



Medicare Special Needs Plans Structure & Process Measures 2010 Performance Results

November 1, 2010

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CMS Contract No. HHSM-500-2006-00060C

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Executive Summary

Background

The National Committee for Quality Assurance (NCQA) assessed Medicare Special Needs Plans (SNP) against five¹ measures of Structure & Process (S&P) quality selected and developed for their relevance to the populations served by SNPs.

- SNP 1—Complex Case Management
- SNP 2—Improving Member Satisfaction
- SNP 3—Clinical Quality Improvement
- SNP 4—Care Transitions
- SNP 6—Coordination of Medicare and Medicaid Coverage

NCQA assessed all three types of SNPs under this program: Dual-Eligible (272 plans); Severe or Disabling Chronic Condition (115 plans); and Institutional (60 plans). In 2010, 447 SNPs were required by CMS to be assessed by NCQA, compared with 702 SNPs assessed in 2009. This drop in number was primarily a result of consolidation among SNP benefit packages. Total enrollment of SNPs increased, so the average enrollment in a SNP benefit package is larger than last year. When reviewing aggregate SNP performance, it is important to note that Dual-Eligible SNPs comprise both the majority of plans (61 percent) participating in the SNP program and the majority of members (73.5 percent) enrolled in SNPs.

Only new SNPs that had not been evaluated in 2009 were required to be assessed against SNP 1–SNP 3, because existing SNPs performed well on these measures last year. Six new plans were evaluated under SNP 1–SNP 3.

These S&P measures, combined with a set of clinical HEDIS^{®2} measures collected from SNPs that are described in a companion report, give CMS a broad assessment of the ability of SNPs to deliver key quality health care services to their members.

Findings

NCQA believes the most significant assessment findings are:

- Care transitions is an area that needs improvement (see 1, below)
- Dual-Eligible SNPs are meeting NCQA's requirements to coordinate Medicare and Medicaid benefits (see 2, below)
- New SNPs are not performing as well as previous cohorts (see 3, below)
- There are differences in performance among individual SNPs and SNP types (see 4 and 5, below).

¹No SNPs were assessed against *SNP 5—Institutional SNPs' Relationship With Facilities* because this measure applies only to Institutional SNPs not assessed in 2009, and there were no new Institutional SNPs to assess.

²HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

1. **SNPs had the lowest scores in the *Care Transitions* measure (SNP 4).** Managing transitions is a well-documented weakness of the U.S. health care system. However, Congress, with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), created SNPs for the purpose of better coordinating the care of individuals with special needs.
 - The lowest percentages of SNPs met the national benchmark³ on the first two elements of SNP 4: Managing Transitions (55 percent) and Supporting Members Through Transitions (60 percent).
 - Although many SNPs had lower scores on transitions elements, they did well on certain factors within the elements. Eighty-nine percent of SNPs met two of the factors in SNP 4: identifying planned transitions such as elective surgery and coordinating services for members shown to be at high risk of a transition, such as a hospitalization.
 - factors requiring Many SNPs had policies in place for transitions but were unable to demonstrate evidence of the policies' implementation—they did not provide reports or materials to show how they actually conduct specific actions required to meet the measure's specifications.

2. **SNPs scored high on *Coordination of Medicare and Medicaid Coverage* (SNP 6).** It is important to note that SNP 6 has more demanding requirements for Dual-Eligible SNPs than for Chronic and Institutional SNPs. Because Dual-Eligible SNPs are required by law to enroll dual-eligible members, they need to have additional systems in place to coordinate Medicare and Medicaid benefits.
 - **Performance by Dual-Eligible SNPs.** Dual-Eligible SNPs have both rigorous requirements and high performance. More than 89 percent met the national benchmark on all three elements that apply only to Dual-Eligible SNPs; those elements cover assisting members with benefits, administratively coordinating benefits and working with state Medicaid agencies.
 - **Performance by Chronic and Institutional SNPs.** The largest range in performance was in Element D (coordinating benefits, including Medicaid eligibility), where 33 percent of Chronic SNPs and 98 percent of Institutional SNPs met the national benchmark. This element applies only to Chronic and Institutional SNPs.
 - **Characteristics of performance across SNP type.** Element E, Service Coordination, is the one element in SNP 6 that applies to all SNP types. Most often met were factors covering assisting members with services. Least-often met were factors regarding educating providers about both types of coverage, and analyzing the adequacy of the SNP's network for providers that accept both Medicare and Medicaid payment.

3. **The six new SNPs did not score as well on *Complex Case Management* (SNP 1), *Member Satisfaction* (SNP 2) and *Clinical Quality Improvement* (SNP 3) as SNPs that reported these measures in 2009.**
 - In 2009, an average of 88 percent of new SNPs met the national benchmark across elements and the average for the six new SNPs was 35 percent.
 - Three SNPs are Private Fee-for-Service (FFS) plans, a different model from most SNPs. With such small numbers, it is difficult to determine whether the model type made a difference in performance.

4. **NCQA saw a wide range of performance across the *Structure & Process* measures.** The following shows the range of performance:
 - **Complex Case Management (SNP 1).** Of the six newly reporting SNPs required to report, between one and three met the national benchmark on the elements.

³ To gauge performance, NCQA created "national benchmarks," which is the percentage of plans that score ≥80 percent on each element that makes up the measures.

- **Improving Member Satisfaction (SNP 2).** Of the six newly reporting SNPs required to report, between one and six met the national benchmark on the elements.
- **Clinical Quality Improvement (SNP 3).** Of the six newly reporting SNPs required to report, one met the national benchmark on the element.
- **Care Transitions (SNP 4).** Of the 447 SNPs required to report, between 55% and 79% of SNPs met the national benchmark on the elements.
- **Coordination of Medicare and Medicaid Coverage (SNP 6).** Of the 447 SNPs required to report performance, between 87% and 95% of SNPs met the national benchmark on the elements.

5. Not only is there differences among SNPs, but there are differences in performance between SNP types.

- Overall, the Institutional SNPs scored the highest on most elements and factors, especially those that involve direct service to patients and providers
- For Dual-Eligible and Chronic SNPs, parts of the Care Transitions measure (SNP 4) showed the lowest performance among returning SNPs. The Care Transitions measure requires managing the clinical process of transferring a member's care plan from one setting to another, as well as communicating important clinical information to members and providers

Objectives and Background

Objectives

Note: Throughout this report, “SNP” or “plan” refers to SNP benefit packages, which are options offered by many organizations under their MA contracts. “MA plans” refers to the collection of Medicare Advantage (MA) products (both SNP and non-SNP benefit packages) offered by an organization through an MA contract.

This report presents the third year of results for SNPs reporting S&P measures developed by CMS and NCQA. CMS contracts with NCQA to conduct a SNP assessment program, which has two parts:

1. Collect data on HEDIS measures chosen for SNPs and analyze results. NCQA submitted the draft report on SNP 2010 HEDIS results on September 28, 2010. The HEDIS measures describe both process and outcomes of care provided under SNPs.
2. Review data submissions on S&P measures developed for SNPs, and analyze the results. The S&P measures support evaluation of SNPs in areas where use of clinical performance measures is not possible for a variety of reasons, including small numbers or lack of data sources. This report presents that analysis.

The report’s objectives are:

- Describe the context in which NCQA developed the S&P measures
- Present a series of tables illustrating numerically SNPs’ performance on the measures, including the percentage of plans that met the 80 percent national benchmark on each element and the percentage of plans that met each factor in each element.
- Analyze the results and provide commentary on their meaning—how SNPs performed, by type and by size, and how the SNPs’ submitted documentation led to their scores.

SNP Overview

SNPs were created by Congress as part of the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the dual eligible; the institutionalized; and individuals with severe or disabling chronic conditions. SNPs are a subgroup of Medicare Advantage (MA) plans. Unique among MA plans, SNPs may limit enrollment.

- *Dual-Eligible SNPs* coordinate benefits and services through Medicare and Medicaid
- *Institutional SNPs and Chronic SNPs* focus on the special needs of those two populations.

Legislation stated that SNPs should emphasize monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries maintain or improve their health status.

Congress has since passed additional legislation extending the authorization for SNPs, beyond the period set in the law that created them. Originally, SNP authority was set to expire in December 2008. Several pieces of legislation have extended the program. Most recently, the Patient Protection and Affordable Care Act:

- Extended SNPs through 2014
- Changed all (including SNP) MA payments by reducing payments differentially by county and adding a pay-for-performance system based on quality rating
- Charged CMS with exploring different approaches to risk adjustment for certain types of SNPs
- Called for SNP enrollees who are not in the special SNP categories to be moved out of SNPs

- Delayed the requirement that dual SNPs contract with states until 2012
- Added a requirement that SNPs be NCQA approved.

Table 1 below outlines the primary differences between SNPs and MA plans.

Table 1. Key Differences Between SNPs and Standard MA Plans⁴

Categories	SNPs	MA plans
Enrollment	<ul style="list-style-type: none"> • Must limit enrollment to targeted special needs individuals. • May target subsets of specific populations (e.g., beneficiaries with CHF or diabetes). • Dual-eligible and institutionalized beneficiaries may enroll and disenroll throughout the year. Chronic care beneficiaries have a one-time enrollment option outside of standard enrollment periods. • One-time passive enrollment of dual-eligibles in 2006 (individuals covered under both Medicare and Medicaid). 	<ul style="list-style-type: none"> • Must be open to all Medicare-eligible beneficiaries. • Lock-in provision for all enrollees with an open-enrollment season.
Benefits	<ul style="list-style-type: none"> • Standard MA benefits. • Must offer Part D prescription drug coverage. 	<ul style="list-style-type: none"> • Standard MA benefits. • Part D coverage is voluntary.
Payments	<ul style="list-style-type: none"> • Standard MA geographic payment schedule, with PMPM payments risk-adjusted by hierarchical condition category (HCC) scores. 	<ul style="list-style-type: none"> • Standard MA geographic payment schedule, with PMPM payments risk-adjusted by hierarchical condition category (HCC) scores.
Marketing	<ul style="list-style-type: none"> • May target specific populations in the market area. • May target subsets of specific populations (on a case-by-case basis) within the market area. 	<ul style="list-style-type: none"> • Must include all Medicare-eligible beneficiaries in the market area.

The SNP program began in 2004 with 11 SNPs, and grew to 702 by February 2008. For 2010, data from the February 2009 SNP Comprehensive Report (Table 2) show a major change in the number of SNPs—back to 447, fewer than were in existence in 2007. At the same time, total population covered by SNPs increased by 4 percent from 2009–2010 (Table 2). There are 255 fewer SNPs reporting to NCQA than in 2009, a decrease of 36 percent. With the decrease in number of plans and increase in enrollment, the overall average covered population per SNP increased from 1,528 to 2,495.

Most beneficiaries are dual-eligible. The range of enrollment is from fewer than 30 members to over 62,000.

Since 2008, CMS has required that all SNPs, regardless of size, report S&P measures each year. In 2009, CMS required every SNP benefit package (identified by a CMS Plan ID) with 30 or more enrollees to also submit audited HEDIS results each year. SNP listed in the *February SNP Comprehensive Report* as having 29 members or fewer are not required to submit HEDIS measures the following year.

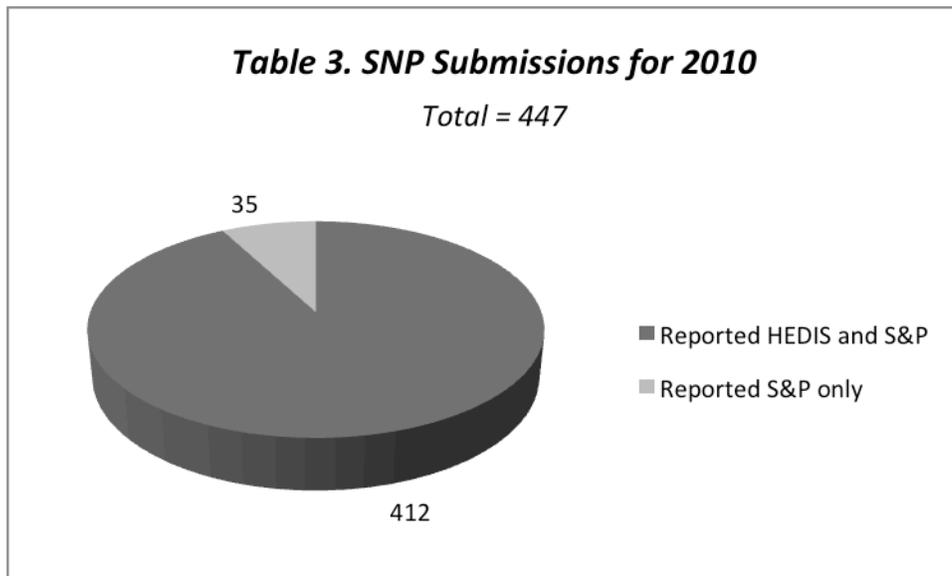
⁴ CMS. *Special Needs Plans—Fact Sheet & Data Summary* <http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FSNPFACT.pdf>

Table 2. SNP Enrollment from *SNP Comprehensive Report* by SNP Type, 2009 and 2010*

SNP Type and Year	SNPs Required to Report S&P Measures	
	Number of SNPs	Subtotal Enrollment
Chronic or Disabling Condition 2010	115	173,479
Dual-Eligible 2010	272	820,262
Institutional 2010	60	121,849
2010 Total	447	1,115,590
Chronic or Disabling Condition 2009	217	165,815
Dual-Eligible 2009	402	769,475
Institutional 2009	83	137,573
2009 Total	702	1,072,863

*SNP enrollment for 2010 was calculated based on the *SNP February 2009 Comprehensive Report* available at www.cms.gov. Enrollment for 2009 was calculated from the February 2008 report.

Table 3 illustrates the total submissions for the S&P measures and HEDIS measures during the 2010 data collection period. Four hundred forty-seven SNPs reported the S&P measures, while 412 also reported the HEDIS measures. Only 381 were required by CMS to report HEDIS measures; an additional 31 reported voluntarily.



Assessing SNP Performance

With the initial rapid growth in the number of SNPs and the MMA requirement to evaluate SNPs, CMS established a performance assessment process that focused on the “specialness” of SNPs.⁵ In March 2007, CMS asked NCQA to develop an assessment approach that would define and assess desirable structural characteristics of SNPs, as well as measure processes and outcomes of care. NCQA developed a phased approach that gradually became a comprehensive system for understanding the quality of care provided to SNP members, considering specific needs.

For the initial 2008 assessment of SNPs, NCQA adapted existing S&P measures based on its current Health Plan Accreditation standards:

- *SNP 1 :Complex Case Management*
- *SNP 2 :Improving Member Satisfaction*
- *SNP 3: Clinical Quality Improvement*

In 2009, CMS and NCQA added measures that more specifically address areas of quality related to SNP populations:

- *SNP 4: Care Transitions*
- *SNP 5: Institutional SNP Relationship With Facility*
- *SNP 6: Coordination of Medicare and Medicaid Coverage*

2010 is the second year of reporting on the added measures.

Anatomy of an S&P Measure

S&P measures evaluate how well SNPs perform in major important areas.

A **measure** is an overall statement of the desired area of performance, accompanied by an explanatory **intent statement**. Each measure consists of one or more **elements**, which are detailed statements of sub-areas in the measure requirements. Each element comprises **factors**, which describe specific functions SNPs are expected to perform.

NCQA establishes scoring guidelines that lead to a score on each **element** of **100%, 80%, 50%, 20%** or **0%**. Scores are based on the number of **factors** in the element met by the plan. NCQA and CMS agreed to set the national benchmark for element score at 80%. Refer to Tables 6, 9 and 12 for lists of the measures, elements and factors evaluated for 2010.

The S&P Evaluation

NCQA requires SNPs to submit documentation, including policies and procedures, and reports showing how they implement the policies and procedures. The review process, conducted by NCQA trained surveyors and overseen by NCQA executives, is similar to NCQA’s process of Health Plan Accreditation.

Because S&P measures evaluate processes that do not change significantly from year to year, CMS has not required SNPs to undergo evaluation on every measure, every year. In NCQA’s voluntary Accreditation

⁵ CMS Legislative Summary, April 2004 Summary of H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. Accessed: August 2008. <http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf>

programs, health plans are assessed every three years on NCQA standards (similar to S&P measures) and yearly for HEDIS reporting. With that model in mind, CMS did not require SNPs that reported in 2009 (operational in 2009 and renewed for 2010) to report SNP 1–3 and 5 in 2010, but did require them to report SNP 4 and SNP 6, since the scores for those measures were, on average, lower than desired in 2009. In addition, focusing attention on transitions and on coordinating dual coverage are key areas, with particular importance for SNP beneficiaries.

SNPs new to the program for FY 2010 were required to report all measures (SNP 1–6). Table 4A shows the SNP assessment reporting requirements, including HEDIS measures, for 2010. Table 4B gives further detail on the elements of S&P measures required by SNP type.

Table 4A. SNP Assessment Requirements FY 2010

Applies to SNPs With Contracts in FY 2009
S&P Measures
<ul style="list-style-type: none"> • Case Management* • Improving Member Experience* • Improving Clinical Care* • Care Transitions** • Institutional SNP Relationship With Facility* • Coordination of Medicare and Medicaid Coverage**
Clinical Measures—HEDIS 2010
<ul style="list-style-type: none"> • Colorectal Cancer Screening • Glaucoma Screening in Older Adults • Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Pharmacotherapy of COPD Exacerbation • Controlling High Blood Pressure • Persistence of Beta Blocker Treatment After a Heart Attack • Osteoporosis Management in Older Women • Antidepressant Medication Management • Follow-Up After Hospitalization for Mental Illness • Annual Monitoring for Patients on Persistent Medications • Potentially Harmful Drug-Disease Interactions • Use of High Risk Medication in the Elderly • Care for Older Adults*** • Medication Reconciliation Post-Discharge*** • Board Certification

*Newly reporting SNPs only

**All SNPs

*** SNP-only HEDIS measure

Table 4B. S&P Measures Reporting Requirements for 2010

Measure/Element	Returning SNPs Required (Y or N)	Newly Reporting SNPs Required (Y or N)	SNP Type Exceptions
SNP 1: Complex Case Management			
A: Identifying Members for Case Management	N	Y	
B: Access to Case Management	N	Y	
C: Case Management Systems	N	Y	
D: Frequency of Member Identification	N	Y	
E: Providing Members With Information	N	Y	
F: Case Management Process	N	Y	
G: Informing and Educating Practitioners	N	Y	
SNP 2: Improving Member Satisfaction			
A: Assessment of Member Satisfaction	N	Y	
B: Opportunities for Improvement	N	Y	
SNP 3: Clinical Quality Improvements			
A: Relevance to Members	N	Y	
SNP 4: Care Transitions			
A: Managing Transitions	Y	Y	
B: Supporting Members Through Transitions	Y	Y	
C: Identifying Unplanned Transitions	Y	Y	
D: Reducing Transitions	Y	Y	
SNP 5: Institutional SNP Relationship With Facility			
A: Monitoring Members' Health Status	N	Y	Chronic/Duals
B: Monitoring Changes in Members' Health Status	N	Y	Chronic/Duals
C: Maintaining Members' Health Status	N	Y	Chronic/Duals
SNP 6: Coordination of Medicare and Medicaid Coverage			
A: Coordination of Benefits for Dual-Eligible Members	Y	Y	Chronic/Institutional
B: Administrative Coordination for Dual-Eligible Benefit Packages	Y	Y	Chronic/Institutional
C: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages*	Y	Y	Chronic/Institutional
D: Administrative Coordination for Chronic Condition and Institutional Benefit Packages**	Y	Y	Dual-Eligible
E: Service Coordination**	Y	Y	

Other Exceptions:

* Element 6C is not applicable (NA) for Dual-Eligible SNPs in states that do not enter into agreements with SNPs or if state agencies refuse to enter into agreements; however, SNPs must provide documentation to demonstrate this.

** Element 6D and 6E are NA for chronic and institutional SNPs with fewer than 5% dual-eligible members.

Support for the Evaluation Process

In addition to assessing SNPs, NCQA provided support by educating SNPs about required measures, data collection and data submission tools. Most prominently, CMS and NCQA held a conference in January 2010 that featured national leaders in quality care for older adults and focused particularly on care transitions. NCQA also held 24 training sessions that covered the following topics.

- An introduction to NCQA and SNP assessment (an overview of how NCQA created HEDIS and S&P measures and how it collects and measures data)
- The SNP subset of HEDIS measures
- The NCQA Interactive Data Submission System (IDSS) (for HEDIS results)
- S&P measures
- The NCQA Interactive Survey System (ISS) (for S&P measure results)

More than 1,000 people attended the sessions; some attendees participated in more than one session. NCQA created the introduction specifically for SNPs that were new to NCQA or the to the SNP assessment program, and targeted those plans with telephone and e-mail outreach.

NCQA also held four “open-door forum” conference calls, presented at stakeholder and industry conferences, and provided numerous individual and ad-hoc consultations. The conference calls allowed SNPs to ask questions and get clarification from NCQA’s SNP assessment team prior to data submission.

To promote accurate, consistent review of plan results, NCQA provided three training sessions on evaluating S&P measures (one all-day, in-person session and two Webinar training sessions) and weekly calls for surveyors. NCQA also engaged key industry stakeholders; for example, the SNP Alliance, America’s Health Insurance Plans, Blue Cross Blue Shield Association, and the Association for Community Affiliated Plans.

As in previous years, NCQA provided information to SNPs through e-mail reminders and updates to the NCQA Web site, which posts FAQs and policy updates and allows organizations to submit questions via the Policy Clarification Support (PCS) system.

The Measure Development Process

The process used to develop the SNP measures included identifying issues most relevant to the SNP population; translating evidence and guidelines into measures; field-testing; and a Public Comment period. The Geriatric Measurement Advisory Panel (GMAP), convened by NCQA at the direction of CMS, reviewed all SNP requirements. The GMAP includes leading geriatricians, representatives of managed care organizations, providers, consumers and policy makers, and provides guidance on the development and maintenance of measures that focus on care provided to Medicare beneficiaries.

Structure & Process Measure Results

S&P measures assess how SNPs perform specific functions that affect members' quality of care. There are four Structure and Process measures that only newly reporting SNPs had to report in 2010.

- *SNP 1: Complex Case Management*
- *SNP 2: Improving Member Satisfaction*
- *SNP 3: Clinical Quality Improvement*
- *SNP 5: Institutional SNP Relationship with Facilities.*
 - This measure applies only to Institutional SNPs; there were no Institutional SNPs newly reporting in 2010

Refer to Table 4B for the complete list of elements required for reporting by newly reporting and returning SNPs.

CMS required all SNPs to report on the following two measures:

- *SNP 4: Care Transitions*
- *SNP 6: Coordination of Medicare and Medicaid Coverage.*

The first section below describes the number of SNPs reporting in 2010, followed by statistics on overall performance in 2010.

The remaining sections of the report are organized by measure. Each section includes tables that show performance by SNP type and enrollment size. Because so few new plans are reporting on SNP 1–3 and none are reporting on SNP 5, this report focuses on SNP 4 and 6—the most challenging measures and the measures that all SNPs were required to report.

S&P Measure Submission

All SNPs that were required to report S&P measures did so. Of these, 441 are returning and six are newly reporting. Of the six, four were Dual-Eligible SNPs and two were Chronic SNPs; there were no newly reporting Institutional SNPs.

Overall Performance (Tables 5A and 5B)

The tables in this section show performance on all required measures, by element. For each element, the number and percentage of SNPs at a given score are provided—where 100% indicates the highest level of performance on the factors and 80% shows the percent of SNPs that met the benchmark. We provide separate tables for returning SNPs and new SNPs (new SNPs report on more measures).

Table 5A—for returning SNPs—shows that SNPs tend to score higher on *SNP 6: Coordination of Medicare and Medicaid* than they do on *SNP 4: Care Transitions*. It is worth mentioning, however, that Dual-Eligible SNPs have different reporting requirements for SNP 6 than do the Chronic and Institutional SNPs. Within SNP 4, SNPs scored highest on Element C, Reducing Transitions, and scored lowest on Element A, Managing Transitions. Performance is highest on SNP 6 on administrative coordination of dual-eligible benefit packages by Dual-Eligible SNPs, and lowest on Service Coordination by all SNPs. Comparison within SNP 6 is somewhat challenging because different elements apply to different SNP subgroups.

Table 5B shows the performance of the six new SNPs across all the SNP measures. In general, scores on these measures are relatively low compared with those of returning SNPs—with percentages at the national benchmark ranging from 0%–50% (one plan scored 100% on one element), compared with the range for returning SNPs at 56%–96.3%. Among the different measures, new SNPs tend to score somewhat higher on complex case management measures than they do on other measures.

Table 5A. S&P Performance of Returning SNPs (N=441) for Measures Submitted in 2010

Elements	Total SNPs Eligible for Measure	Percentage at Nat'l Benchmark*(%)	Number (N) and Percentage (%) of SNPs With Each Score									
			100%		80%		50%		20%		0%	
			N	%	N	%	N	%	N	%	N	%
SNP 4: Care Transitions												
A. Managing Transitions	441	56.0	114	25.9	133	30.2	97	22.0	71	16.1	26	5.9
B. Supporting Members Through Transitions	441	60.5	146	33.1	121	27.4	69	15.6	51	11.6	54	12.2
C. Identifying Unplanned Transitions	441	78.7	347	78.7			22	5.0			72	16.3
D. Reducing Transitions	441	80.7	270	61.2	86	19.5	42	9.5	19	4.3	24	5.4
SNP 6: Coordination of Medicare and Medicaid Coverage												
A. Coordination of Benefits for Dual-Eligible Members	270	95.2	236	87.4	21	7.8	2	0.7	2	0.7	9	3.3
B. Administrative Coordination of Dual-Eligible Benefit Packages	270	96.3	260	96.3	0	0.0	8	3.0	0	0.0	2	0.7
C. Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	262	89.7	235	89.7							27	10.3
D. Administrative Coordination for Chronic Condition and Institutional Benefit Packages	146	91.8	86	58.9	48	32.9	2	1.4	3	2.1	7	4.8
E. Service Coordination	417	88.5	260	62.4	109	26.1	26	6.2	12	2.9	10	2.4

* The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator. Some elements do not have all five scoring options; where there is no scoring option for an element, the corresponding empty cell is shown in gray.

Table 5B. S&P Performance of Newly Reporting SNPs (N=6) for Measures Submitted in 2010

Elements	Total SNPs Eligible for Measure	Percentage at Nat'l Benchmark*(%)	Number (N) and Percentage (%) of SNPs With Each Score									
			100%		80%		50%		20%		0%	
			N	%	N	%	N	%	N	%	N	%
SNP 1: Complex Case Management												
A. Identifying Members for Case Management	6	50.0	2	33.3	1	16.7	0	0.0	2	33.3	1	16.7
B. Access to Case Management	6	33.3	2	33.3			0	0.0	1	16.7	3	50.0
C. Case Management Systems	6	33.3	2	33.3			0	0.0	1	16.7	3	50.0
D. Frequency of Member Identification	6	33.3	1	16.7	1	16.7			0	0.0	4	66.7
E. Providing Members With Information	6	16.7	1	16.7	0	0.0			0	0.0	5	83.3
F. Case Management Process	6	33.3	2	33.3	0	0.0	0	0.0	4	66.7	0	0.0
G. Informing and Educating Practitioners	6	16.7	1	16.7			0	0.0			5	83.3
SNP 2: Improving Member Satisfaction												
A. Assessment of Member Satisfaction	6	16.7	1	16.7			0	0.0	0	0.0	5	83.3
B. Opportunities for Improvement	1	100.0	1	100			0	0.0			0	0.0
C. Improving Satisfaction	NA	NA	NA	NA	NA	NA			NA	NA	NA	NA
SNP 3: Clinical Quality Improvement												
A. Relevance to Members	6	16.7	1	16.7	0	0.0	0	0.0	1	16.7	4	66.7
B. Clinical Measurement Activities	NA	NA	N	NA	NA	NA	NA	NA	NA	NA	NA	NA
SNP 4: Care Transitions												
A. Managing Transitions	6	0.0	0	0.0	0	0.0	0	0.0	1	16.7	5	83.3
B. Supporting Members Through Transitions	6	16.7	0	0.0	1	16.7	0	0.0	0	0.0	5	83.3
C. Identifying Unplanned Transitions	6	16.7	1	16.7			0	0.0			5	83.3
D. Reducing Transitions	6	0.0	0	0.0	0	0.0	1	16.7	0	0.0	5	83.3
SNP 5: Institutional SNP Relationship With Facility												
A. Monitoring Members' Health Status	0	NA	NA	NA							NA	NA
B. Monitoring Changes in Members' Health Status	0	NA	NA	NA	NA	NA			NA	NA	NA	NA
C. Maintaining Members' Health Status	0	NA	NA	NA							NA	NA

Note: Shaded cells indicate that the specific score was not a standard option for the element.

Elements	Total SNPs Eligible for Measure	Percentage at Nat'l Benchmark*(%)	Number (N) and Percentage (%) of SNPs With Each Score									
			100%		80%		50%		20%		0%	
			N	%	N	%	N	%	N	%	N	%
SNP 6: Coordination of Medicare and Medicaid Coverage												
A. Coordination of Benefits for Dual-Eligible Members	2	50.0	1	50.0	0	0.0	0	0.0	0	0.0	1	50.0
B. Administrative Coordination of Dual-Eligible Benefit Packages	2	50.0	1	50.0	0	0.0	0	0.0	0	0.0	1	50.0
C. Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	2	50.0	1	50.0	0						1	50.0
D. Administrative Coordination for Chronic Condition and Institutional Benefit Packages	4	0.0	0	NA	0	0.0	0	0.0	0	0.0	4	100.0
E. Service Coordination	6	16.7	1	16.7	0	0.0	0	0.0	0	0.0	5	83.3

* The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator.

Note: Shaded cells indicate that the specific score was not a standard option for the element.

Performance on SNP 1–3—Only New SNPs Reporting (Table 6)

The following sections examine individual factor scores. Table 6 shows performance on SNP 1–3. Because these measures are reported only by new SNPs, they represent the experience of the six plans. The highest performance appears to be for the two Dual-Eligible SNPs, both of which met 30 of 43 applicable factors. The lowest performance is from the four chronic SNPs, which all met seven factors. Overall, all SNPs met 5 of 43 applicable factors

Importance

SNP 1, 2 and 3 measure performance on basic processes necessary for covering Medicare beneficiaries with special needs.

- **SNP 1: Complex Case Management** requires SNPs to have thorough processes for identifying, assessing and educating members with complex illnesses, and actively coordinating their care. Many SNP members are eligible for case management because many members tend to be more frail or have multiple comorbidities.
- **SNP 2: Improving Member Satisfaction** reflects requirements included in NCQA Health Plan Accreditation standards. It requires that plans systematically assess member satisfaction and identify opportunities for improvement.

- **SNP 3: Clinical Quality Improvement** requires that plans identify clinical issues relevant to their members, such as osteoporosis or prevention of falls. This is the initial requirement for newly reporting SNPs in 2010. The complete measure then requires SNPs to measure and analyze their performance on the issues and to identify opportunities to improve care. All SNPs will report on the full measure in 2011.

Results

Performance on the three original SNP S&P measures is lower for the six plans than for the hundreds of plans that reported in 2009. Because of the vast difference in numbers and the changes in applicable factors, a statistical comparison cannot be made, but in 2009, with 345 new plans reporting the same measures for the first time, the average percentage meeting the national benchmark across 10 elements was 88 percent. This year, the comparable percentage (from Table 4B) is 35 percent.

Additional Performance Detail

Because half of the newly reporting plans are Private Fee-For-Service (PFFS) plans that operate differently from traditional SNPs, it is difficult to draw conclusions on overall quality compared with previous reporters. The small sample is dominated by one company, which operates four of the six SNPs, including the PFFS plans, which do not have provider networks and care coordination models and thus tend to have a difficult time demonstrating performance for measures that require intense care coordination (e.g., SNP 1, SNP 4, SNP 6).

Table 6. Performance of Newly Reporting SNPs on SNP 1, 2 and 3, by Factor, 2010

Elements and Factors of SNP 1, 2 and 3	Overall (N=6) %	Dual (N=2) %	Chronic (N=4) %
SNP 1: Complex Case Management			
A. Identifying Members for Case Management. The organization uses the following data sources to analyze the health status of members.			
1. Claim or encounter data	50.0	100.0	25.0
2. Hospital discharge data	50.0	100.0	25.0
3. Pharmacy data	33.3	100.0	0.0
4. Laboratory results	33.3	100.0	0.0
5. Data collected through the UM process, if applicable	66.7	100.0	0.0
B. Access to Case Management: The organization has multiple avenues for members to be considered for case management services, including:			
1. Health information line referral	33.3	100.0	0.0
2. Disease Management program referral	50.0	100.0	25.0
3. Discharge planner referral	50.0	100.0	25.0
4. UM referral, if applicable	33.3	100.0	0.0
5. Member self-referral	33.3	100.0	0.0
6. Practitioner referral	33.3	100.0	0.0
7. Other	33.3	100.0	0.0

Elements and Factors of SNP 1, 2 and 3	Overall (N=6) %	Dual (N=2) %	Chronic (N=4) %
C. Case Management Systems. The organization uses case management systems that support:			
1. Evidence-based clinical guidelines or algorithms to conduct assessment and management	33.3	100.0	0.0
2. Automatic documentation of the staff member's identification and date and time action on the case or interaction with the member occurred	50.0	100.0	25.0
3. Automated prompts for follow-up, as required by the case management plan	33.3	100.0	0.0
D. Frequency of Member Identification. The organization systematically identifies members who qualify for case management.			
1. The organization systematically identifies members at least monthly	16.7	50.0	0.0
2. The organization systematically identifies members at least quarterly	16.7	50.0	0.0
3. The organization systematically identifies members less frequently than every 6 months	66.7	0.0	100.0
4. The organization systematically identifies members every 6 months	0.0	0.0	0.0
E. Providing Members With Information. The organization provides eligible members with the following case management program information in writing and in-person or by telephone case management systems. The organization uses case management systems that support:			
1. How to use the services	16.7	50.0	0.0
2. How members become eligible to participate	16.7	50.0	0.0
3. How to opt in or opt out.	16.7	50.0	0.0
F. Case Management Process. The organization's case management procedures address the following with members:			
1. Their right to decline participation or disenroll from case management programs and services offered by the organization	33.3	100.0	0.0
2. Initial assessment of their health status, including condition-specific issues	100.0	100.0	100.0
3. Documentation of their clinical history, including medications	100.0	100.0	100.0
4. Initial assessment of activities of daily living	100.0	100.0	100.0
5. Initial assessment of their mental health status, including cognitive functions	100.0	100.0	100.0
6. Initial assessment of life-planning activities	33.3	100.0	0.0
7. Evaluation of their cultural and linguistic needs, preferences or limitations	33.3	100.0	0.0
8. Evaluation of their caregiver resources	100.0	100.0	100.0
9. Evaluation of their available benefits	33.3	100.0	0.0
10. Development of a case management plan, including long-term and short-term goals that take into account the patients' or responsible party's goals and preferences	33.3	100.0	0.0
11. Identification of barriers to meeting their goals or complying with the plan	33.3	100.0	0.0
12. Development of a schedule for follow-up and communication	33.3	100.0	0.0
13. Development and communication of their self-management plans	33.3	100.0	0.0
14. A process to assess their progress against case management plans	33.3	100.0	0.0

Elements and Factors of SNP 1, 2 and 3	Overall (N=6) %	Dual (N=2) %	Chronic (N=4) %
G: Informing and Educating Practitioners. The organization provides practitioners with written information about the program that includes the following:			
1. Instructions on how to use services	16.7	50.0	0.0
2. How the organization works with a practitioner's patients in the program.	16.7	50.0	0.0
SNP 2: Improving Member Satisfaction			
A. Assessment of Member Satisfaction. The organization assesses member satisfaction by:			
1. Identifying the appropriate population	16.7	50.0	0.0
2. Drawing appropriate samples from the affected population, if a sample is used	16.7	50.0	0.0
3. Collecting valid data.	16.7	50.0	0.0
B. Opportunities for Improvement. The organization identifies opportunities for improvement.			
1. The organization does not identify any opportunities for improvement	0.0	0.0	0.0
2. The organization identifies one opportunity for improvement	0.0	0.0	0.0
3. The organization identifies 2 or more opportunities for improvement	100.0	100.0	0.0
SNP 3: Clinical Quality Improvements			
A. Relevance to Members. The organization selects three measures to assess performance and identify clinical improvements that are likely to have an impact on its membership.			
1. The organization does not select measures that are relevant to the membership	66.7	0.0	100.0
2. The organization selects 1 measure that is relevant to the membership	16.7	50.0	0.0
3. The organization selects 2 measures that are relevant to the membership	0.0	0.0	0.0
4. The organization selects 3 measures that are relevant to the membership	16.7	50.0	0.0

Performance on SNP 4, All SNPs Reporting (Tables 7–9)

This section provides an analysis of *SNP 4: Care Transitions*, and examines the factor level. As noted earlier, data show that this measure is the most challenging for SNPs. Institutional SNPs scored highest on this measure (Tables 7 and 9). Performance by size of SNP did not display a strong or consistent pattern (Table 8). Compared with performance on this measure for 2009, there is improvement, even though NCQA increased the number of elements and performance expectations.

Importance

Both the Affordable Care Act and the American Recovery and Reinvestment Act (ARRA) require efforts to address prevalent problems that occur when patients make a transition from one care setting to another. Improving care quality during transitions is particularly important for SNPs, whose members have a high likelihood of experiencing both planned and unplanned hospitalizations and other types of transitions.

NCQA developed SNP 4 to address this problem. The measure draws from the work of Eric Coleman, MD, whose Care Transitions ProgramSM has demonstrated how to improve care transitions using transition coaches. Coleman spoke at NCQA's educational event for SNPs in January 2010, pointing out that adverse

events resulting from transitions, such as medication errors between two care settings, cost the nation over \$17 billion per year.

The SNP 4 statement and intent, below, convey the performance expectations.

Measure statement: *The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.*

Intent statement: *The organization makes a special effort to coordinate care when members move from one setting to another, such as when they are discharged from a hospital. Actively coordinating transitions can avoid risks to patient safety, such as when two settings prescribe incompatible medications.*

Changes and Maintenance of Requirements

Expectations for Care Transitions are higher and more specific in 2010 than they were in 2009. NCQA split the original Element A, Managing Transitions into two elements: Element A, Managing Transitions and Element B, Supporting Members Through Transitions. To clarify what was expected of the SNPs with regard to patients and providers/care settings, elements were divided by factors pertaining to actions directed at providers and care settings, and to actions directed at members. The last factor both Element A and Element B requires the SNP to analyze its performance on the other factors in the elements.

The analysis requirement is also more demanding for 2010. In 2009, SNPs were required to provide a plan to conduct an analysis of aggregate performance on managing transitions. In 2010, SNPs must provide an actual analysis in order to receive full credit for Elements A and B.

To accommodate these changes, the remaining two elements of SNP 4 were renumbered, though content is unchanged: Identifying Unplanned Transitions is Element C; Preventing Transitions is Element D.

Results

Care Transitions was the most challenging measure for SNPs in 2010. 55 percent of SNPs achieved the national benchmark for Element A and 60 percent achieved the benchmark for Element B—the lowest percentages for returning SNPs on any element. Tables 7–9 show how SNPs performed on this measure.

Performance by SNP Type. Table 7 shows the percentage of the reporting SNPs that met the national benchmark on each element, overall and by type. Institutional SNPs had the highest performance by SNP type and by element; their lowest performance, 80%, was on Element C, Identifying Unplanned Transitions. This was still higher than either Chronic or Dual-Eligible SNP performance on any element. Chronic SNPs had the lowest performance by SNP type, with fewer than half meeting the national benchmark on Elements A and B. Performance of the Dual-Eligible SNPs was close to the overall performance and represented over 60 percent of all reporting SNPs.

Performance by SNP Size. Table 8 shows the percentage of the reporting SNPs that met the national benchmark (80%) on each element, overall and by SNP size or number of enrollees. As in 2009, the patterns by size are less clear. Performance ranges from 85 percent of SNPs with more than 2,500 members meeting the national benchmark on Elements C and D, to 46 percent of SNPs with between 100 and 499 members meeting the benchmark for Element A. The smallest SNPs (0–99 members) scored higher on Elements A and B, compared with larger SNPs. The largest plans scored higher than others on Elements C and D.

Performance by Factor Within Elements. Table 9 shows the percentage of SNPs that met each factor, overall and by SNP type. There is considerable variation by factor across the elements. Performance on Element A ranges from 98 percent of Institutional SNPs meeting the factor to identify an upcoming transition, to 35 percent of Chronic SNPs meeting the factor to transfer the patient's care plan from one setting to the next. Factors where SNPs scored the highest were identifying planned transitions, educating members about transitions and coordinating services for members at risk of a transition. The lowest performance was on

factors requiring intervening in care transition, such as sending care plans or notifying a member's usual source of care about a transition, and analyzing the SNP's performance on transitions of care.

Comparison With 2009 Results. The SNPs reporting this year scored higher on SNP 4 than the SNPs reporting in 2009.

- In 2009, the percentage of SNPs meeting the benchmark for SNP 4 elements varied from 44 percent of returning SNPs (in 2009) on the former Element A (now Elements A and B) to 73 percent of returning SNPs (in 2009) on the former Element B (now Element C).
- In 2010, the percentage of SNPs meeting the benchmark varied from 55 percent on Element A to 79 percent on Element D.

The general trends and areas of high and low performance were similar to results in 2009.

Additional Performance Details

NCQA staff observed the following patterns in SNP performance on SNP 4.

Element A, Managing Transitions. SNPs demonstrated that they had difficulty meeting requirements of this element, with the lowest percentage of SNPs reaching the national benchmark. NCQA refined requirements for Elements A and B in 2010, requiring SNPs to have both written policies and reports showing evidence that SNP operations implemented the policies for each factor. In 2009, NCQA required SNPs to provide a plan for conducting an aggregate analysis of their management of care transitions. In 2010, NCQA expanded the requirements by requiring SNPs to track their performance and analyze their performance, in relation to all the other factors, to earn a score of 100% for Elements A and B.

One area where most SNPs scored highly was in identifying planned transitions in advance, such as scheduled surgery. In addition, SNPs that automatically enroll a hospitalized member in case management did well on systematic processes that increased coordination after transitions. Often, case management enrollment automatically generated a notification to the member's physician.

Areas where SNPs' documentation showed difficulty in meeting Element A were:

- **Implementation:** Some SNPs had policies for Element A but did not have documentation that the policies were implemented. Also, some policies were general, or the SNP could not demonstrate evidence of implementation for transitions to care settings other than to and from the hospital. NCQA requires that policies be specific to the transition type; for example, facility-to-facility transition requires different support than does hospital-to-home transition.
- **Time frames:** Some SNPs implemented a policy but did not meet the time frame of "one business day," as specified in the measure. If the measure specifies a period, as in factor 2, or requires the SNP to specify its own period, operational reports must show that the SNP meeting the time frame.
- **Clinical information:** SNP challenges were sending the care plan, including clinical information from the hospital to the next care setting and notifying the member's usual source of care (e.g., a primary care physician) of a transition within a specified period.
- **Analysis:** Many SNPs had difficulty demonstrating performance for factor 4, which requires the SNP to conduct an annual analysis of its aggregate performance of managing transitions. NCQA looks for evidence that the SNP tracks its own performance in a meaningful way, including collecting and analyzing data and identifying barriers or areas for improvement, based on the analysis. Some SNPs compiled data but did not provide evidence that the data were analyzed or that areas for improvement were identified. Some did not demonstrate that analysis is conducted on a regular and routine basis.

Element B, Supporting Members Through Transitions. The SNPs scored slightly higher on this element than they did on 4A. According to research by Eric Coleman, presented at the CMS/NCQA SNP conference, supporting members through the transition process—particularly hospital discharge—can have a positive effect on health outcomes and help contain costs. Element B requires SNPs to communicate with members

about the transition process for planned and unplanned transitions from any care setting to another care setting; thus, the requirements are broader.

The highest performance was on factor 3 (giving members a SNP representative to contact for consistent support throughout the transition process). Some SNPs have scripts for contacting members after discharge, with questions about follow-up physician appointments and about understanding prescribed medications. Many Institutional SNPs have their employed nurse practitioners conduct in-person follow-up with patients. Since most Institutional SNP member transitions tend to occur between the hospital and institutional facility where they reside, care coordination and follow up is more consistent and systematic.

Difficult areas were:

- *Implementation:* As in 4A, SNPs sometimes had a policy for communicating with members but no evidence of actual communication. Where members were already identified for case management, communication with the case manager was well-documented.
- *Analysis:* Some SNPs recently implemented quality-improvement programs for reducing re-admissions, but, as in 4A, performance on the factor requiring analysis was generally low.

Doing It Well. One group of 17 SNPs in Minnesota provided an outstanding example of care coordination and analysis of performance. The SNPs are all assigned care coordinators who are county employees. In collaboration with the state, the SNPs created a uniform care transition log that shows the type of transition and any action taken related to the transition, including communication with the member and other providers about the transition, sharing of the care plan and any change in health status, and to whom such communications were given, and when. This allows the SNPs and the state to measure overall performance on a specific set of requirements and compare plans using the same criteria. It also allows SNPs to provide concrete evidence of policy implementation.

Element C, Identifying Unplanned Transitions. Performance on this element was relatively high, with approximately 80 percent of SNPs receiving notification from both hospitals and long-term care facilities of member admission. Many SNPs require such notification in their contracts with facilities.

Element D: Preventing Transitions. SNPs generally performed well on Element D: approximately 80 percent met the national benchmark. Since most SNPs are part of larger MA health plans, they can use claims data to stratify members by risk. Many use predictive modeling software to assign risk scores for members likely to be hospitalized, or use case managers to coordinate care for members identified as at high risk for unplanned transitions (e.g., those with specific medication regimens or who have experienced recent falls or hospital admissions).

SNPs that did not perform well on this element often missed the factor requiring analysis. Some SNPs analyzed data only for members enrolled in case management rather than for the entire population. Element D requires SNPs to analyze planned and unplanned admission and readmission rates (to the ER and to other facilities) and to identify areas for improvement based on the analysis. Often SNPs provided considerable data on admissions—particularly admissions per 1,000 enrollees and average length of stay in a hospital—but failed to provide a detailed level of analysis of their rates or of specific conditions/issues causing admissions and re-admissions (e.g., CHF, COPD, medication adverse events). NCQA believes that the SNPs must be able to identify such issues if they are to reduce admissions, particularly unplanned admissions.

Table 7. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Type, by Element, 2010

Elements of SNP 4: Care Transitions	All SNPs Reporting (N=447) Nat'l Benchmark* (%)	Dual Eligible (N=272) Nat'l Benchmark* (%)	Institutional (N=60) Nat'l Benchmark* (%)	Chronic (N=115) Nat'l Benchmark* (%)
A: Managing Transitions	55.3	51.5	93.3	44.3
B: Supporting Members Through Transitions	60.0	57.4	96.7	47.0
C: Identifying Unplanned Transitions	77.9	77.9	80.0	76.5
D: Reducing Transitions	79.6	78.3	91.7	76.5

* The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator.

Table 8. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Size, by Element, 2010

Elements of SNP 4: Care Transitions	Percentage at Nat'l Benchmark* by Number of Enrollees					
	All (N=447) Nat'l Benchmark*	0-99 (N=94)	100-499 (N=113)	500-999 (N=67)	1,000-2,499 (N=77)	≥2,500 (N=96)
A: Managing Transitions	55.3	73.4	46.0	47.8	49.4	58.3
B: Supporting Members Through Transitions	60.0	71.3	61.1	50.7	57.1	56.3
C: Identifying Unplanned Transitions	77.9	71.3	75.2	79.1	79.2	85.4
D: Reducing Transitions	79.6	77.7	77.9	77.6	79.2	85.4

* The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator.

Table 9. Performance on Care Transitions (SNP 4) by Factor, All SNPs Reporting 2010 (N=447) (Percentage of SNPs That Met Each Factor, Not That Met Benchmarks)

SNP 4: Care Transitions Elements and Factors	Overall (N=447) % Met	Dual (N=272) % Met	Institutional (N=60) % Met	Chronic (N=115) % Met
A. Managing Transitions, The organization facilitates safe transitions by either conducting or assigning to providers the following tasks and monitoring system performance:				
1. For planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, identifying that a planned transition is going to happen	89.9	90.1	98.3	85.2
2. For planned and unplanned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, sharing the sending setting's care plan with the receiving setting within 1 business day of notification of the transition	50.6	51.1	76.7	35.7
3. For planned and unplanned transitions from any setting, notifying the patient's usual practitioner of the transition	60.4	56.6	93.3	52.2
4. For all transitions, conducting an analysis of the organization's aggregate performance on the above aspects of managing transitions	49.3	38.9	75.4	60.9
B. Supporting Members Through Transitions. The organization facilitates safe transitions by either conducting to assigning to providers the following tasks and monitoring system performance.				
1. For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process within a specified timeframe	61.1	59.2	96.7	47.0
2. For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about changes to the member's health status and plan of care	59.5	56.6	96.7	47.0
3. For planned and unplanned transitions from any setting to any other setting, providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system	83.9	84.2	96.7	76.5
4. For all transitions, conducting an analysis of the organization's aggregate performance on the above aspects of managing transitions	49.8	40.7	68.4	61.7
C. Identifying Unplanned Transitions. The organization identifies transitions by reviewing the following for facilities in its network:				
1. Reports of hospital admissions within one business day of admission	81.2	82.7	81.7	77.4
2. Reports of admissions to long-term care facility within one business day of admission	79.4	79.8	80.0	78.3
D. The organization minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by:				
1. Analyzing data at least monthly, to identify individual members at risk of transition	81.2	81.4	96.5	73.0
2. Coordinating services for members at high risk of having a transition	89.0	91.2	91.7	82.6
3. Educating members or responsible parties about transitions and how to prevent unplanned transitions	85.5	84.9	88.3	85.2
4. Analyzing aggregate admissions and readmissions.	66.4	59.9	87.5	71.3

Performance on SNP 6, All SNPs Reporting (Tables 10–12)

A high percentage of SNPs met the benchmark on the elements of SNP 6. Three elements of this measure apply to Dual-Eligible SNPs only; one element applies to Chronic and Institutional SNPs only; and one element applies to all three SNP types. Institutional SNPs performed best on those two elements (Tables 10 and 12). There were no large differences by SNP size (Table 11).

Importance

Coordinating coverage of members who are eligible for both Medicare and Medicaid is a crucial administrative function that SNPs must perform. Medicare is a federal program, uniform across the country, while Medicaid is a state-federal program that is somewhat different in each state. Of the more than one million members enrolled in SNPs, 73 percent are in dual-eligible plans. Many more members of chronic and institutional SNPs are dual-eligible also, so that the total percentage of dual-eligible SNP members is most likely over 80 percent. Dual-eligible members have the vulnerability of lacking financial resources, and depend on their SNPs for many social services paid by Medicaid, such as transportation, and for medical care.

The statement and intent of SNP 6 express this importance:

Statement: *The organization coordinates Medicare and Medicaid benefits and services for members.*

Intent: *The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers.*

Requirement Changes and Maintenance

NCQA split Element A into two elements: Coordination of Benefits for Dual-Eligible Members, and Administrative Coordination of Dual-Eligible Benefit Packages. Element A focuses on provision of information and assistance directly to members; Element B focuses on the administrative functions of tracking eligibility and adjudicating claims. This is a change in how the elements are organized, not a content change. NCQA did not increase expectations for coordination of Medicare and Medicaid coverage.

Some states do not contract with SNPs for Medicaid, which results in SNPs being unable to meet some requirements of the measure. These SNPs receive a score of “NA,” if they demonstrate their inability to comply with requirements because of state regulations.

Some states coordinate their Medicaid programs with SNP programs. Expectations of coordination are higher for Dual-Eligible SNPs. The following provides a high-level overview of SNP 6 requirements.

Elements A–C apply to Dual-Eligible SNPs

- Element A: Coordination of Benefits for Dual-Eligible Members
- Element B: Administrative Coordination of Dual-Eligible Benefit Packages
- Element C: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages

For these elements, SNPs must demonstrate a documented process. Element C requires that SNPs work toward a contract with the state. There are several reasons why SNPs might have difficulty meeting the requirements of these elements: some states do not share information with SNPs; Medicare does not require a contract with states; and many states refuse to contract with SNPs making some performance out of their control.

The Medicare Improvement and Patient Protection Act (MIPPA) and the Affordable Care Act have provisions that will require Dual-Eligible SNPs to obtain contracts with state Medicaid agencies to coordinate Medicare and Medicaid benefits, starting in 2012, in order to continue operating as Dual-Eligible SNPs.

- Element D**
- Element D: Administrative Coordination for Chronic Condition and Institutional Benefit Packages

This element applies only to Chronic Condition and Institutional SNPs with at least 5 percent dual-eligible members. This reflects expectation for coordination for benefit packages that do not primarily target dual-eligible beneficiaries. SNPs must demonstrate a documented process.

- Element E**
- Element E: Service Coordination,

This element applies to all SNPs. SNPs must demonstrate both a documented process and evidence of operations that meet the element.

Results

Overall performance on SNP 6 was higher than performance in other required areas.

Performance by SNP Type. Table 10 shows performance on achieving national benchmarks by SNP type. 96 percent of Dual SNPs met the national benchmark on Element B; 88 percent of Chronic met the national benchmark on Element E. Performance on this element varied from 86 percent for Chronic SNPs to 91 percent for Institutional SNPs.

Performance by SNP Size. Table 11 shows how SNPs with different enrollment sizes scored on the elements of SNP 6. Larger plans demonstrated better performance: All plans met the national benchmark on Element A. SNPs with 100–499 members had the lowest scores.

Performance by Factor Within Elements. Table 12 shows the percentage of SNPs that met each factor in each element of SNP 6.

- *Elements A–C (Dual-Eligible SNPs only):* More than 90 percent of Dual-Eligible SNPs met every factor in the first two elements. The highest performance was on Element B, factor 1. More than 89 percent of Dual-Eligible SNPs met Element C, which has only one factor.
- *Element D (Chronic and Institutional SNPs only):* 39 percent of Chronic SNPs met the requirements of factor 1; 98 percent of Institutional SNPs met factor 1. This combination yielded the lowest overall percentage (62 percent) of SNPs meeting a factor in SNP 6. Between 87 percent and 91 percent of plans met the other factors.
- *Element E (all SNP types):* Uniformly high percentages of SNPs met the first three factors, with the exception that only 75 percent of Chronic SNPs met factor 2, educating providers about coordinating benefits. The lowest performance was on factor 4: assessing adequacy of the network to provide access. This is the only factor on which Chronic SNPs performed better than the other two types.

Comparison With 2009 Performance. Plan performance in 2010 shows a higher proportion of plans meeting the national benchmark than the new and returning SNPs that reported in 2009:

- In 2009, performance against the national benchmark varied from 71 percent for new SNPs (new in 2009) on Element D (now Element E) to 90 percent of returning SNPs (for 2009) on Element C (now Element E).
- In 2010, performance against the national benchmark varied from 87 percent on Element E to 96 percent on Element B (Dual-Eligible SNPs only).

Additional Performance Details

Overall, SNPs demonstrated high performance on SNP 6. The biggest challenge for Dual-Eligible SNPs is coordinating with state Medicaid programs. Differences among state approaches to managing Medicaid patients also affect the ability of all SNPs to coordinate services (Element E).

Dual-Eligible SNPs frequently met the factors regarding benefit coordination, providing benefit information to members and helping members maintain Medicaid eligibility. Far less frequent was their ability to demonstrate assessment of network adequacy for meeting the needs of dual-eligible members. Dual-Eligible SNPs that demonstrated the required activities often began as social HMOs or operated Medicaid plans and later added Medicare SNPs to their product lines. Those that started as Medicare plans found it difficult to coordinate Medicaid services.

Institutional SNPs did well on Elements D and E, with the exception of the factor that requires assessing network adequacy. This may be the result of stable networks and members—once members are in an institution and eligible for Medicaid, their situation and eligibility status stay the same. Institutional SNPs often supply their own employed providers to follow and coordinate care for members.

Chronic SNPs demonstrated high performance on giving members information about their eligibility and scored lowest on identifying members about to lose their eligibility. They scored lower on the requirements regarding Medicaid services than the other types of SNPs.

Element E applies to all SNPs and shows the most interesting comparisons. Factors regarding assisting members were met more often. 75 percent of Chronic SNPs met the factor that requires educating providers about dual coverage. SNPs most often failed to demonstrate that they met the requirement to assess whether their network access is adequate, and to collect and analyze data.

"Access" includes having enough providers to meet the needs of the population and the ability of members to make an appointment with a provider in a timely manner. In addition, there should be providers available who speak members' languages, who accept Medicaid and who meet any specialty requirements (e.g., endocrinologists, for SNPs that focus on diabetes). Some plans provided GeoAccess reports showing the availability of providers by area; some included data on how many providers were accepting new patients. Some SNPs surveyed members about access, which is an acceptable method for assessing network adequacy. Nearly all SNPs performed a form of adequacy assessment for Medicare providers; fewer were able to demonstrate assessment of their networks for providers that also accept Medicaid.

Table 10. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by SNP Type, 2010

Elements of SNP 6: Coordination of Medicare and Medicaid Coverage	Percentage at National Benchmark by Type of SNP			
	All SNPs Reporting (N=447)	Dual-Eligible (N=272)	Institutional (N=60)	Chronic (N=115)
A. Coordination of Benefits for Dual-Eligible Members	94.9	94.9	NA	NA
B. Administrative Coordination of Dual-Eligible Benefit Packages	96.0	96.0	NA	NA
C. Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	89.4	89.4	NA	NA
D. Administrative Coordination for Chronic Condition and Institutional Benefit Packages	89.3	NA	91.2	88.2
E. Service Coordination	87.5	87.1	91.2	86.3

*The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator.

Table 11. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by Enrollment Size, 2010

Elements of SNP 6: Coordination of Medicare and Medicaid Coverage	Percentage at National Benchmark* by Number of Enrollees					
	All SNPs Reporting (N=447)	0-99 (N=94)	100-499 (N=113)	500-999 (N=67)	1,000-2,499 (N=77)	≥2,500 (N=96)
A. Coordination of Benefits for Dual-Eligible Members	94.9	96.8	90.9	90.2	96.4	100.0
B. Administrative Coordination for Dual-Eligible Benefit Packages	96.0	96.8	93.9	98.0	94.5	97.1
C. Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	89.4	96.7	88.7	86.0	87.0	91.2
D. Administrative Coordination for Chronic Condition and Institutional Benefit Packages	89.3	87.3	86.5	100.0	85.7	95.8
E. Service Coordination	87.5	86.2	80.6	89.1	90.8	92.5

*The National Benchmark is the proportion of SNPs with performance at the 80% or 100% level. The benchmark does not include scores of NA in the denominator.

Table 12. Performance on Coordination of Medicare and Medicaid Coverage (SNP 6) by Element and Factor, All Reporting Plans by Type (N=447), 2010
(Percentage of SNPs That Met Each Factor, Not That Met Benchmarks)

Elements and Factors of SNP 6: Coordination of Medicare and Medicaid Coverage	Overall N=447	Dual (N=272)	Institutional N=60	Chronic N=115
	%	%	%	%
A. Administrative Coordination for Dual-Eligible Members. The organization coordinates Medicare and Medicaid benefits by:				
1. Giving prospective members information about benefits they are eligible to receive from both programs	94.5	94.5	NA	NA
2. Informing members about maintaining their Medicaid eligibility	94.1	94.1	NA	NA
3. Providing information to members about benefits they are eligible to receive from both programs	96.7	96.7	NA	NA
4. Giving members access to staff who can advise them on use of both Medicaid and Medicare	96.3	96.3	NA	NA
5. Giving members clear explanations of their benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers	96.0	96.0	NA	NA
6. Giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program	92.3	92.3	NA	NA
B. Administrative Coordination of Dual-Eligible Benefit Packages. The organization coordinates Medicare and Medicaid benefits by:				
1. Using a process to identify changes in members' Medicaid eligibility	97.1	97.1	NA	NA
2. Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible	97.4	97.4	NA	NA
C. Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages. The organization maintains a documented relationship with the state Medicaid agency to foster coordinated care, by having or working toward a contract or agreement for administering any part of the Medicaid benefit package.				
The organization either has or is working toward an agreement with state Medicaid agency	89.4	89.4	NA	NA
The organization does not have and is not working toward an agreement	10.6	10.6	NA	NA
D. Administrative Coordination for Chronic Condition and Institutional Benefit Packages—Full				
1. Using a process to identify any changes in members' Medicaid eligibility	62.0	NA	98.2	39.8
2. Informing members about maintaining Medicaid eligibility	87.3	NA	91.2	84.9
3. Providing information to members about benefits they are eligible to receive for both Medicare and Medicaid	90.0	NA	91.2	89.2
4. Providing members access to staff who can advise them on use of both Medicare and Medicaid	90.7	NA	93.0	89.2
E. Service Coordination. The organization coordinates delivery of services covered by Medicare and Medicaid through the following:				
1. Assisting members with accessing network providers that participate in both the Medicare and Medicaid programs or providers that accept Medicaid patients	87.7	87.1	91.2	87.2
2. Educating providers about coordinating Medicare and Medicaid benefits for which members are eligible and about members' special needs	88.4	92.3	91.2	75.5
3. Helping members obtain services funded by either program when assistance is needed	93.1	94.1	96.5	88.3
4. Assessing adequacy of the network to provide access for members at least semi-annually	69.9	66.5	67.9	80.6

S&P Measures Background

S&P measures development occurred in two phases:

1. SNP 1–SNP 3 were developed in 2008. They are based on NCQA Accreditation standards and address the fundamental processes and systems needed to deliver quality care to SNP beneficiaries—complex case management, member experience and clinical quality improvement.
2. SNP 4–6 were developed in 2009. They assess issues more specific to SNPs: care transitions; Institutional SNP relationships with nursing home facilities; and coordination of Medicare and Medicaid coverage for Dual-Eligible SNPs.

Measure Development

- Step 1** NCQA staff interviewed health plans, employers and other stakeholders about the product, content, focus and existing evaluation metrics.
- Step 2** NCQA convened an expert work group (in this case, the SNP Technical Advisory Panel, with guidance from the NCQA GMAP) to provide ongoing advice about specific program content. The SNP Technical Expert Panel included individuals representing SNPs, policy makers and researchers.
- Step 3** NCQA staff used feedback from the interviews and committees as guidelines to draft the measures, which were vetted through the NCQA Review Oversight Committee (ROC), which reviews all accreditation decisions, the Consumer Advisory Council, the Purchaser Advisory Council and the Health Plan Advisory Council.
- Step 4** NCQA released the draft measures for Public Comment, to allow SNPs and stakeholders to provide feedback. NCQA used the feedback to refine the measures and reporting criteria.
- Step 5** With CMS approval, NCQA released the final version of SNP 4–6 in February 2009.

NCQA refined the existing measures for 2010, based on the 2009 assessment and the reporting process. While no new measures were added, some measures were reconfigured and some requirements were refined. Refer to the Appendix for the S&P measure technical specifications.

Data Collection

S&P measures assess systems that support member care management and the degree to which the SNPs implemented desired policies and procedures. SNPs report the measures to NCQA using the Survey Tool component of NCQA's Web-based Interactive Survey System (ISS). All SNP responses must be supported by documentation, such as policies and procedures or internal reports that demonstrate compliance with S&P measure requirements. Trained NCQA surveyors and staff review the Survey Tool, which includes SNP self-assessment of performance and supporting documentation.

Before the 2010 data collection process, NCQA collected data on the profile of each SNP benefit package, in accordance with CMS requirements. SNPs were required to be operational as of January 1, 2009, with a renewed contract for 2010. SNPs that had no members as of the CMS were not required to report for *SNP 2: Improving Member Satisfaction* and *SNP 3: Clinical Quality Improvement*; they could report "NA" because there were no data to be analyzed.

For organizations with multiple (four or more) SNPs that used centralized policies and procedures and systems (e.g., case management assessment systems or complaint and appeal processes) NCQA offered primary entity review. Of the 447 SNPs that reported the S&P measures, 114 were from 16 entities that underwent a primary entity review. NCQA allowed these SNPs to provide centralized results, when centralized processes applied. During the data collection and submission process, NCQA provided technical support for result submission.

NCQA conducted substantial outreach to ensure that all SNPs completed the Survey Tool, including free training sessions. NCQA sent multiple e-mails to all SNPs and to key stakeholder industry organizations (SNP Alliance, America's Health Insurance Plans, Association for Community Affiliated Plans, Blue Cross and Blue Shield Association) to notify them of the sessions.

NCQA sent regular reminders that Survey Tools were due by June 30, 2010, and included this message at each training session, at the open door forums and on the NCQA Web site. After the deadline, NCQA contacted SNPs that had not submitted a Survey Tool, by e-mail and follow-up telephone call.

Additional technical assistance was provided for plans that lost or forgot their password or that had difficulty uploading information to the ISS server. By July 12, all benefit packages required to submit had done so.

Data Validation

S&P measures undergo a two-step validation process. First, NCQA verifies that every complete Survey Tool includes documentation. If no documentation is attached to the Survey Tool, NCQA allows a brief period in which the SNP may resubmit. After this initial completeness check, an independent NCQA surveyor reviews the documentation and survey responses.

Surveyors have an in-depth understanding of the measures and survey processes. They are trained by NCQA and are required to complete at least three surveys each year. NCQA reviews surveyors' education level, interpersonal skills, analytical and critical thinking skills, computer literacy and time management skills, and requires surveyors to have work experience and documented success in primary or tertiary health care delivery (preferably in a managed care setting), including quality improvement, utilization management or disease management. Surveyors must also have experience or formal training in continuous quality improvement process management; for example, as a member of a QI Committee or CQI team, or as a staff member of the quality improvement department.

Twenty-nine surveyors reviewed SNP-submitted documentation. Surveyors had the authority to change responses to align with documentation. Once the surveyor review was complete, surveys were examined by the Executive Review Team (whose members are internal NCQA staff trained to review S&P measures) to determine if assessments were correct and if scoring modifications were warranted.

After the initial review and validation, CMS and NCQA gave SNPs the opportunity for reassessment of elements where they scored less than 100%. Plans were allowed to submit additional documentation and clarification.⁶ Reassessment occasionally resulted in higher scores.

On October 6, 2010, NCQA provided final SNP-specific results to CMS. Those results form the basis of this report.

⁶SNPs were only allowed to submit documentation that existed on or before the survey submission date.

Limitations

An important limitation in the third year of this activity is the limited look-back period. SNPs were required to submit data approximately four months after the final measures were released. So that an organization is not held accountable for compliance with measures before their release, S&P measures reflect the prior three months of performance. Many plans had recently created documented processes and could not get their actual operations in compliance with their policies.

Future review will require a longer look-back period, which will provide a more robust picture of SNP performance.

Another limitation is the very small number of newly reporting plans in 2010, which makes it impossible for NCQA to compare statistics from newly reporting plans with statistics from returning plans.

Next Steps

These analyses may provide a more robust understanding of the quality of care provided by SNPs:

- Analysis of results for the SNP and MA programs informed by demographic and health characteristics of beneficiaries.
- Analysis of results by additional organizational characteristics, such as affiliation with different types of parent organizations and years in business.
- Analysis of the relationship between HEDIS results and S&P measure results.
- With an additional year of S&P results, analysis of how results improve from prior submissions, particularly in the areas of lowest performance.
- Experience reports from SNP beneficiaries through SNP-specific results on the CAHPS^{®7} survey and Medicare Health Outcomes Survey (HOS). CMS uses these surveys to collect beneficiary-reported results for MA plans, but the current survey process does not produce results for individual SNPs.

⁷CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

