eAppendix

Data Description

This study utilized two separate claims-based databases from 2014 and 2015. First, in order to obtain information on I-SNP beneficiaries, we accessed a unique longitudinal database of all UnitedHealthcare I-SNP data. This database contains the claims for UnitedHealthcare I-SNP members submitted to the plan by the nursing homes and other plan providers (e.g., physicians, hospitals, etc.). UnitedHealthcare I-SNP records and claims in the database are generally for Part A and B services in which the site code is inpatient (hospital, skilled nursing facility, etc.), outpatient, or the emergency room. These are claims that a nursing home and individual providers would have submitted to Medicare if the beneficiaries were enrolled in traditional Medicare.

Health care utilization on traditional Medicare beneficiaries was obtained from the CMS 5% Sample Limited Data Set. The 5% sample includes Part A (inpatient) and Part B (physician, outpatient) claims. This sample draws from individuals all over the country, including the markets in which UnitedHealthcare I-SNPs are in operation.

Sample Construction

Identifying long-stay residents

In order to qualify for coverage, all individuals in the I-SNP are long-term nursing home residents. However, it can be challenging to identify long-term nursing home residents using Medicare fee-for-service claims. In order to identify the timing of long-term nursing home residence in the fee-for-service 5% sample, we used a validated methodology.¹ The approach leverages the “place of delivery” code to identify whether physician services were delivered in the nursing home. The presence of physician claims delivered in the nursing home setting is used to positively identify Medicare FFS beneficiaries who are long-stay nursing home residents.

Identifying mature I-SNP nursing homes

Facilities were considered to be “mature” in terms of their I-SNP model adoption if they met the following criteria: (1) 12 months involvement with the I-SNP model, (2) an I-SNP membership of at least 30 residents, and (3) 30% of the long stay population enrolled in the I-SNP. Nursing homes not meeting these criteria were unlikely to have altered practice patterns in
meaningful ways. Therefore, I-SNP members in these non-mature facilities were excluded from our analyses.

Ultimately, 755 of the 1,065 nursing homes in operation in the geographic areas included in the study were identified as mature I-SNP facilities. Relative to national averages, these 755 nursing homes were fairly similar in terms of ownership (after excluding government-owned facilities) but more likely to be part of a chain. Additionally, these nursing homes were larger, on average, relative to other nursing homes.

Reference