 2 top concern)

These 3 issues have been the top concerns for member SNPs & MMPs for the last four years

Example of Measurement Challenge: *Small Respondent Sample Size for HOS*

SNP Health Plans' Data on HOS Respondents			
Total H# Enrollment In Follow-up HOS measurement year	**Baseline** HOS Respondents (Time 1) *CMS randomly selects 1200 members to survey.*	**Follow-up** HOS Respondents from Time 1 who responded in Time 2	**Proportion of total enrollment** that the HOS cohort represents which was used in Stars measurement
8,887	404	171	1.9%
11,500	1173	248	2.2%
47,932	474	101	0.2%
10,945	413	199	3.8%
1,579	208	99	6.3%
9,100	336	219	2.4%



Insight:

SNPs deploying ways to find quality or experience issues without waiting for HOS & CAHPS survey results

Member plans continue to report challenges with the Health Outcomes Survey and CAHPS self-report measures.

However—plans are finding ways to gather member self-report and experience information without depending on HOS or CAHPS survey results

SNP Alliance

Strategies around Member Feedback & HOS/CAHPS

- Health Plans conduct **their own off-cycle or targeted item surveys using** CAHPS & HOS
- SNP **members invited to in-person Stakeholder meeting twice yearly for in-depth conversation around HOS and CAHPS results**
- Plan has incorporated some **HOS and CAHPS items into Member Experience surveys and feedback communication**
- Plan conducts **additional surveys and interviews around specific plan actions**, e.g., care coordination services

NOTE: *One issue reported, especially by smaller plans, is the survey vendor cost of tailored and off-cycle surveys. Another issue is the challenge (lack of) provider bandwidth to attend to and respond to results. Providers are in multiple plan networks and have other quality measurement initiatives internally.*

2019 Survey Results on QI with Providers:

2/3 of Plans report they have Quality Improvement projects specifically for their SNP/MMP members where they are working with a set of providers and sharing/analyzing data to evaluate effect

MEASURE focus: Transitions of Care

NCQA made changes to HEDIS measures in 2018. We surveyed members on the ***Transitions of Care*** measure and found 50% of plans reported substantial problems with the measure, with 17% reported some problems. The overwhelming issues raised were:

- **Heavy provider burden- timeliness of documentation on notification & receipt, access to information by health plan, need for extensive chart review**
- **Out of health plan control (data and actions to achieve measure are controlled by providers)**
- **Regulatory hurdles (e.g., treatment programs; confidentiality of data)**

While we understand and appreciate how this is an area of healthcare that could be improved and could have substantial impact to the member, this is a measure for which health plans have little control
The administrative burden is a substantial hurdle. Providers struggle with the turn around times. Challenges include complications with multiple software systems (ex. EHR, Care Management software) to allow data to be ingested into the members medical record. Integrated health plans will have a clear systematic advantage.
Issues: timeliness of notification from hospital systems, inconsistent access to discharge plans, and the regulatory challenges with being able to be notified when members are entered into treatment programs for AODA.

Current SNPA Work & Changes RE: Stars…

SNPA WORK

- **HOS -**
  - SNPA *HOS White Paper* (2018) & meeting w/ CMS Medicare Quality Director & team (2019)
  - *HOS Coalition Statement* (2018)
  - Comment letters – Advance & Final Call Letters, Proposed & Final Rules (2016-2020)
- **Cut-Points & Attention to** high dual/disabled/LIS populations
  - SNPA Comment letters to CMS
  - SNPA sits on the RAND Stars TEP (2018-2020)
- **SDOH Adjustment**
  - Stratification - request for modeling/testing/reporting
  - SNPA letters, meetings, calls indicating need for many measures to be stratified/adjusted
- **New Measures, Exclusions**
  - SNPA Comment letters to CMS, NCQA; meetings & calls

CHANGES (LAST FEW YEARS)

- **HOS**
  - **CMS** proposes increase in sample size and additional case mix adjustment for HOS (2020)
- **Cut-Points**
  - **CMS** sets guardrails for variation year over year and proposes other methodological changes to increase stability and improve utility/accuracy of Star thresh holds
- **SDOH Adjustment**
  - Measures added to the *Categorical Adjustment Index* (first 6, then 9, then many of the measures added)
  - **NCQA** agrees to stratify measures that are sensitive to dual/disabled/LI characteristics of the population
- **New Measures, Exclusions**
  - **NCQA** excludes 9 measures from Stars rating for I-SNPs and signals intent to address same issues among NHLOC members (FIDE-SNPs)
  - **NCQA** made some adjustments to the TOC measure in early 2020.

From RAND TEP on Medicare Stars – November 7, 2019

How many contracts fall under a single Parent Organization?

Of 306 Parent Organizations in 2019, the majority have only a single contract (i.e., contract and Parent Organization are one and the same).

But there are a small number of very large Parent Organizations that have more than 5 contracts:

- *3% have between 6 and 10*
- *1% have between 11 and 30*
- *2% have more than 30*

Current approach is most Star measures and Rating is at the Contract level

# of Contracts	%age of Parent Organizations	# of Parent Organizations
1	63%	192
2	17%	51
3	8%	25
4	4%	12
34	<1%	1
46	<1%	1
69	<1%	1

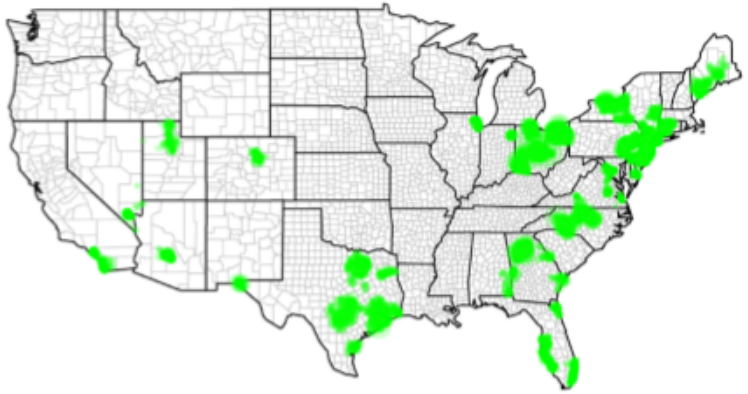
https://www.rand.org/content/dam/rand/pubs/conf_proceedings/CF400/CF417/RAND_CF417.presentation.pdf

From RAND TEP on Medicare Stars – November 7, 2019

Contract service areas vary in size

- Beneficiaries might find it hard to compare contracts using contract-level measures of performance

Contract 1001 Service Area

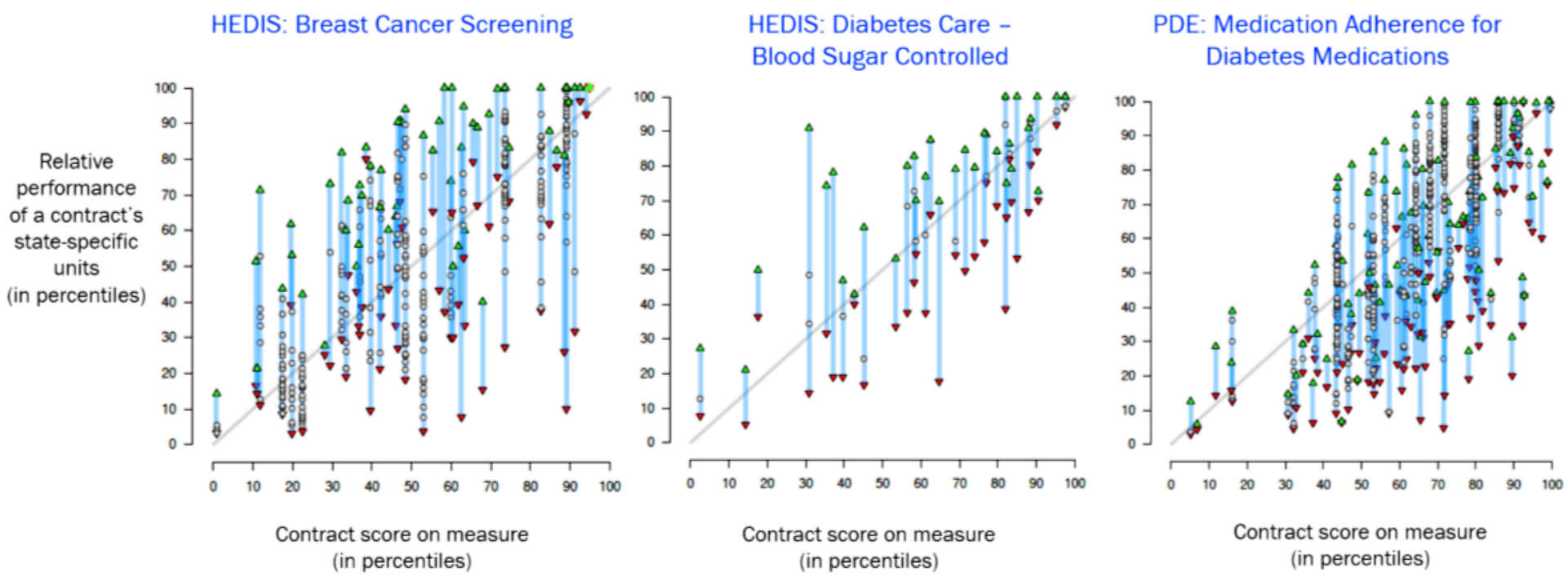


Contract 1002 Service Area

- "Local" measurement of contract performance could help beneficiaries compare among plans in their local areas

From RAND TEP on Medicare Stars – November 7, 2019

High-performing contracts are not necessarily high performing across all states in which they operate

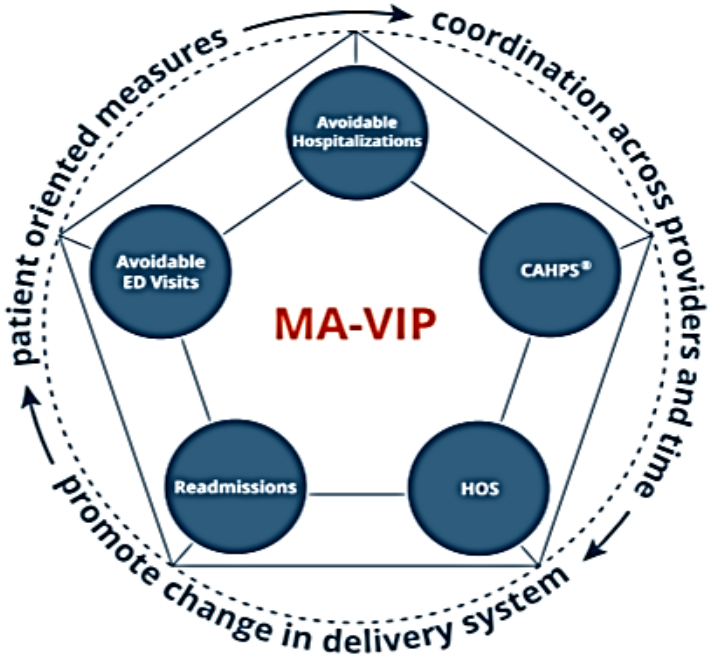


Only geographic units located in states with greater than or equal to 10 contracts meeting sample size and/or reliability criteria for the measure are depicted

VOICES CALLING FOR CHANGE: *MedPAC*

MedPAC's Proposed *Value Incentive Program* to Replace Medicare Stars Quality Bonus Program (Report to Congress, June 2019) See: http://medpac.gov/-public-meetings-/meeting-details/march-2020-public-meeting

- Commission plans to design this program to ***replace*** the current QBP.
- ***Removes*** NCQA HEDIS® measures and PQA PDE measures.
- Administrative measures ***removed***; plans to be held accountable for insurance functions through compliance standards rather than quality programs.
- Quality calculated for each Parent Organization within a local market.
- Scoring methodology uses ***prospective*** performance targets.
- Uses peer groups (i.e., fully dual-eligible beneficiaries versus non-fully dual-eligible beneficiaries) to convert quality measure performance to financial rewards and penalties.
- ***Applies budget neutrality*** to the MA quality payment program.
- Aligns a small group of measures with other programs to reduce burden on providers.
- Measurement should be largely calculated or administered by CMS, preferably with data already being reported, such as ***claims and encounter data***.



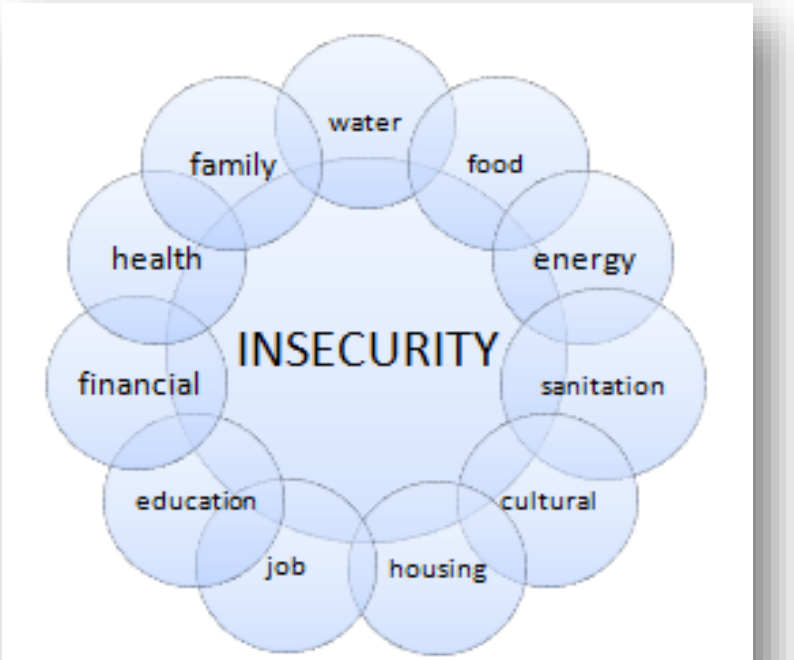
GORMAN HEALTH GROUP

Thanks to the Gorman Group – from their 2019 Star Ratings Summit

Examining SNP/MMP Populations

Focus on: ***Social Determinants of Health***

The SNP Alliance Survey revealed plans are using multiple data sources to locate social determinant of health risk factor information on their members, in order to proactively reach out, and tailor care strategies



Top SDOH Risk Factors reported in 2019 SNP Alliance Annual Survey

(Input from plan care managers was requested to respond to this question):

The top SDOH observed risk factors reported were:

- Low income/poverty (83% reporting this as a top issue)
- Lack of available mental health services and supports in the community (72%)
- Housing instability/transience (72%)
- Lives alone/few social supports (61%)
- Low health literacy/education (50%)
- Transportation challenges (38%)
- Food insecurity (33%)

N=18 plans

2019 Annual Survey Result:

Typical Data Sources for SDOH Factors:

- Health risk assessments
- Internal care management records
- Member services information gathered through phone contact
- Claims data, encounter data, including ICD-10 “z” coded visits
- Member surveys
- Initial member enrollment forms
- Medical record information from providers
- External care management records
- State long-term services and supports data
- State Medicaid data
- American Community Survey data
- Census data
- County data, county health rankings
- Community (regional) health assessments

Limitations Reported

- ***Lack of standard*** SDOH elements or screening tools; different definitions, time periods, and granularity of data
- ***Barriers to reaching and engaging*** the member; transience of living arrangements impacts person and participation; also the individual may not wish to answer SDOH related questions
- ***Timeframe, decay***, and ***sensitivity*** of information
- ***Multiple organizations*** and service providers asking about SDOH - who, when, what, how….burnout, information overlap or misalignment
- SDOH information may be ***hard to access, search, aggregate*** (e.g., written note in progress note or service/visit record)
- Concern about identifying needs without having the community or other resources ***able to respond timely, effectively—linking and building capacity important***

How Plans are Making Use of SDOH Data they Have:

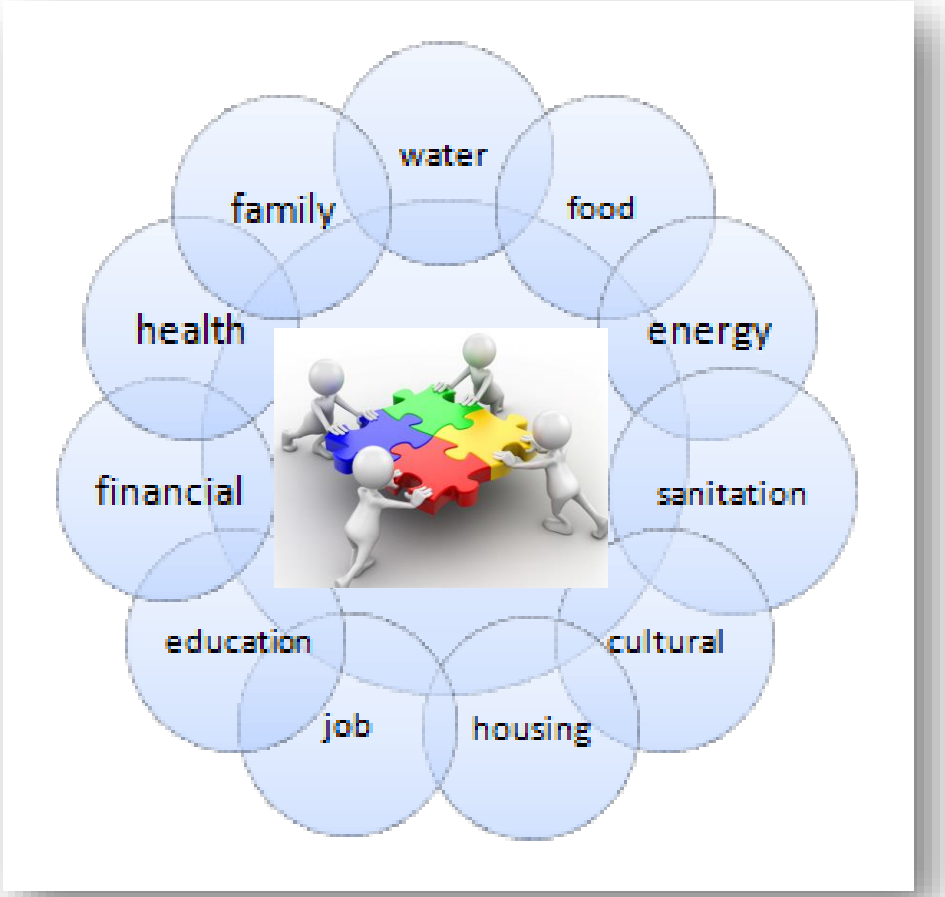
1. For ***member outreach and education***
2. To modify ***care management strategies and methods***
3. To modify ***Model of Care***
4. To analyze **quality reports/results**
5. Modify ***member materials and education***
6. To modify ***customer servicer/member services protocols***
7. To change their ***algorithm/stratification on identifying high risk groups***

Collaborative SDOH-focused Partnerships

Last 3 years' (2017-2019) of
SNP Alliance Annual Survey results indicate plans have **active** partnerships to serve individuals with care and SDOH complexity.

<u>2019 Data on Partnership Areas:</u>

- ***Food: 67%*** (N=12/18)
- ***Transportation: 67%*** (N=12/18)
- ***Housing: 56%*** (N=10/18)
- ***Social Support: 47%*** (N=8/17)
- ***Health Literacy: 47%*** (N=8/17)



From most recent Survey – partnerships

Housing – Our health outreach workers have expertise in helping members attain/retain housing. We also pay a small care management fee to an organization that provides housing to some of our marginally housed seniors. Transportation – We provide over 5,000 rides every month for members, including significant non-emergency transportation, partnering with a regional organization. Meals - We partner with several meal delivery organizations and medically tailored meal organizations to provide home-delivered meals for members who need them.

Key Partnerships & Services for our SNP members include: A Place for Mom https://www.aplaceformom.com; Meals on Wheels - https://www.mealsonwheelsamerica.org/; Life Springs- http://www.lifespringmeals.com/ Med Trans: https://www.natmedtrans.com/ Aunt Bertha: https://www.auntbertha.com/ Altegra (Golden Touch): http://altegrahealth

Questions?

Executive Summary

- ***Special Needs Plans and Medicare and Medicaid Plans have invested substantially in care models, processes, methods to reach and serve their populations and begin to address SDOH issues with partners.***

- ***These plans report significant challenges with the current Medicare quality measurement system.***

LOOKING AHEAD: *2020 Annual Survey*

- ***Timeframe:*** *Discuss (May/June); Revise/"test" (July/August), Distribute (September)*
- ***Revisions:*** *Recognition of 2020 PHE/COVID-19 effects*
- ***Opportunity:*** *Potential of this unique data set to present SNP/MMP sole focus on complex care vulnerable populations*
- ***Action:*** *Engage in the PE/Quality Leadership Group – this membership group leads the SNPA work around performance evaluation, including the Annual Survey*
  (PE/Quality call is second Wednesday of every month from 1-2 ET
- *For more information contact: Deborah Paone - dpaone@snpalliance.org*

Discussion

Addendum: Additional National Data

National Trends:

Special Needs Plans

& MMPs

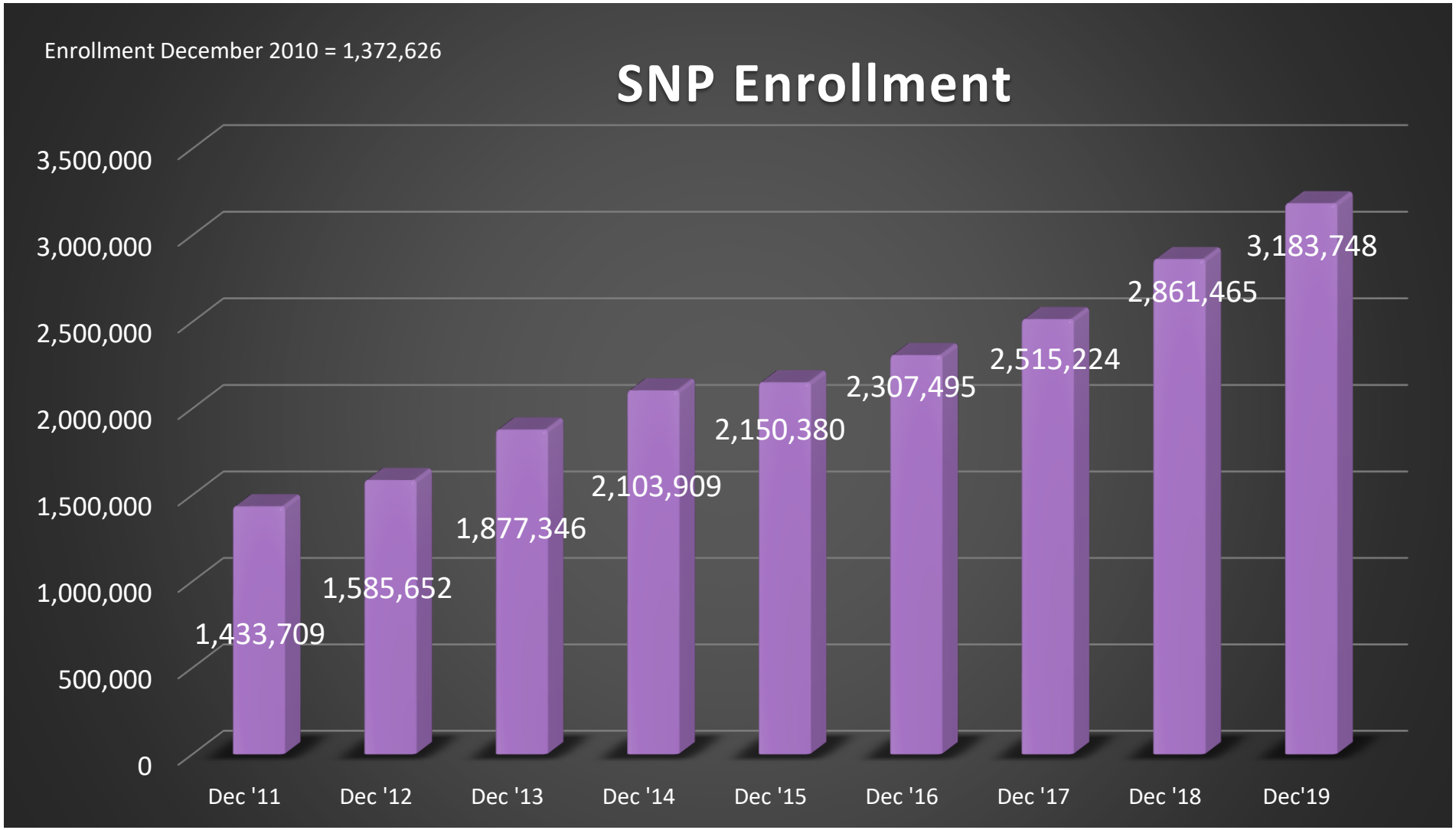
Compared to all Medicare Advantage Plans

Looking at 5-year MA Trends

National Data (CMS) – 2019-2015

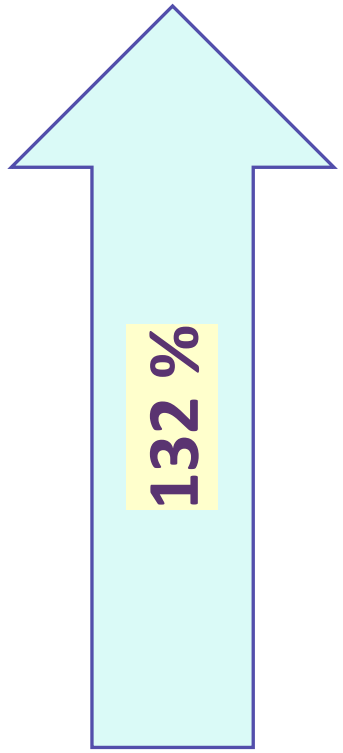
- Growth overall – MA and SNPs
- MA enrollment grew 35%
- SNP enrollment (all types) grew 53%
- MMP enrollment grew 20%

Sources: *MedPAC March 2020 Report to Congress: Medicare Payment Policy*
MedPAC March 2016 Report to Congress: Medicare Payment Policy
ICRC Monthly MMP Enrollment March 2019 to March 2020



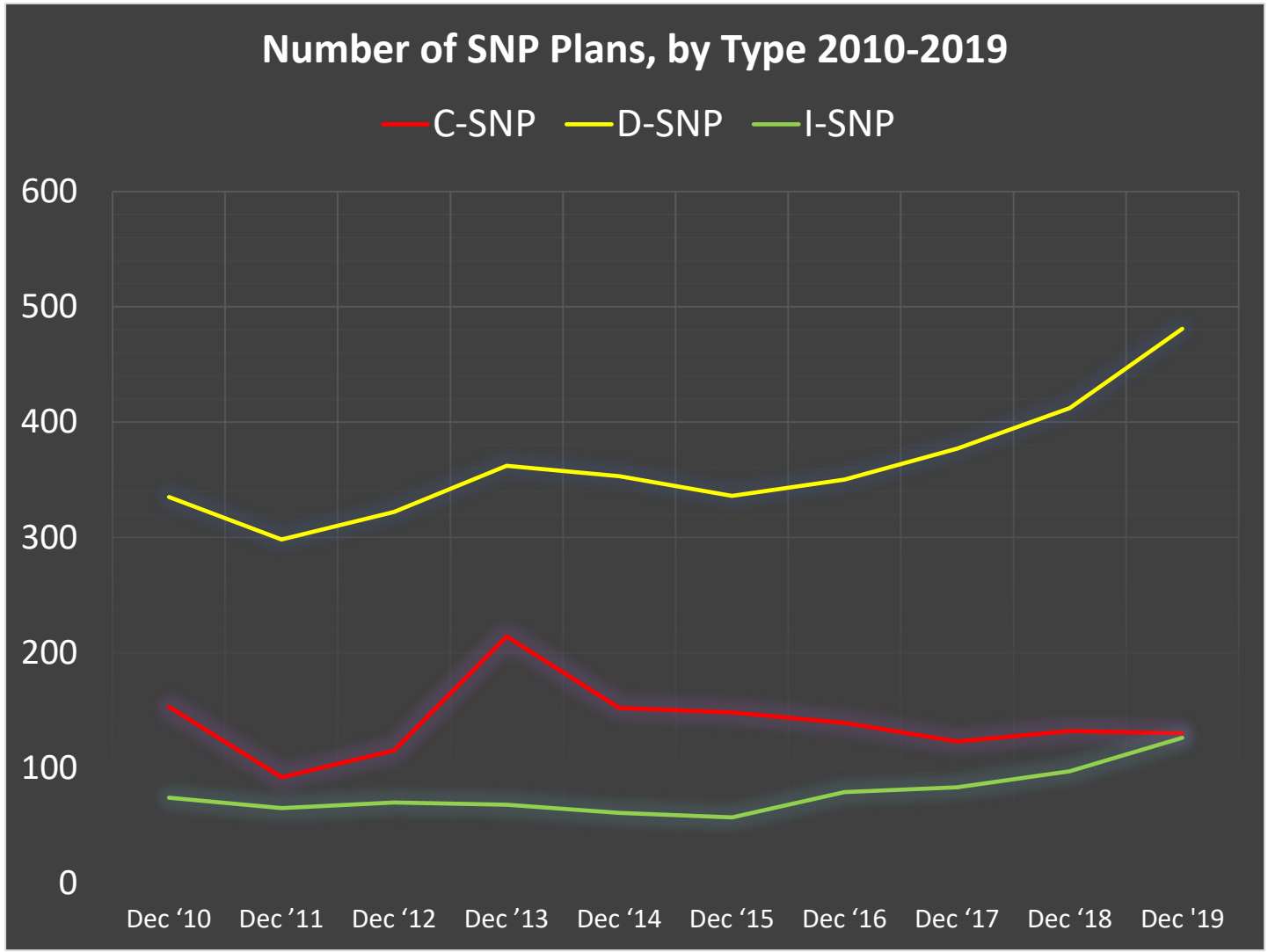
10-year Enrollment Growth

(since Dec 2010)



Source: CMS; Monthly Reports - https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

Number of SNP Plans – 10 Year View				
Time Period	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**
Dec ‘14	152	353	61	**566**
Dec ‘15	148	336	57	**541**
Dec ‘16	139	350	79	**568**
Dec ‘17	123	377	83	**583**
Dec ‘18	132	412	97	**641**
Dec ’19	129	480	125	**734**



Source: CMS; Monthly Reports - https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

From: ***A Dozen Facts about MA in 2019***

Gretchen Jacobson, Meredith Freed, Anthony Damico, and Tricia Neuman, KFF

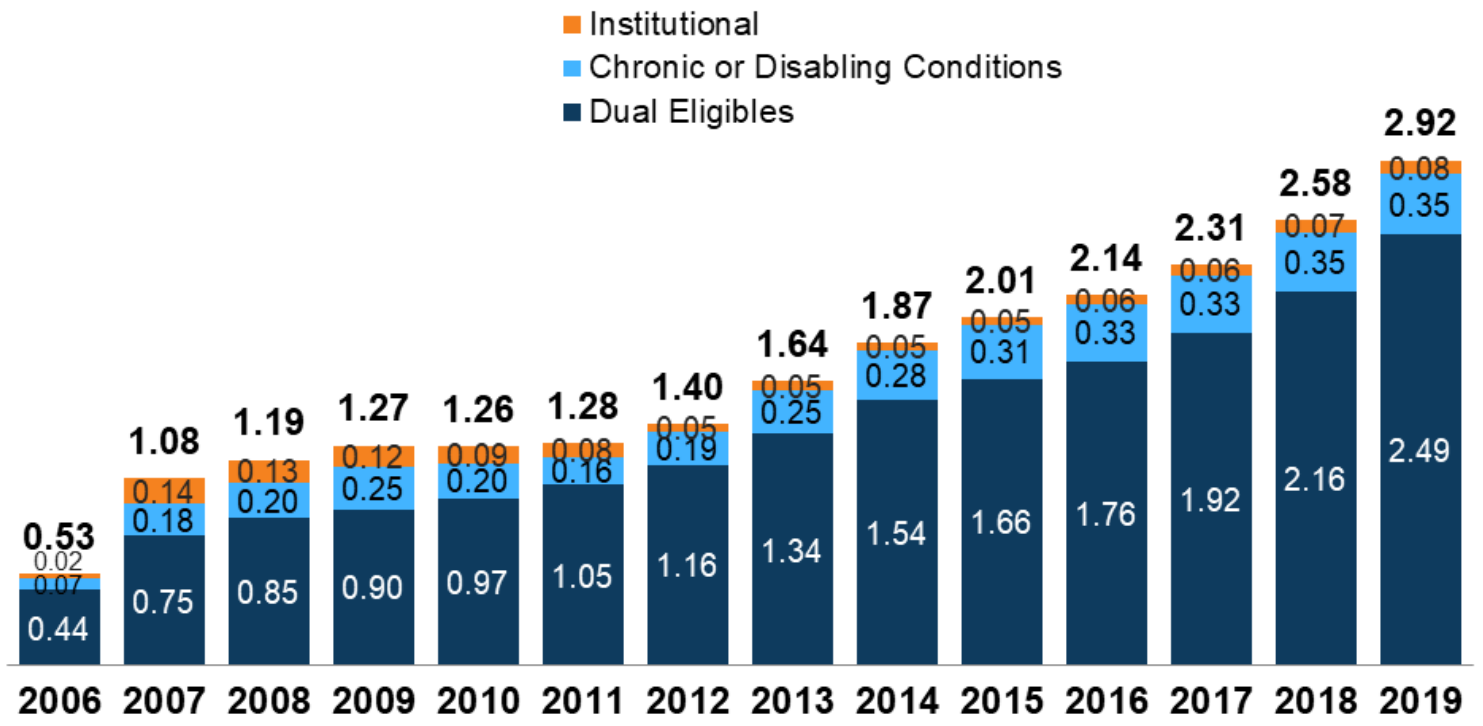
- ✓ Enrollment in SNPs increased modestly last year.
- ✓ In 7 states, DC and PR, enrollment in SNPs comprised at least 20% of Medicare Advantage enrollment

(51% in DC, 49% in PR, 25% in SC, 22% in NY, 21% in AR, 20% in AZ, 20% in FL, 20% in GA, and 20% in TN).

- ✓ Most C-SNPs enrollees (93%) are in plans for people with diabetes or cardiovascular disorders in 2019.
- ✓ Enrollment in I-SNPs has been increasing but is still less than 100,000 beneficiaries.

Figure 12

Number of Beneficiaries in Special Needs Plans, 2006-2019 (in millions)



NOTE: Numbers may not sum to the total due to rounding. Includes enrollment in Puerto Rico.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2006-2019.

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https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/