



**Medicare Special Needs Plans
Performance Results:
HEDIS 2011 and Structure & Process Measures**

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Executive Summary

Overview

This report provides results of measurement of care provided by Special Needs Plans (SNP) to Medicare beneficiaries. Data are divided into two sections, a discussion of HEDIS^{®1} measures and a discussion of Structure & Process (S&P) measures.

The Centers for Medicare & Medicaid Services (CMS) required 369 SNPs to submit data from the Healthcare Effectiveness Data and Information Set (HEDIS) for this report. Results cover 32 HEDIS measures, 28 of clinical performance and 4 measures of board certification². All measures were selected for their relevance to SNP populations. As required, results were audited by NCQA Certified HEDIS Compliance Auditors. HEDIS data reflect care provided in 2010 and reported in HEDIS 2011, and compare results with care reported in 2009 and 2010.

NCQA assessed SNPs against six S&P measures that address the structures, systems and processes in place to address quality of care in six areas.

1. SNP 1: Complex Case Management
2. SNP 2: Improving Member Satisfaction
3. SNP 3: Clinical Quality Improvement
4. SNP 4: Care Transitions
5. SNP 5: Institutional SNP Relationship With Facility
6. SNP 6: Coordination of Medicare and Medicaid Coverage.

All SNPs were required to report the full set of S&P measures for 2011. NCQA assessed all three types of SNPs under this program: Dual-Eligible (D-SNP—286 plans); Severe or Disabling Chronic Condition (C-SNP—80 plans); and Institutional (I-SNP—58 plans).

Four hundred twenty-four SNPs met CMS requirements to be assessed in 2011, 23 fewer than in 2010. SNP offerings appear to be stabilizing after several years of rapid growth, followed by a sharp decline in the number of plans after 2009. While the number of SNP benefit packages declined in 2011, enrollment increased by slightly more than 100,000 beneficiaries.

Findings

HEDIS Findings

NCQA analyzed data reported for 2009–2011. Data show a steady improvement in SNP program performance on HEDIS measures over this three-year period. On average, SNPs improved performance more between 2010 and 2011 than they did between 2009 and 2010. Although SNP program performance averaged lower than performance of the Medicare Advantage (MA) program, the performance gap between the two continues to decrease. For some measures, there is no statistical difference in performance between the SNP and MA program, for a handful of measures, the SNP program performance is higher than the MA performance. There continue to be performance differences among the three types of SNPs.

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

² This report does not include the results from the Plan All-Cause Readmission measure, which is a first-year measure reported for the first time in 2011.

Highlights of HEDIS Results

- **Three-year trend for the SNP program as a whole (including all SNPs regardless of tenure).** For program-wide results, the overall trend is improvement from 2009–2010 and from 2010–2011. 15 of the 32 measures (47 percent) showed statistically significant improvement from 2009 to 2010 and from 2010 to 2011. Just looking at the one-year period from 2010–2011, SNPs showed significant improvement on 18 measures. Three *Board Certification* measures showed a significant decrease in performance from 2010–2011, but only 1 of the board-certification measures had a significant decrease over the full three-year period.

On average, scores improved by 4.5 percentage points over the three-year period. Three *Care for Older Adults* measures had an average increase of 20.7 percentage points from 2010–2011. Refer to Table 4A.

Note: To provide a complete picture of the SNP environment, NCQA distinguished aggregate program performance from benefit package performance. Program-level analysis includes data from all SNP submissions, regardless of whether the plan was able to meet the HEDIS reporting guideline of at least 30 members in a denominator that would allow benefit package-level reporting.

- **Biggest Improvements.** The following measures showed overall improvements of 5 percentage points or more from 2009–2011 for the SNP program as a whole:
 - *Colorectal Cancer Screening*
 - *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
 - *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event*
 - *Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event*
 - *Controlling High Blood Pressure*
 - *Care for Older Adults—Advance Care Planning*
 - *Care for Older Adults—Medication Review*
 - *Care for Older Adults—Functional Status Assessment*
 - *Active Board Certification—Geriatrics.*

Three *Care for Older Adults* measures showed the most gains (16.1, 21.1 and 24.9 percentage points, respectively). An additional measure, *Care for Older Adults—Pain Screen*, showed a large gain (8.5 percentage points) from 2010–2011, but because performance decreased from 2009–2010, it did not make the 2009–2011 list.

- **Three-year trend for three-year reporters.** The SNPs that reported HEDIS results in all three years outperformed the SNP program overall (those that reported in any one of the three years). On average, the three-year reporters had higher results across all measures in each year, 2009–2011. For SNPs that reported in all three years, 15 measures showed statistically significant improvement over the whole three-year period, 2009–2011, as well as for the period 2010 to 2011. This represents 2.5 percentage point improvement in one-year and a 3.8 percentage point improvement for the three-year results (2009–2011). Seven measures rose by at least 10 percentage points over the three-year period.

Three *Board-Certification* measures had a statistically significant decrease from 2010–2011. Three *Care for Older Adults* measures had an average increase of 13 percentage points from 2010–2011. Refer to Table 4B.

- **SNP and MA program performance.** For HEDIS 2011, SNPs had statistically significant higher performance than MA plans on 7 (4 Clinical, 3 Board Certification) of 27 required measures both groups are required to report. This is compared to outperforming MA plans on 5 HEDIS 2010 measures. There was no statistically significant difference in performance between the SNPs and the MA plans on 4 measures in both HEDIS 2011 and HEDIS 2010. Please note that MA plans report HEDIS measures at the contract level, which may include SNP beneficiaries as some MA contracts include SNP plan benefit packages. However, these represent a small portion of the MA population, as indicated by the eligible population data for each measure. It is also important to note that given the criteria of the SNP program,

one could expect that SNPs enrollee a more vulnerable population than the overall MA program. Therefore, comparisons should be made with caution.

- **Program performance by SNP type.** Continuing a three-year trend, I-SNPs had statistically significant higher results overall on more measures (7) than either D-SNPs or C-SNPs. On average, I-SNPs scored three percentage points higher than C-SNPs and 6.9 percentage points higher than D-SNPs. I-SNP rates were at least 5 percentage points higher than either D-SNPs or C-SNPs on 19 measures. D-SNPs improved significantly on 17 measures (53 percent) from 2010–2011. C-SNPs improved on 11 measures (34 percent) and I-SNPs improved on 7 measures (22 percent). Refer to Table 6.
- **Plan benefit package-level performance.** In addition to the aggregate performance analyses noted above, NCQA also evaluates performance at the benefit package-level. The analyses represent results from individual plan performance. Looking at 2011 SNP results across all measures at the benefit package level, nine measures had a large percentage point difference (40 points or more) between SNPs scoring in the 10th percentile and those in the 90th percentile. The same nine measures also showed a large difference (at least 20 percentage points) between the 90th percentile and the mean score, and thus present the greatest opportunities for improvement. This is particularly true for three *Care for Older Adults* measures, which had differences of more than 50 percentage points, on average, between the mean score and those in the 90th percentile. Refer to Table 9.

For 27 measures, more than 50 percent of SNPs improved their results from 2009 – 2011. For 7 of these measures, more than 70 percent increased performance from 2009 – 2011.

From 2010 to 2011, there were five measures where at least 70 percent of the SNPs improved performance, including two of the *Care for Older Adults* measures. The following measure results demonstrated the greatest variation and therefore, opportunities for SNPs to improve performance: *Antidepressant Medication Management—Continuation Phase, Medication Reconciliation Post-Discharge, Potentially Harmful Drug-Disease Interactions—History of Falls*. Refer to Table 10.

S&P Results

NCQA analyzed data from the 424 SNP benefit packages required to report for 2011. SNPs had to be operational as of January 1, 2010, and renewed for January 1, 2011; data reflect SNP operations for 2010. CMS required all SNPs to report all six measures (SNP 1–SNP 6) for 2011. Under CMS' direction and approval, NCQA made structural changes and, in some cases, content and scoring-related changes to some measures, making it difficult to compare results from previous years, so we present the most recent data only.

A S&P **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 that are met by a plan. ***For these analyses, we established a national benchmark to gauge performance, which is the percentage of plans scoring 80 percent or above on each element that makes up the measures.***

Highlights of S&P Results

- **NCQA saw a wide range of performance within and across S&P measures.**
 - *Complex Case Management (SNP 1).* SNPs performed consistently well on this measure. On average, 97 percent of SNPs met the national benchmark on four of seven elements (Element A, Identifying Members for Case Management, Element B: Access to Case Management, Element D: Frequency of Member Identification and Element F: Case Management Process); and 84 percent met the national benchmark on two elements (Element C: Case Management Systems and Element G: Informing and Educating Practitioners). The notable exception was Element E: Providing Members with Information, where 69.3 percent met the national benchmark.
 - *Improving Member Satisfaction (SNP 2).* For the most part, SNPs collect, analyze and identify opportunities for improvement regarding member satisfaction, using complaint and appeal data or CAHPS survey data. For the two elements in this measure, 84.5 percent and 91.6 percent of SNPs met the national benchmark, respectively.
 - *Clinical Quality Improvement (SNP 3).* 96.9 percent of SNPs achieved the national benchmark for this measure.
 - *Care Transitions (SNP 4).* SNPs did best on Element F: Reducing Transitions, where 80.7 percent met the benchmark. While overall scores for this measure were lower than the other measures, there was variation among the elements: 39.3 percent of SNPs met the national benchmark score for Element C: Analyzing Performance, while 63.4 percent met the benchmark for Element B: Supporting Members Through Transitions. For Element D: Identifying Unplanned Transitions, 77.4 percent of SNPs met the benchmark.
 - *Institutional SNP Relationship With Facilities (SNP 5).* This measure applies only to I-SNPs, which compose the smallest number of SNP benefit packages (58 of 424). I-SNPs performed well on two elements (Element A: Monitoring Members' Health Status and Element C: Maintaining Members' Health Status), where 96.2 percent of the I-SNPs met the national benchmark for both elements. Scores were lower for Element B: Monitoring Changes in Members' Health Status, with 76.9 percent of I-SNPs achieving the national benchmark.
 - *Coordination of Medicare and Medicaid Coverage (SNP 6).* D-SNPs have more rigorous requirements for this measure than the other two SNP types. Scores ranged from a high of 97.6 percent of SNPs meeting the benchmark for Element A: Coordination of Benefits for Dual-Eligible Members, which is for D-SNPs only to a low of 59.6 percent meeting the benchmark on Element F: Network Adequacy Assessment.
- **Differences in scores across SNP types.**
 - Overall, I-SNPs scored highest on most elements, especially those that involve direct service to patients and providers. For example, I-SNPs scored highest on five of six elements for SNP 4 and on five of seven elements for SNP 1.
 - C-SNP scores improved 20 percentage points for SNP 4, Element A: Managing Transitions and 12.8 percentage points for SNP 4, Element B: Supporting Members Through Transitions, compared to the 2010 results.
 - It should be noted that the I-SNP category, which has the smallest number of benefit packages (58) is dominated by a handful of SNP organizations that account for the majority of the benefit packages. In fact, one organization accounts for approximately 40 percent of all the I-SNP benefit packages. Thus, this organization's performance has a strong effect on the overall results for the I-SNP category.
- **SNPs scored high on Coordination of Medicare and Medicaid Coverage (SNP 6).** It is important to note that Coordination of Medicare and Medicaid Coverage (SNP 6) has more demanding requirements for D-SNPs than for C-SNPs and I-SNPs. While I-SNPs and C-SNPs may enroll beneficiaries that are dually eligible, D-SNPs are required by law to enroll only dual-eligible members. D-SNPs are also required by law (MIPAA) to have additional systems in place to coordinate Medicare and Medicaid benefits.
 - *Performance by D-SNPs.* Elements A–C apply only to D-SNPs, which performed well on Coordination of Benefits for Dual-Eligible Members (Element A) (97.6 percent met the benchmark) and Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages (Element C) (91.8 percent met the

benchmark). D-SNPs scored lower for Administrative Coordination of Dual-Eligible Benefit Packages (Element B) (82.9 percent met the benchmark), which requires plans to have a process to identify changes in members' Medicaid eligibility and coordinate adjudication of Medicare and Medicaid claims for which they are contractually responsible.

- *Performance by C-SNPs and I-SNPs.* Although I-SNPs outperformed C-SNPs on all the elements both C-SNPs and I-SNPs are required to report, C-SNPs showed a 55.9 percentage point increase in the number of SNPs meeting the benchmark score (88.9 percent, up from 33 percent in 2010) on Administrative Coordination for Chronic Condition and Institutional Benefit Packages (Element D), which is a modified version of Coordination of Benefits for Dual-Eligible Members (Element A) that applies only to C-SNPs and I-SNPs.
- *Performance across SNP type.* All SNP types must report Service Coordination (Element E) and the new element, Network Adequacy Assessment (Element F). I-SNPs outperformed C-SNPs and D-SNPs for these requirements.
- *Network Adequacy Assessment.* All SNP types had a lower percentage of SNPs meet the benchmark score for Network Adequacy Assessment (Element F), which requires SNPs to assess network adequacy for Medicare and Medicaid providers. SNPs tended to conduct solid network adequacy assessments for Medicare network providers, but often did not have such data for Medicaid. Approximately two-thirds of the I-SNPs (66.7 percent) and D-SNPs (61.6 percent) met the national benchmark. For C-SNPs, 46.5 percent met the benchmark score.
- **SNPs had the lowest percentage of plans meeting the benchmark score in the *Care Transitions measure (SNP 4)*.** Element 4 scores lag consistently behind the other five measures. Even though performance cannot be directly compared with earlier years, this has been a measure where SNPs' performance in the past has been less strong than other areas.
 - The lowest percentage of SNPs met the national benchmark on the elements that focus on analyzing performance regarding transition activities (Element C) and analyzing actual transitions (Element E). The percentage of SNPs meeting the benchmark these elements was 39.3 percent and 46.4 percent, respectively.
 - A majority of SNPs met the benchmark for areas related to managing transitions (Element A, 76.4 percent), identifying unplanned transitions (Element D, 77.4 percent) and reducing transitions (Element F, 80.7 percent). Although below the percentage meeting the benchmark on the other measures, the majority (more than 75 percent) of SNPs scored at the 80 percent or 100 percent level for these elements.
 - Many SNPs had extensive policies and procedures in place to address care transitions, but were unable to demonstrate evidence of implementation—they did not provide reports or materials to show how they actually conduct specific actions required to meet the measure's specifications. Many SNPs have data collection systems in place to collect and analyze performance data on care transitions, as required for Element C, but did not begin data collection or analysis activities in time to report for 2011.³

Conclusion

HEDIS 2011 results show improvement for many measures, and SNPs continue to narrow the performance gap, performing as well or better than MA plans on some measures. SNP performance on the S&P measures highlights some areas of very strong performance and some areas for improvement.

³The 2011 submission deadline was moved to February 2011 from a previous deadline of June 30, as it was in prior years. Many SNPs did not have sufficient time to revise their procedures and/or systems as a result of this change in the submission deadlines.

Objectives and Background

Objectives

This report presents the fourth year of results for SNPs reporting HEDIS performance measures and S&P measures. The report displays SNP performance in a table format, and discusses performance results, provides an overview of the criteria used to select the measures and examines the data collection and validation process. The *Data Limitations* section considers the challenges and constraints of SNP assessment.

CMS contracts with NCQA to conduct a SNP assessment program, which has two parts:

1. *Collect data on select HEDIS measures and analyze results.*
2. *Review data submissions on S&P measures, and analyze the results.*
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's objectives are:

- Describe the context in which NCQA developed the HEDIS and S&P measures.
- Present a series of tables illustrating SNP performance on HEDIS and S&P measures. For HEDIS, show year-to-year SNP performance and performance compared with Medicare Advantage (MA) plans. For S&P measures, show the percentage of plans that met the national benchmark (scored above 80 percent) on each element, as well as the percentage of plans that met each factor in each element.
- Analyze the results and provide qualitative and quantitative analyses.

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 (Medicare & Medicaid eligible); the institutionalized; and individuals with severe or disabling chronic conditions. SNPs are a type of MA plan. Unlike other types of MA plans, SNPs may limit enrollment to these specific subgroups.

- *Dual-Eligible SNPs (D-SNP)* enrolls beneficiaries eligible for Medicare and Medicaid
- *Institutional SNPs (I-SNP)* enrolls beneficiaries that are institutionalized or are institutional eligible
- *Chronic SNPs (C-SNP)* enroll beneficiaries with certain chronic or disabling conditions.

Initial legislation passed in 2003 authorizing the SNP program stated that SNPs should emphasize monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries maintain or improve their health status. Originally, SNP authority was set to expire in December 2008, but Congress has acted since then to extend and revise the program for SNPs beyond the period set in the law that created them.

Most recently, the Medicare Improvement and Patient Protection Act (MIPPA) and the Patient Protection and Affordable Care Act (PPACA):

- Extended SNPs through 2014
- Changed MA payments for all MA plans (including SNPs) by reducing them differentially by county and adding a quality bonus payment (QBP) system based on quality rating (effective in 2014)
- Charged CMS with exploring different approaches to risk adjustment for certain types of SNPs
- Called for SNPs to disenroll individuals who did not meet certain eligibility requirements or have specific severe chronic or disabling conditions
- Delayed the requirement that dual SNPs contract with states until 2012, for new SNPs, and until 2013, for existing SNPs operating in the same service areas
- Added a requirement that SNPs be NCQA approved.

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 specific subsets of special needs 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. 	
Marketing	<ul style="list-style-type: none"> • May target special needs populations in the market area. • May target specific subsets of special needs 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 with 11 SNPs in 2004 and grew to 702 by February 2008. Although the number of SNP benefit packages has steadily declined since then (dropping to 447 in 2010 and to 424 in 2011), the total population covered by SNPs increased by 10 percent from 2010 to 2011 (Table 2). Much of the decline in plans can be attributed to consolidation of SNP benefit packages by MA plans. With the decrease in the number of plans and the increase in enrollment, the overall average covered population per SNP increased from 2,495 to 2,890 members.

Most SNP enrollees are dual-eligible. Enrollment in D-SNPs ranges from fewer than 10 to more than 68,000 members.

Since 2008, CMS has required that all SNPs report S&P measures each year, regardless of size. Starting in 2009, CMS required every SNP benefit package (identified by a CMS Plan ID) with 30 or more enrollees to

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

submit audited HEDIS results each year. SNPs listed in the February *SNP Comprehensive Report* as having 29 members or fewer are not required to submit HEDIS measures the following year.

Figure 1 illustrates the total submissions for the S&P measures and HEDIS measures during the 2011 data collection period—424 SNPs reported S&P measures; 369 SNPs also reported HEDIS measures.

Figure 1. SNP Submissions for 2011 (N = 424)

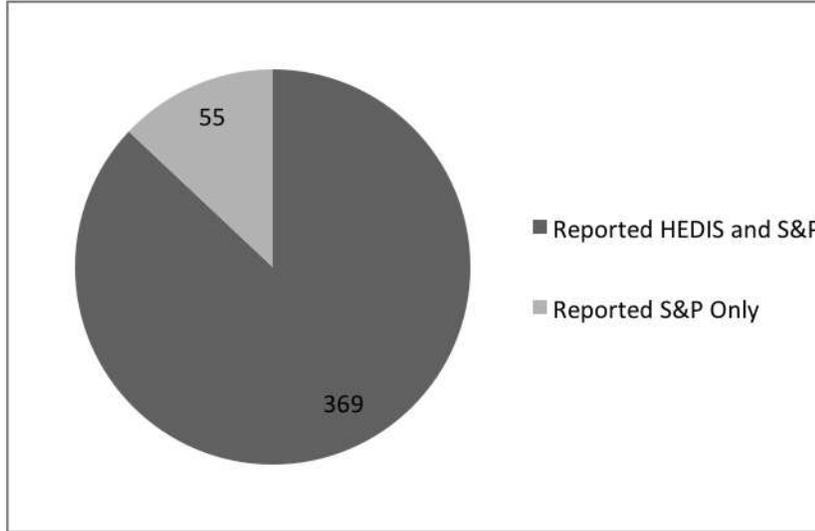


Table 2 illustrates the total submissions for S&P measures and HEDIS measures during the 2011 data collection period. As SNP organizations continue to consolidate benefit packages with low enrollment, the percentage of SNPs required to report HEDIS continues to increase—from 67 percent in 2009, to 85 percent in 2010, to 87 percent in 2011.

Table 2. SNP Enrollment as of February 2010 and February 2009 SNP Comprehensive Reports

SNP Type and Year	SNPs Required to Report HEDIS		SNPs Required to Report S&P Measures	
	Number of SNPs	Subtotal Enrollment	Number of SNPs	Subtotal Enrollment
Chronic or Disabling Condition 2010	85	173,473	115	173,479
Dual-Eligible 2010	256	809,084	272	820,262
Institutional 2010	40	121,204	60	121,849
2010 Total	381	1,103,761	447	1,115,590
Chronic or Disabling Condition 2011	68	124,411	80	142,708
Dual-Eligible 2011	259	888,109	286	991,423
Institutional 2011	42	95,794	58	92,013
2011 Total	369	1,108,314	424	1,225,251

The decrease in number of plans resulted in a higher percentage of SNPs that could report quality measures and in stronger reporting. Refer to Table 3.

Table 3. HEDIS Reporters by Denominator Size

Measures	Total Submissions		Denominator ≥30		Denominator <30	
	N	%	N	%	N	%
Colorectal Cancer Screening	369	100.0	304	82.4	65	17.6
Glaucoma Screening in Older Adults	369	100.0	308	83.5	61	16.5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	369	100.0	119	32.2	250	67.8
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	367	99.5	115	31.2	252	68.3
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	367	99.5	115	31.2	252	68.3
Controlling High Blood Pressure	362	98.1	302	81.8	60	16.3
Persistence of Beta-Blocker Treatment After a Heart Attack	367	99.5	44	11.9	323	87.5
Osteoporosis Management in Older Women	369	100.0	100	27.1	269	72.9
Antidepressant Medication Management—Acute Phase	363	98.4	82	22.2	281	76.2
Antidepressant Medication Management—Continuation Phase	363	98.4	82	22.2	281	76.2
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	365	98.9	101	27.4	264	71.5
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	365	98.9	101	27.4	264	71.5
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	369	100.0	341	92.4	28	7.6
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	369	100.0	138	37.4	231	62.6
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	369	100.0	329	89.2	40	10.8
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	369	100.0	179	48.5	190	51.5
Annual Monitoring for Patients on Persistent Medications—Total Rate	369	100.0	353	95.7	16	4.3
Medication Reconciliation Post-Discharge	364	98.6	309	83.7	55	14.9
Care for Older Adults—Advance Care Planning	366	99.2	349	94.6	17	4.6
Care for Older Adults—Medication Review	360	97.6	343	93.0	17	4.6
Care for Older Adults—Functional Status Assessment	365	98.9	348	94.3	17	4.6
Care for Older Adults—Pain Screening	362	98.1	345	93.5	17	4.6
Active Board Certification—Family Medicine	344	93.2	344	93.2	0	0.0
Active Board Certification—Internal Medicine	344	93.2	344	93.2	0	0.0
Active Board Certification—Geriatrics	344	93.2	344	93.2	0	0.0
Active Board Certification—Other Physician Specialists	344	93.2	344	93.2	0	0.0
Potentially Harmful Drug-Disease Interactions—History of Falls	369	100.0	167	45.3	202	54.7
Potentially Harmful Drug-Disease Interactions—Dementia	369	100.0	219	59.3	150	40.7
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	369	100.0	75	20.3	294	79.7
Potentially Harmful Drug-Disease Interactions—Total Rate	369	100.0	256	69.4	113	30.6
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	369	100.0	350	94.9	19	5.1
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	369	100.0	350	94.9	19	5.1

Note: NCQA's HEDIS policy is that rates based on denominators smaller than 30 should not be reported.

Assessing SNP Performance

In March 2007, CMS asked NCQA to develop an assessment approach that would define and assess desirable structural characteristics of SNPs (the Structure & Process measures), as well as measures of clinical performance (HEDIS measures). For the S&P measures, NCQA developed a phased approach that gradually became a comprehensive system for understanding the quality of care provided to SNP members, with consideration of specific needs. On the HEDIS side, NCQA selected clinical measures from existing HEDIS measures required by MA plans.

Structure & Process Measures

For the initial 2008 assessment of SNPs, NCQA adapted existing health plan accreditation standards to create the following S&P measures:

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

In 2009, CMS and NCQA developed three additional measures designed to specifically assess SNP performance with regard to specific SNP subpopulations:

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

In 2010, CMS and NCQA required returning SNPs (that submitted in 2009) to submit *SNP 4: Care Transitions* and *SNP 6: Coordination of Medicare and Medicaid Coverage* for a second year, and required new SNPs to submit all six S&P measures.

In 2011, SNPs were required to report all S&P measures.

HEDIS

In 2009, two HEDIS measures were added to the SNP reporting requirement:

- *Care for Older Adults*
- *Medication Reconciliation Post-Discharge.*

In 2011, CMS and NCQA required reporting of a new HEDIS measure, *Plan All-Cause Readmissions*, which assesses the rate of hospital readmissions within 30 days of an initial hospital admission.

New Submission Date

In past years, the submission date for the S&P and HEDIS measures has been June 30 of the reporting year. For 2011, CMS and NCQA moved the submission date for S&P measures to February 28. The SNP HEDIS submission dates did not change in 2011.

HEDIS Results

SNP Program Performance Changes, HEDIS 2009 – HEDIS 2011 (Tables 4a and 4b)

Tables 4a and 4b show a three-year trend in SNP performance on HEDIS measures. The two tables differ as follows:

- **Table 4a shows results aggregated across plans for the SNP program as a whole.** It includes all 32 measures and results from all plans that reported in any of the three years. For the analysis presented in this table, results for statistical significance tests between 2009 and 2011 and between 2010 and 2011 were based on a non-paired t-test ($p < 0.05$).
- **Table 4b shows results only for SNPs that reported HEDIS measures in all three reporting years (2009–2011).** NCQA analyzed the results for statistically significant differences between HEDIS 2009 and HEDIS 2010 and between HEDIS 2010 and HEDIS 2011, using a paired t-test ($p < 0.05$) to illustrate performance differences among the same group of SNPs between different time periods.

All SNPs reporting in any of the three years. For program-wide results (Table 4a), the overall trend is improvement from 2009–2010 and from 2010–2011, with 15 of the 32 measures (47 percent) showing statistically significant improvement from 2009–2010 and from 2010–2011. SNPs showed significant improvement on 18 measures from 2010–2011. Three *Board Certification* measures showed a significant decrease in performance from 2010–2011, but only one of these measures had a significant decrease over the full three-year period.

On average, scores improved by 4.5 percentage points over the three-year period. Three *Care for Older Adults* measures had an average increase of 20.7 percentage points from 2010–2011.

Plans reporting over the entire three-year period. On average, the three-year reporters had higher results across all measures in each year, 2009–2011. For SNPs that reported in all three years, 19 measures showed significant improvement over the entire three-year period, including 15 measures for which improvement was also statistically significant, as well as for the period 2010 to 2011. This represents a 2.5 percentage point improvement in the one-year results and a 3.8 percentage point improvement for the three-year results of the plans that reported in all three years (2009–2011). Seven measures rose by at least 10 percentage points over the three-year period.

Three nonclinical *Board-Certification* measures had a statistically significant decrease from 2010–2011. Three *Care for Older Adults* measures had an average increase of 13 percentage points from 2010–2011.

SNP-Only Measures introduced in 2009. We now have three years of data on the five SNP-only measures NCQA introduced in 2009. All of the measures show significant improvement from 2010 and three show significant improvement from 2009–2011. Three *Care for Older Adults* measures showed increases from 2009–2011: *Advance Care Planning* (16.1 percentage points); *Medication Review* (21.1 percentage points); and *Functional Status Assessment* (24.9 percentage points). While overall rates for the SNP-only measures remain relatively low, compared with some more mature measures such as *Annual Monitoring for Patients on Persistent Medications* or *Persistence of Beta-Blocker Treatment After a Heart Attack*, they show significant improvement.

Biggest Improvements. The following measures showed overall improvements of 5 percentage points or more from 2009–2011 for the SNP program as a whole:

- *Colorectal Cancer Screening*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
- *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event*
- *Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event*

- Controlling High Blood Pressure
- Care for Older Adults—Advance Care Planning
- Care for Older Adults—Medication Review
- Care for Older Adults—Functional Status Assessment
- Active Board Certification—Geriatrics.

Table 4a. HEDIS Performance for SNP Program, HEDIS 2009 – HEDIS 2011

This table includes program-wide results for all SNPs combined that reported in any of the three years.

Measures	HEDIS 2009	HEDIS 2010	HEDIS 2011		Significant Change (p<0.05)	
	Overall Rate	Overall Rate	Eligible Pop.	Overall Rate	09–11	10–11
Colorectal Cancer Screening	48.1	48.9	374,855	53.7	*	*
Glaucoma Screening in Older Adults	60.3	62.1	492,840	64.5	*	*
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	19.8	24.7	24,599	29.5	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	52.5	58.2	15,626	63.2	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	69.1	75.6	15,626	79.6	*	*
Controlling High Blood Pressure	53.6	56.4	443,036	58.8	*	*
Persistence of Beta-Blocker Treatment After a Heart Attack	78.1	79.7	5,211	82.8	*	*
Osteoporosis Management in Older Women	17.4	17.2	15,091	17.4		
Antidepressant Medication Management—Acute Phase	58.7	58.9	13,837	58.4		
Antidepressant Medication Management—Continuation Phase	44.5	45.6	13,837	45.6		
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	51.7	53.2	14,698	54.7		
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	33.5	34.5	14,698	36.8	*	
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	89.2	91.2	397,689	92.5	*	*
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	92.0	93.5	23,239	94.2	*	*
Annual Monitoring for Patients on Persistent Medications—Diuretics Monitoring	89.6	91.6	293,961	92.9	*	*
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	72.8	72.2	38,512	71.9		
Annual Monitoring for Patients on Persistent Medications—Total Rate***	88.6	90.5	753,401	91.6	*	*
Medication Reconciliation Post-Discharge**	31.7	29.7	212,177	33.8		*
Care for Older Adults—Advance Care Planning	12.6	17.6	671,208	28.7	*	*
Care for Older Adults—Medication Review	44.2	49.8	659,383	65.3	*	*
Care for Older Adults—Functional Status Assessment	23.8	25.8	671,118	48.7	*	*
Care for Older Adults—Pain Screening	42.2	34.8	660,145	43.3		*

**The measure is based on events or a disease or condition; a member with multiple events or a targeted disease or condition may be counted in the measure multiple times.

*** Indicates a summary measure that results from combining the measures above it.

Measures	HEDIS 2009	HEDIS 2010	HEDIS 2011		Significant Change (p<0.05)	
	Overall Rate	Overall Rate	Eligible Pop.	Overall Rate	09–11	10–11
Active Board Certification—Family Medicine	68.5	68.1	318,024	68.5		
Active Board Certification—Internal Medicine	75.9	77.2	503,172	75.4		*
Active Board Certification—Geriatrics	59.1	69.6	16,366	65.5	*	*
Active Board Certification—Other Physician Specialists	73.7	76.6	1,308,753	73.7		*
A lower rate is better for the following measures						
Potentially Harmful Drug-Disease Interactions—History of Falls	19.7	19.8	37,128	20.5		
Potentially Harmful Drug-Disease Interactions—Dementia	34.0	33.6	85,529	34.2		
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	18.1	18.9	10,740	18.2		
Potentially Harmful Drug-Disease Interactions—Total Rate***	28.8	28.5	133,397	29.1		
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	31.8	32.3	684,075	30.1	*	*
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	10.2	10.2	684,075	8.5	*	*

**The measure is based on events or a disease or condition; a member with multiple events or a targeted disease or condition may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

Table 4b. HEDIS Performance for Three-Year Reporting SNPs, HEDIS 2009 – HEDIS 2011

This table includes program-wide results for those SNPs that reported HEDIS 2009, 2010 and 2011 results.

Measures	HEDIS 2009	HEDIS 2010	HEDIS 2011		Significant Change (p<0.05)	
	Overall Rate	Overall Rate	Eligible Pop.	Overall Rate	09–11	10–11
Colorectal Cancer Screening	48.8	51.1	325,617	55.4	*	*
Glaucoma Screening in Older Adults	60.9	62.2	448,673	64.5	*	*
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	18.8	24.2	22,484	29.5	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	52.1	56.1	12,790	63.2	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	70.3	75.8	12,790	80.7	*	*
Controlling High Blood Pressure	53.8	57.6	360,758	60.1	*	*
Persistence of Beta-Blocker Treatment After a Heart Attack	79.7	80.4	4,453	83.2	*	*
Osteoporosis Management in Older Women	17.4	17.0	13,879	17.6		
Antidepressant Medication Management—Acute Phase	59.3	58.9	12,871	58.1		
Antidepressant Medication Management—Continuation Phase	45.2	45.5	12,871	45.4	*	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	54.1	53.9	12,965	55.6		
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	35.4	35.1	12,965	38.1	*	*
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	89.0	91.1	344,341	92.4	*	*
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	91.8	93.4	19,841	94.2	*	*
Annual Monitoring for Patients on Persistent Medications—Diuretics Monitoring	89.3	91.5	251,663	92.9	*	*
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	72.7	72.1	35,391	71.8		
Annual Monitoring for Patients on Persistent Medications—Total Rate***	88.3	90.3	651,236	91.5	*	*
Active Board Certification—Family Medicine	69.7	69.7	201,056	70.7	*	*
Active Board Certification—Internal Medicine	76.6	78.0	305,631	76.2		*
Active Board Certification—Geriatrics	55.6	69.2	10,271	66.2		*
Active Board Certification—Other Physician Specialists	73.5	76.9	841,037	74.4		*
Care for Older Adults—Advance Care Planning	16.0	18.9	494,008	26.4	*	*
Care for Older Adults—Medication Review	51.2	53.0	488,638	64.4	*	*
Care for Older Adults—Functional Status Assessment	28.2	25.6	497,903	43.7	*	*
Care for Older Adults—Pain Screening	48.9	37.4	489,453	42.5	*	*

Measures	HEDIS 2009	HEDIS 2010	HEDIS 2011		Significant Change (p<0.05)	
	Overall Rate	Overall Rate	Eligible Pop.	Overall Rate	09-11	10-11
A lower rate is better for the following measures						
Potentially Harmful Drug-Disease Interactions—History of Falls	20.1	20.0	33,454	20.6		*
Potentially Harmful Drug-Disease Interactions—Dementia	34.8	33.8	79,341	34.0	*	
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	18.7	18.9	9,486	17.9		*
Potentially Harmful Drug-Disease Interactions—Total Rate***	29.5	28.8	122,432	29.1	*	
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	32.9	33.8	595,572	29.9	*	*
Use of High-Risk Medications in the Elderly—At Least Two High-Risk Medications	10.9	11.1	595,572	8.4	*	*

* *The measure is based on events or a disease or condition; a member with multiple events or a targeted disease or condition may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

SNP Program and MA Program Performance (Table 5)

SNP and MA program performance. The data in Table 5 provide SNP program performance for the 27 measures both SNP and MA plans are required to report in the context of overall MA program performance. Please note that MA plans report HEDIS measures at the contract level, which may include SNP beneficiaries as some MA contracts include SNP plan benefit packages. However, these represent a small portion of the MA population, as indicated by the eligible population data for each measure. The results were analyzed for statistically significant differences ($p < 0.05$) between SNP and MA results.

For HEDIS 2011, SNPs significantly outperformed MA plans on 7 (4 Clinical, 3 *Board Certification*) of 27 required measures both groups are required to report. This is compared to outperforming MA plans on 5 HEDIS 2010 measures. There was no statistically significant difference in performance between the SNPs and the MA plans on 4 measures in both HEDIS 2011 and HEDIS 2010.

Table 5. HEDIS Performance for SNPs and MA Plans

This table shows population-based performance for all SNPs and all MA plans.

Measures	SNPs—2011		MA Plans—2011		Difference in Rates SNP—MA		Significant Difference b/w MA and SNP Rates (p<0.05)	
	Eligible Pop.	Overall Rate	Eligible Pop.	Overall Rate	2011	2010****	2011	2010
Colorectal Cancer Screening	374,855	53.7	3,780,009	62.3	-13.7	-8.6	*	*
Glaucoma Screening in Older Adults	492,840	64.5	6,246,201	67.8	-4.9	-3.3	*	*
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24,599	29.5	198,737	36.1	-4.2	-6.6	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	15,626	63.2	81,978	67.2	-3.8	-4.0	*	*
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	15,626	79.6	81,978	77.3	0.5	2.3		*
Controlling High Blood Pressure	443,036	58.8	3,875,336	64.6	-7.2	-5.8	*	*
Persistence of Beta-Blocker Treatment After a Heart Attack	5,211	82.8	41,387	83.7	-2.5	-0.9	*	
Osteoporosis Management in Older Women	15,091	17.4	126,561	23.1	-5.6	-5.7	*	*
Antidepressant Medication Management—Acute Phase	13,837	58.4	91,771	67.3	-9.1	-8.9	*	*
Antidepressant Medication Management—Continuation Phase	13,837	45.6	91,771	54.1	-8.8	-8.5	*	*
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	14,698	54.7	46,850	56.9	-3.0	-2.2	*	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	14,698	36.8	46,850	38.0	-3.6	-1.2	*	
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	397,689	92.5	3,377,768	91.9	0.9	0.6	*	
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	23,239	94.2	203,043	93.6	0.9	0.6	*	
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	293,961	92.9	2,625,181	92.1	1.1	0.8	*	*
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	38,512	71.9	129,554	69.3	3.0	2.6	*	*
Annual Monitoring for Patients on Persistent Medications—Total Rate***	753,401	91.6	6,335,546	91.6	0.5	0.1		
Medication Reconciliation Post-Discharge**	212,177	33.8						
Care for Older Adults—Advance Care Planning	671,208	28.7						
Care for Older Adults—Medication Review	659,383	65.3						
Care for Older Adults—Functional Status Assessment	671,118	48.7						
Care for Older Adults—Pain Screening	660,145	43.3						

Measures	SNPs—2011		MA Plans—2011		Difference in Rates SNP—MA		Significant Difference b/w MA and SNP Rates (p<0.05)	
	Eligible Pop.	Overall Rate	Eligible Pop.	Overall Rate	2011	2010****	2011	2010
Active Board Certification—Family Medicine	318,024	68.5	624,503	66.9	-1.1	1.6		
Active Board Certification—Internal Medicine	503,172	75.4	955,191	70.2	3.3	5.2	*	*
Active Board Certification—Geriatrics	16,366	65.5	30,695	55.2	6.7	10.3	*	*
Active Board Certification—Other Physician Specialists	1,308,753	73.7	2,255,649	69.7	1.8	4.0		*
Lower is better for the rates below								
Potentially Harmful Drug-Disease Interactions—History of Falls	37,128	20.5	371,829	16.0	3.9	4.4	*	*
Potentially Harmful Drug-Disease Interactions—Dementia	85,529	34.2	509,495	27.5	6.1	6.7	*	*
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	10,740	18.2	70,757	11.5	7.3	6.7	*	*
Potentially Harmful Drug-Disease Interactions—Total Rate***	133,397	29.1	952,081	21.8	6.7	7.3	*	*
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	684,075	30.1	7,982,121	21.5	10.0	8.6	*	*
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	684,075	8.5	7,982,121	4.9	4.8	3.5	*	*

**The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

****Gaps in performance were calculated from *HEDIS 2010 Performance Results*, September 28, 2010.

Note: Medication Reconciliation Post Discharge and Care for Older Adults are not reported by MA plans.

SNP Program Performance by SNP Type (Table 6)

Program performance by SNP type. The data in this table focus on performance by SNP type. Continuing a three-year trend, I-SNPs had statistically significant higher scores overall on more measures (7) than either D-SNPs or C-SNPs. I-SNP rates were at least 5 percentage points higher than either D-SNPs or C-SNPs on 19 measures. Conversely, D-SNPs improved significantly on 17 measures (53 percent) from 2010–2011. C-SNPs improved on 11 measures (34 percent) and I-SNPs improved on 7 measures (22 percent).

Table 6. SNP Program Performance by SNP Type, HEDIS 2011 and HEDIS 2010

This table displays program-wide results for all SNPs, by SNP type.

Measures	Dual SNPs					Institutional SNPs					Chronic SNPs				
	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011
	#	Rate	#	Rate		#	Rate	#	Rate		#	Rate	#	Rate	
Number of total SNPs	260		264			42		41			67		107		
Colorectal Cancer Screening	260	53.8*	264	49.1*	*	42	61.7*	40	58.0*		67	47.1*	106	42.4*	*
Glaucoma Screening in Older Adults	260	63.0	263	60.5	*	42	71.1	41	69.6*		67	66.7	107	60.3	*
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	260	30.4	264	25.5	*	42	22.7*	41	19.3*		67	31.8	107	29.4	
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	259	63.3	264	57.8*	*	42	57.7	41	46.3*	*	66	63.5	102	63.3*	
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	259	81.0	264	78.3*	*	42	71.8	41	59.2*	*	66	72.1	102	72.6*	
Controlling High Blood Pressure	254	59.0	254	56.8		42	65.5	38	57.4	*	66	55.3	82	54.8	
Persistence of Beta-Blocker Treatment After a Heart Attack	259	83.5	264	81.3	*	42	83.1	41	84.8		66	79.0	102	73.7*	*
Osteoporosis Management in Older Women	260	18.7	264	18.3		42	13.4	41	14.6		67	16.1	102	16.9	
Antidepressant Medication Management—Acute Phase	256	57.6	264	58.3		42	66.4	41	65.7		65	58.6	102	57.5	
Antidepressant Medication Management—Continuation Phase	256	44.7	264	44.8		42	54.7	41	52.6		65	45.2	102	45.5	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	257	54.9	263	53.6		42	40.8	41	41.3		66	52.7	107	50.8	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	257	37.0	263	34.7		42	28.3	41	27.3		66	34.9	107	33.6	
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	260	92.1*	264	90.8	*	42	94.1	41	92.9		67	93.8	102	91.8	*

* Denotes a rate that is statistically different ($p < 0.05$) than the rates of the other two SNP types in the same measurement year.

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

*** Indicates a summary measure that results from combining the measures above it.

Measures	Dual SNPs					Institutional SNPs					Chronic SNPs				
	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011
	#	Rate	#	Rate		#	Rate	#	Rate		#	Rate	#	Rate	
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	260	94.0	264	93.3		42	94.8	40	93.8		67	94.7	102	93.8	
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	260	92.5*	264	91.1*	*	42	94.6	41	93.3		67	94.2	102	92.3	
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	260	69.5	264	69.9		42	92.0*	41	91.1*		67	69.9	102	68.6	
Annual Monitoring for Patients on Persistent Medications—Total Rate***	260	91.1*	264	89.8*	*	42	94.2	41	93.0		67	93.5	102	91.7	
Medication Reconciliation Post-Discharge**	257	35.7	258	33.7*		41	23.2	39	20.7		66	33.7	107	23.4	
Care for Older Adults—Advance Care Planning	258	24.0	249	17.2*	*	42	69.2*	37	50.4*	*	66	19.4	107	11.6*	
Care for Older Adults—Medication Review	253	63.1	257	51.1	*	41	70.6	37	36.7	*	66	73.8	107	49.0	
Care for Older Adults—Functional Status Assessment	258	42.4*	257	23.9	*	41	71.9	37	54.9*	*	66	66.3	107	24.9	
Care for Older Adults—Pain Screening	255	40.3	257	36.0*	*	41	45.7	37	58.0*		66	59.7*	107	26.5*	
Active Board Certification—Family Medicine	243	68.0	254	68.8		37	76.2*	37	71.3	*	64	65.9	94	65.6	
Active Board Certification—Internal Medicine	243	75.2	250	76.9		37	77.6	37	80.0		64	74.3	101	76.5	
Active Board Certification—Geriatrics	243	65.5	253	71.7	*	37	67.0	37	68.2		64	63.9	101	64.6	
Active Board Certification—Other physician specialists	243	73.4	250	76.4	*	37	74.3	37	76.7		64	74.2	101	77.2	

Measures	Dual SNPs					Institutional SNPs					Chronic SNPs				
	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011	2011		2010		2010 vs. 2011
	#	Rate	#	Rate		#	Rate	#	Rate		#	Rate	#	Rate	
A lower rate is better for the following measures															
Potentially Harmful Drug-Disease Interactions—History of Falls	260	20.5	259	20.1		42	21.1	41	19.5		67	19.1	101	19.1	
Potentially Harmful Drug-Disease Interactions—Dementia	260	36.6	264	36.1		42	26.4*	41	27.4*		67	36.8	102	35.1	
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	260	18.6	264	19.6		42	12.9*	40	14.2*		67	20.6	102	20.2	
Potentially Harmful Drug-Disease Interactions—Total Rate***	260	30.4	264	30.1		42	24.7*	41	24.7*		67	29.0	102	28.2	
Use of High-Risk Medications in the Elderly—At least One High-Risk Medication	260	30.6	263	34.4*	*	42	27.2	41	26.8		67	30.0	102	29.5	
Use of High-Risk Medications in the Elderly—At least Two Different High-Risk Medications	260	8.9	263	11.8*	*	42	6.0	41	5.9		67	8.3	102	8.4	

* Denotes a rate that is statistically different ($p < 0.05$) than the rates of the other two SNP types in the same measurement year.

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

*** Indicates a summary measure that results from combining the measures above it.

2010: SNP Program Performance by CMS Region (Table 7)

This section reports SNP performance by CMS region. The analysis includes results from all SNPs.

- *Region 1:* Boston (ME, NH, VT, MA, RI, CT)
- *Region 2:* New York (NY, NJ, PR, VI)
- *Region 3:* Philadelphia (PA, MD, WV, DC, DE, VA)
- *Region 4:* Atlanta (KY, NC, SC, GA, FL, AL, MS, TN)
- *Region 5:* Chicago (OH, IN, IL, MI, WI, MN)
- *Region 6:* Dallas (LA, AR, OK, TX, NM)
- *Region 7:* Kansas City (IA, MO, KS, NE)
- *Region 8:* Denver (ND, SD, CO, WY, MT, UT)
- *Region 9:* San Francisco (AZ, NV, CA, HI, Guam, American Samoa)
- *Region 10:* Seattle (ID, OR, WA, AK)

NCQA conducted statistical significance testing of each region's rates compared to the average of the remaining regions. Although there are many statistically significant differences, there was no clear indication of one region performing better than others. The average performance by region across all of the measures was 65.3 percent and the spread between all of the regions was 2.6 percentage points, thus, there was not a lot of variation. Four of the regions scored better than the average (regions 1, 3, 9 and 10), with one region (region 9) scoring the highest overall (66.3).

Table 7. SNP Program Performance by CMS Region, HEDIS 2011

This table displays program-wide results for all SNPs combined in each region.

REGIONAL PERFORMANCE RATES																			
1		2		3		4		5		6		7		8		9		10	
Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate
Number of SNPs per Region																			
7		47		22		79		74		26		4		5		93		11	
Colorectal Cancer Screening																			
3,682	54.8	106,558	53.7	46,821	45.0*	50,291	54.6	36,673	43.3	20,042	51.4	1,118	60.3	2,360	54.4	96,724	62.1*	8,043	3,682
Glaucoma Screening in Older Adults																			
7,249	71.5	124,013	58.0	48,979	65.5	60,769	65.0	64,548	64.3	25,669	67.1	1,405	72.8*	2,477	68.0	149,161	68.6	6,504	64.6
Use of Spirometry Testing in the Assessment and Diagnosis of COPD																			
283	26.5	5,857	31.6	3,438	27.2*	3,449	32.7	2,866	23.0	1,239	34.4	49	34.7	184	41.3	6,679	29.2	467	25.5
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event																			
145	71.7	2,436	44.2	2,941	67.9	2,797	65.5	2,942	66.4*	697	64.4	49	67.3*	97	77.3*	2,971	68.1*	491	63.1*
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event																			
145	86.9	2,436	66.2	2,941	80.2	2,797	81.4	2,942	84.1	697	81.3	49	77.6*	97	90.7	2,971	82.3	491	83.7
Controlling High Blood Pressure																			
5,338	53.3	131,368	56.5	58,710	52.2	66,211	55.1	43,715	56.6	21,815	58.5	2,215	61.7	1,989	70.2*	104,824	68.9*	4,553	61.2*
Persistence of Beta-Blocker Treatment After a Heart Attack																			
88	88.6	1,451	78.3	759	84.1	719	82.6	670	85.4	250	83.2	21	85.7*	25	92.0	1,113	85.4	97	88.7
Osteoporosis Management in Older Women																			
202	12.9	2,853	11.8	1,536	14.1*	1,903	17.6	3,017	11.2*	759	22.1	43	30.2*	100	43.0	4,386	25.1*	263	15.6
Antidepressant Medication Management—Acute Phase																			
85	51.8	4,440	48.2	1,188	56.6	1,866	57.2	1,454	62.4*	545	56.3	40	60.0*	108	74.1	3,803	69.8	218	67.0*
Antidepressant Medication Management—Continuation Phase																			
85	44.7	4,440	36.6	1,188	45.6	1,866	43.4	1,454	52.7*	545	40.9	40	60.0*	108	63.0*	3,803	54.1	218	58.7*

*Denotes a rate that is statistically different (p<0.05) than the combined rate for the other nine regions.

REGIONAL PERFORMANCE RATES																			
1		2		3		4		5		6		7		8		9		10	
Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate
Number of SNPs per Region																			
7		47		22		79		74		26		4		5		93		11	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge																			
90	47.8*	2,846	66.4	2,646	50.8	2,364	40.1	2,222	54.5*	648	53.9	54	38.9*	194	80.9	3,241	56.2	393	64.4
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge																			
90	36.7*	2,846	45.9	2,646	31.9	2,364	23.9	2,222	35.1*	648	33.5	54	18.5*	194	60.8	3,241	41.4	393	48.3
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring																			
4,824	93.4	112,017	91.7	50,322	92.8	52,432	93.8	46,149	93.2	21,798	92.5	2,041	95.2*	1,955	93.5	98,674	92.0	5,922	90.3*
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring																			
262	95.8	5,814	93.0	3,036	94.2	3,053	95.4	3,764	95.5	817	94.5	116	97.4*	68	98.5	5,876	93.8	365	90.7
Annual Monitoring for Patients on Persistent Medications—Diuretics Monitoring																			
4,299	94.6	69,761	92.0	41,776	93.1	43,158	93.8	41,718	93.9	15,078	93.1	1,491	96.2*	1,627	93.4	69,111	92.4	4,871	90.4*
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring																			
346	76.3	7,555	54.3	5,547	78.4*	4,548	76.2	7,288	83.2	1,173	69.2	61	63.9*	421	77.0	9,467	71.0*	1,987	74.2
Annual Monitoring for Patients on Persistent Medications—Total Rate**																			
9,731	93.4	195,147	90.4	100,681	92.2	103,191	93.1	98,919	92.8	38,866	92.1	3,709	95.2*	4,071	91.8	183,128	91.1	13,145	87.9*
Medication Reconciliation Post-Discharge																			
3,613	42.1	47,597	27.3	29,938	35.8	30,581	29.7	38,060	30.4	9,011	40.1	895	5.5	950	62.9	47,274	42.3	3,283	40.7*
Care for Older Adults—Advance Care Planning																			
9,796	64.3	175,661	12.7*	72,313	13.7*	89,589	23.9	92,338	41.3	34,335	18.8	2,984	16.2*	2,175	27.7	181,150	46.4*	8,566	29.8*
Care for Older Adults—Medication Review																			
9,796	84.6	175,661	56.5*	72,313	73.3	89,589	68.1*	89,815	66.5	33,483	45.0	2,984	82.3*	2,175	77.5	172,700	71.4	8,566	67.1
Care for Older Adults—Functional Status Assessment																			
9,796	81.6	175,661	32.5*	72,313	57.5*	89,589	51.3*	92,338	62.9	34,245	25.9	2,984	31.1*	2,175	47.1	181,150	55.7*	8,566	47.7*
Care for Older Adults—Pain Screening																			
9,796	76.6	175,661	39.6*	72,313	56.2	89,589	40.4*	89,815	47.2	34,245	23.9	2,984	21.3	2,175	40.3	172,700	43.8*	8,566	47.9

*Denotes a rate that is statistically different (p<0.05) than the combined rate for the other nine regions.

**Indicates a summary measure that results from combining the measures above it.

REGIONAL PERFORMANCE RATES																			
1		2		3		4		5		6		7		8		9		10	
Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate	Elig. Pop	Rate
Number of SNPs per Region																			
7		47		22		79		74		26		4		5		93		11	
Active Board Certification—Family Medicine																			
4,124	74.3*	29,017	62.2	21,057	82.5*	98,955	62.7*	82,915	80.3	22,790	59.2	2,169	77.1*	1,408	81.9*	50,732	60.1*	4,857	83.9
Active Board Certification—Internal Medicine																			
13,838	81.1*	78,150	75.0	32,140	82.8*	184,955	73.0*	89,428	82.4	37,486	64.8	2,076	79.7	894	78.1*	58,621	73.1	5,584	81.6
Active Board Certification—Geriatrics																			
520	71.2*	3,369	72.6	1,530	85.9*	4,449	49.9*	3,613	75.3	910	34.0	54	70.4*	114	44.7*	1,627	67.5	180	82.8
Active Board Certification—Other Physician Specialists																			
34,175	78.1*	205,284	74.1	93,115	84.1	408,373	70.3*	286,190	77.8	80,986	63.1	8,859	70.9	7,285	79.7*	167,031	71.5	17,455	82.7
Lower is better for the rates below																			
Potentially Harmful Drug-Disease Interactions—History of Falls																			
514	24.3	6,105	20.2*	4,811	18.7	4,781	20.5	4,812	20.4	2,241	21.3	43	16.3	330	20.9	12,796	20.7	491	30.1
Potentially Harmful Drug-Disease Interactions—Dementia																			
1,580	33.2	21,253	43.6	7,405	33.6*	10,782	33.6	20,843	25.8	2,873	39.5	121	32.2*	428	24.8	18,839	32.7	1,165	38.5
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure																			
133	10.5	2,404	27.7	1,353	19.3	1,269	17.2	1,361	12.8	610	16.1	25	4.0*	82	8.5	3,339	15.1*	123	8.1
Potentially Harmful Drug-Disease Interactions—Total Rate**																			
2,227	29.8	29,762	37.5	13,569	26.9*	16,832	28.6	27,016	24.2	5,724	29.9	189	24.9*	840	21.7	34,974	26.6	1,779	34.1
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication																			
9,761	23.0*	181,013	35.2	74,222	28.6*	90,693	32.6*	92,460	25.3	35,021	35.6	3,050	23.4*	3,263	22.0	183,328	26.4	8,885	29.6
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications																			
9,761	4.4	181,013	11.4	74,222	7.6*	90,693	9.4*	92,460	5.9	35,021	11.5	3,050	4.9*	3,263	4.9	183,328	6.5	8,885	8.0

*Denotes a rate that is statistically different (p<0.05) than the combined rate for the other nine regions

**Indicates a summary measure that results from combining the measures above it.

SNP Program Performance by Enrollment Size (Table 8)

This table displays program-wide performance for all SNPs by enrollment. Statistically significant changes are displayed within enrollment size categories and denote a change from 2010 to 2011 within that specific enrollment category. Overall, the largest plans (more than 2,500 members), which compose the majority of total SNP enrollment as well as the majority of plans in the SNP program, as well as those with 100-499 members showed the most improvement from 2010–2011, with 13 and 12 measures respectively, increasing significantly. The smallest plans (30–99 members) and mid-size plans (500–999 members) had the fewest number of measures (3) with significant improvement. Plans with 1,000–2,499 members showed improvement on 6 measures. Interestingly, the plans with 100-499 members also had significant decreases in three of the *Active Board Certification* measures (*Internal Medicine, Geriatrics, Other Physician Specialists*).

While only one enrollment category had any statistically significant decreases from 2010–2011, (100–499), all of the enrollment categories had multiple measures that either remained static or decreased. The 500–999 enrollment category had the most measures decrease (13) while also having the lowest number of significant increases (3). The two categories with the highest number of increased measures (1,000–2,499; >2,500) also had the fewest number of measures decrease (7) from 2010–2011.

The two smallest enrollment categories (30–99; 100–499) had the highest average HEDIS scores as compared to the other enrollment size categories over the three-year period 2009–2011. The two largest plan categories had the largest percentage point increases over the three-year period (4.7 and 4.5 percent, respectively). The smallest plan categories had increases of 4.6 and 3.2 percentage points. The mid-size plans showed the smallest increase (2 percentage points) over the three-year period.

NCQA could not test for statistical significance of the differences among SNP sizes. Given that statistical significance is a function of both effect size and sample size, the mean of the larger SNPs would dominate the mean of the sizes against which comparisons are made. It should be noted that as enrollment size increases, it is more likely that statistically significant differences will be found for progressively smaller effect sizes.

**Table 8. SNP Overall Program Performance by Enrollment Size, HEDIS 2011 and HEDIS 2010
(Based on enrollment as of February 2010)**

Measures	RATE BY SNP ENROLLMENT SIZE														
	30–99			100–499			500–999			1,000–2,499			≥2,500		
	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff
Number of SNPs With Reportable Results	15	30		92	122		60	75		102	82		100	103	
Colorectal Cancer Screening	37.5	37.0		50.1	39.0	*	48.3	43.0	*	49.5	46.2		54.4	49.6	*
Glaucoma Screening in Older Adults	64.9	58.2		68.7	59.9	*	62.6	61.3		63.2	63.2		64.7	62.0	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0	20.0		31.5	20.0	*	23.4	24.1		29.7	23.4	*	29.6	25.0	*
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	85.7	37.1	*	68.6	60.7	*	63.8	59.5		65.3	60.5	*	62.6	57.7	*
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	85.7	68.6		80.2	78.3		79.5	79.9		83.2	78.5	*	78.9	74.6	*
Controlling High Blood Pressure	55.7	43.4		57.9	53.2		56.0	54.6		58.9	56.1		58.9	56.7	
Persistence of Beta-Blocker Treatment After a Heart Attack	87.5	83.3		87.5	81.5		81.3	80.8		81.5	77.6		83.0	79.8	*
Osteoporosis Management in Older Women	13.0	33.3		12.7	17.1		15.1	15.9		13.7	14.0		18.3	17.7	
Antidepressant Medication Management—Acute Phase	66.7	75.0		56.9	62.6		63.6	66.0		60.4	63.3		58.0	58.1	
Antidepressant Medication Management—Continuation Phase	33.3	50.0		43.6	52.8		50.1	52.9		49.3	53.8		45.0	44.4	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	83.3	48.1		44.8	49.5		41.7	46.8		53.4	50.8		55.9	54.4	
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	33.3	37.0		28.8	32.2		26.8	31.0		37.4	33.7		37.4	35.0	
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	91.6	92.5		93.2	89.8	*	93.0	91.6		91.9	91.3		92.5	91.2	*
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	100.0	96.4		96.9	93.2	*	94.4	95.6		94.7	94.1		94.0	93.2	
Annual Monitoring for Patients on Persistent Medications—Diuretics Monitoring	92.8	93.5		94.1	90.6	*	93.2	91.8		92.7	92.0		92.9	91.5	*
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	79.5	84.7		81.4	77.7		78.0	79.1		81.6	78.7		69.0	70.2	
Annual Monitoring for Patients on Persistent Medications—Total Rate***	91.5	92.6		93.1	89.6	*	92.2	91.2		91.6	90.8		91.6	90.4	*

RATE BY SNP ENROLLMENT SIZE															
Measures	30-99			100-499			500-999			1,000-2,499			≥2,500		
	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff	2011 Rate	2010 Rate	Sig Diff
Medication Reconciliation Post-Discharge**	33.3	14.3	*	31.1	25.5		30.1	32.1		26.6	27.2		35.6	30.3	
Care for Older Adults—Advance Care Planning	39.1	31.4		49.9	24.1	*	35.6	22.1	*	38.3	29.2		26.5	15.3	*
Care for Older Adults—Medication Review	71.0	47.5	*	75.8	52.9	*	65.4	57.7		68.5	52.4	*	64.6	48.9	*
Care for Older Adults—Functional Status Assessment	48.1	33.0		62.4	26.5	*	50.5	28.9	*	51.5	32.6	*	47.9	24.5	*
Care for Older Adults—Pain Screening	47.9	39.6		52.5	36.2	*	46.8	37.8		48.8	37.5	*	42.1	34.2	*
Active Board Certification—Family Medicine	74.3	73.2		65.5	66.7		70.4	68.8		68.6	67.6		69.5	68.6	
Active Board Certification—Internal Medicine	81.2	74.5		72.2	76.1	*	77.0	76.3		76.9	78.3		75.6	77.9	
Active Board Certification—Geriatrics	78.1	73.6		56.5	68.1	*	72.1	71.3		65.6	64.2		68.6	74.0	
Active Board Certification—Other Physician Specialists	76.6	68.3		68.9	75.8	*	74.6	76.5		75.0	77.5		75.3	77.8	
Lower is better for the rates below															
Potentially Harmful Drug-Disease Interactions—History of Falls	22.6	17.6		22.8	21.6		22.4	21.7		21.5	21.1		20.2	19.6	
Potentially Harmful Drug-Disease Interactions—Dementia	31.3	35.0		26.6	30.5		30.3	31.4		27.7	29.1		36.4	34.6	
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	22.2	5.0		19.0	16.4		18.0	13.9		13.6	13.9		18.9	19.9	
Potentially Harmful Drug-Disease Interactions—Total Rate***	29.3	27.3		25.1	27.0		27.0	27.0		25.6	26.4		30.1	28.9	
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	26.9	28.7		25.5	26.9		28.3	29.8		27.5	28.7		30.7	33.1	
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	5.7	7.9		6.1	6.7		7.5	8.2		6.6	7.6		8.8	10.8	*

*Denotes a rate that is statistically different (p<0.05) from 2010-2011.

**The measure is based on events or a disease or condition; a member with multiple events or a targeted disease or condition may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

SNP Benefit Package Performance (Table 9)

This section focuses on individual SNP benefit package (also called “plan benefit packages, or PBPs”) performance and how performance on each measure is distributed: for each measure, distribution is based on the performance of SNPs that had at least 30 members eligible for the measure.

For minimally acceptable reliability of performance results, a minimum sample size is defined as a denominator ≥ 30 ; therefore, we only report results for individual SNPs with a denominator of at least 30 for each measure. Table 9 includes mean, standard deviation, performance distribution (10th—90th percentiles) and minimum and maximum HEDIS scores for SNPs that met the 30+ criterion for the measures. The number of SNPs included ranged from 353 for *Annual Monitoring for Patients on Persistent Medications—Total Rate*, to 44 for *Persistence of Beta-Blocker Treatment After a Heart Attack*.

Consolidation of benefit packages and growth in the overall SNP population over time has led to higher average enrollments per benefit package, resulting in more plans reporting more measures from 2010—2011.

Data show a wide distribution of performance within each measure. The average span between the 10th and 90th percentile is 34 percentage points; a decrease of 2 percentage points from last year, showing that the gap between the highest and lowest performers for any measure is narrowing. The gap ranges from 9.8 percentage points (*Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring*) to 87.8 points (*Care for Older Adults—Advance Care Planning*). Similar to 2010, the lowest gaps were for measures involving medication management and the highest were for the SNP-only measures (*Care for Older Adults* and *Medication Reconciliation Post-Discharge*).

In order to determine which measures presented the greatest areas for improvement, we looked at the distribution of 2011 SNP scores across all measures at the benefit package level. We determined that nine measures (two *Follow-Up After Hospitalization for Mental Illness* measures, *Annual Monitoring for Patients on Persistent Medication-Anticonvulsant Monitoring*, all four *Care for Older Adults* measures, *Medication Reconciliation Post-Discharge* and *Active Board Certification-Geriatrics* measure) had large percentage point differences (40 points or more) between SNPs scoring in the 10th percentile and those in the 90th percentile. The same nine measures also showed a large difference (at least 20 percentage points) between the 90th percentile and the mean score, and thus present the greatest areas for overall improvement. This is particularly true for three *Care for Older Adults* measures, which had differences of more than 50 percentage points, on average, between the mean score and those in the 90th percentile.

Table 9. SNP Benefit Package Performance, HEDIS 2011

Measures	Total SNPs	Mean	Std. Dev.	Min	Percentile					Max
					10th	25th	50th	75th	90th	
Colorectal Cancer Screening	304	48.1	14.7	11.5	29.1	38.0	49.4	57.4	66.0	84.6
Glaucoma Screening in Older Adults	308	62.1	14.4	7.5	43.9	54.4	63.2	71.8	79.5	93.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	119	30.3	12.2	0.0	16.1	21.6	29.6	38.7	48.0	60.6
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	115	64.8	11.3	16.9	50.0	59.0	66.2	71.7	77.2	86.5
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	115	80.4	11.5	19.6	66.1	76.9	82.2	87.9	92.1	97.4
Controlling High Blood Pressure	302	57.9	12.4	4.3	43.0	49.2	58.2	65.1	74.0	91.5
Persistence of Beta-Blocker Treatment After a Heart Attack	44	84.3	7.6	62.3	75.3	81.3	86.2	89.7	91.7	95.2
Osteoporosis Management in Older Women	100	16.3	11.9	0.0	4.4	9.2	14.7	19.4	28.6	69.2
Antidepressant Medication Management—Acute Phase	82	59.1	12.1	20.2	47.4	52.1	59.2	65.9	72.2	94.9
Antidepressant Medication Management—Continuation Phase	82	45.9	12.8	10.1	32.3	37.9	46.5	53.1	61.4	87.2
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	101	50.3	18.7	1.8	25.0	38.0	50.8	62.2	76.5	86.4
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	101	33.1	17.2	0.0	13.2	21.4	29.8	42.1	60.8	73.0
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	341	92.2	7.0	46.5	86.8	90.5	93.2	95.7	99.0	100.0
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	138	94.8	5.9	40.0	90.2	93.3	95.2	97.8	100.0	100.0
Annual Monitoring for Patients on Persistent Medications—Diuretics Monitoring	329	92.9	6.3	52.0	87.6	91.1	93.3	96.5	100.0	100.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	179	74.3	13.8	23.3	57.4	66.7	74.4	82.1	100.0	100.0
Annual Monitoring for Patients on Persistent Medications—Total Rate***	353	91.3	7.4	43.7	85.8	89.4	92.2	95.2	99.0	100.0
Medication Reconciliation Post-Discharge**	309	31.1	21.2	0.0	7.9	15.6	26.1	44.3	60.0	97.3
Care for Older Adults—Advance care Planning	349	31.4	30.4	0.0	4.2	9.5	18.1	44.0	92.0	100.0
Care for Older Adults—Medication Review	343	66.4	22.1	0.0	38.9	53.0	68.3	83.8	94.2	100.0
Care for Older Adults—Functional Status Assessment	348	48.1	29.6	0.0	11.1	22.4	43.9	71.1	94.7	100.0
Care for Older Adults—Pain Screening	345	44.2	29.3	0.0	12.1	21.5	36.8	68.6	94.4	100.0
Active Board Certification—Family Medicine	344	69.7	16.9	2.7	50.2	63.1	73.6	81.6	87.2	99.2
Active Board Certification—Internal Medicine	344	75.1	12.8	17.0	63.7	68.0	76.8	84.5	88.8	99.3
Active Board Certification—Geriatrics	311	70.9	22.6	0.0	40.0	60.6	73.8	87.0	100.0	100.0
Active Board Certification—Other Physician Specialists	344	74.5	13.6	15.3	54.0	71.4	76.9	82.8	87.9	100.0

Measures	Total SNPs	Mean	Std. Dev.	Min	Percentile					Max
					10th	25th	50th	75th	90th	
Lower is better for the rates below										
Potentially Harmful Drug-Disease Interactions in the Elderly—History of Falls	167	21.2	5.6	7.7	15.5	17.3	20.5	24.7	29.4	39.2
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia	219	33.8	10.0	10.7	20.4	26.8	33.9	41.2	47.4	54.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure	75	17.6	10.2	2.9	8.1	10.0	14.4	21.7	33.7	51.2
Potentially Harmful Drug-Disease Interactions—Total Rate***	256	28.1	7.5	7.7	18.4	22.9	27.1	32.8	38.2	50.1
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	350	28.5	8.8	0.0	17.1	22.2	28.6	34.8	39.8	50.3
Use of High-Risk Medications in the Elderly—At Least Two High-Risk Medications	350	7.5	4.3	0.0	2.4	4.1	7.3	10.1	13.0	21.5

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

SNP Benefit Package Performance Changes, HEDIS 2009–HEDIS 2011 (Table 10; Figure 10)

Table 10 analyzes performance by benefit package, showing the percent of benefit packages that improved performance and that decreased performance, both between 2009–2011 and between 2010–2011. Like Table 9, this table shows results from those individual SNPs that met the reporting criterion of having 30+ members in the denominator for the measure. Comparisons between 2009–2011 were based only on plans with submissions in all three years while comparisons between 2010–2011 were based on plans with submissions in 2010–2011.

For 27 measures, more than 50 percent of SNPs improved their results from 2009–2011. From 2009–2011, at least 70 percent of SNPs increased performance on 7 measures (*Colorectal Cancer Screening; Use of Spirometry Testing in the Assessment and Diagnosis of COPD; Care for Older Adults—Advance Care Planning* measures; and *Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days*), and on 3 *Annual Monitoring of Patients on Persistent Medications* measures.

Table 10. SNP Benefit Package Performance Changes, HEDIS 2009–HEDIS 2011

Measures	Percentage of SNPs With Changes in Performance 2009–2011	
	Improved Performance	Decreased Performance
Colorectal Cancer Screening	88.7	10.7
Glaucoma Screening in Older Adults	69.8	30.2
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	81.3	18.7
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	67.5	32.5
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	70.1	29.9
Controlling High Blood Pressure	69.8	30.2
Persistence of Beta-Blocker Treatment After a Heart Attack	59.3	40.7
Osteoporosis Management in Older Women	54.4	45.6
Antidepressant Medication Management—Acute Phase	51.0	49.0
Antidepressant Medication Management—Continuation Phase	57.1	42.9
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	55.6	42.9
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	60.3	39.7
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	75.5	19.4
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	62.6	26.4
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	77.7	17.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	50.8	39.3
Annual Monitoring for Patients on Persistent Medications—Total Rate***	75.4	19.1
Medication Reconciliation Post-Discharge**	44.7	53.6
Care for Older Adults—Advance Care Planning	80.7	17.2
Care for Older Adults—Medication Review	60.0	38.5
Care for Older Adults—Functional Status Assessment	60.8	37.2
Care for Older Adults—Pain Screening	31.8	66.7
Active Board Certification—Family Medicine	54.8	45.2
Active Board Certification—Internal Medicine	45.2	54.8

Measures	Percentage of SNPs With Changes in Performance 2009–2011	
	Improved Performance	Decreased Performance
Active Board Certification—Geriatrics	39.2	50.8
Active Board Certification—Other Physician Specialists	55.8	44.2
Potentially Harmful Drug-Disease Interactions in the Elderly—History of Falls	45.7	53.2
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia	58.8	41.2
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure	57.1	40.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Total Rate****	55.3	44.1
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	62.9	37.1
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	66.7	33.3

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

****Indicates a summary measure that results from combining the measures above it.

Percent of SNPs With Changes in Performance 2009-2011

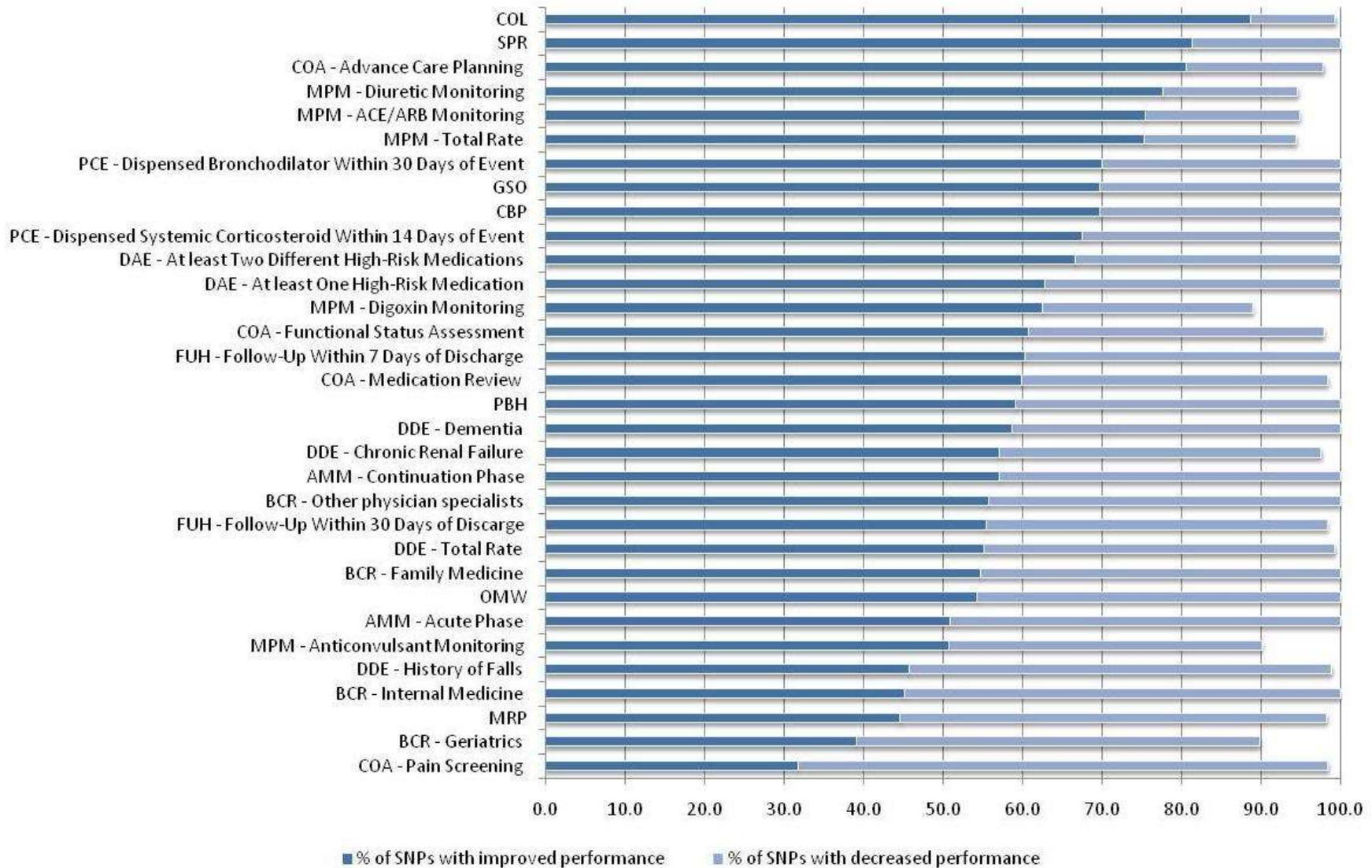


Figure 10

SNP HEDIS Data Submissions by Measure (Tables 11a and 11b)

These tables describe the number of SNPs reporting each HEDIS measure as well as categorize reasons some SNPs were not able to report valid rates for certain measures. A total of 369 SNPs were required to submit HEDIS measure results (Table 11a).

Based on its review, NCQA Certified HEDIS Auditors categorized each measure as follows.

- Did Report Categories (Table 11a)
 - *Denominator* ≥ 30 is designated as a *Reportable Rate* for individual plans.
 - *Denominator* < 30 receives a *Not Applicable (NA)* audit designation, denoting SNPs with fewer than 30 members in the denominator for the measure. These rates are not considered *individually* reportable.
- Did Not Report Categories (Table 11b)
 - *Did Not Report (NR)* indicates that the SNP chose not to report a specific measure. Twenty-four SNPs chose not to report *Controlling High Blood Pressure*, by far the largest number of SNPs in any Did Not Report category.
 - *Materially Biased (BR)* is a determination made by NCQA Certified HEDIS Auditors. HEDIS measure rates generally have a 95 percent confidence interval. If auditors determine that a measure's rate is likely to be biased by more than ± 5 percentage points due to data errors, the auditors designate the rate as materially biased.
 - *Did Not Offer Benefit Required (NB)* indicates that the SNP did not offer the benefit required for the measure. Of the 32 measures, 15 assess medication management and require data from a pharmacy benefit for calculation.

Table 11a reports the numbers of submissions by measure; Table 11b reports the number of SNPs that did not report a specific measure. In Table 11b, all eligible SNPs reported, unless there was a material bias.

There were 17 measures where more than 80 percent of the SNPs had a sufficient population (denominator of at least 30 members) to report the measures, up from 15 measures in 2010. The measures where the highest number of SNPs had sufficient populations were *Use of High-Risk Medications in the Elderly* measures (*At Least One High-Risk Medication* and *At Least Two High-Risk Medications*), both of which had 350 SNPs (94.9 percent of the plans reporting) with measure denominators of ≥ 30 members, followed closely by the four *Care for Older Adults* measures, where an average of 346 SNPs (93.8 percent) were able to report. In addition, the *Board Certification* measures, for which the denominators are physicians rather than members, were reported by 344 SNPs (93.2 percent).

SNPs are less likely to be able to report for measures that address conditions that are more rare or if the measure is for a new case of a condition. *Persistence of Beta-Blocker Treatment After a Heart Attack* had the lowest number of SNPs with reportable rates (44; 11.9 percent). The four measures related to depression medication management and mental illness had low reportable rates as well (22.2 percent and 27.4 percent, respectively).

Table 11a. SNP HEDIS 2011 Data Submission by Measure—Did Report

Measures	Total Submissions		Denominator ≥30		Denominator <30	
	N	%	N	%	N	%
Colorectal Cancer Screening	369	100.0	304	82.4	65	17.6
Glaucoma Screening in Older Adults	369	100.0	308	83.5	61	16.5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	369	100.0	119	32.2	250	67.8
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	367	99.5	115	31.2	252	68.3
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	367	99.5	115	31.2	252	68.3
Controlling High Blood Pressure	362	98.1	302	81.8	60	16.3
Persistence of Beta-Blocker Treatment After a Heart Attack	367	99.5	44	11.9	323	87.5
Osteoporosis Management in Older Women	369	100.0	100	27.1	269	72.9
Antidepressant Medication Management—Acute Phase	363	98.4	82	22.2	281	76.2
Antidepressant Medication Management—Continuation Phase	363	98.4	82	22.2	281	76.2
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	365	98.9	101	27.4	264	71.5
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	365	98.9	101	27.4	264	71.5
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	369	100.0	341	92.4	28	7.6
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	369	100.0	138	37.4	231	62.6
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	369	100.0	329	89.2	40	10.8
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	369	100.0	179	48.5	190	51.5
Annual Monitoring for Patients on Persistent Medications—Total Rate***	369	100.0	353	95.7	16	4.3
Medication Reconciliation Post-Discharge**	364	98.6	309	83.7	55	14.9
Care for Older Adults—Advance Care Planning	366	99.2	349	94.6	17	4.6
Care for Older Adults—Medication Review	360	97.6	343	93.0	17	4.6
Care for Older Adults—Functional Status Assessment	365	98.9	348	94.3	17	4.6
Care for Older Adults—Pain Screening	362	98.1	345	93.5	17	4.6
Active Board Certification—Family Medicine	344	93.2	344	93.2	0	0.0
Active Board Certification—Internal Medicine	344	93.2	344	93.2	0	0.0
Active Board Certification—Geriatrics	344	93.2	344	93.2	0	0.0
Active Board Certification—Other Physician Specialists	344	93.2	344	93.2	0	0.0
Lower is better for the rates below						
Potentially Harmful Drug-Disease Interactions in the Elderly—History of Falls	369	100.0	167	45.3	202	54.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia	369	100.0	219	59.3	150	40.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure	369	100.0	75	20.3	294	79.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Total Rate***	369	100.0	256	69.4	113	30.6

Measures	Total Submissions		Denominator ≥30		Denominator <30	
	N	%	N	%	N	%
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	369	100.0	350	94.9	19	5.1
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	369	100.0	350	94.9	19	5.1

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

Table 11b. SNP HEDIS 2011 Data Submission by Measure—Did Not Report

Measures	DID NOT REPORT CATEGORIES	
	Materially Biased	
	N	%
Colorectal Cancer Screening	0	0.0
Glaucoma Screening in Older Adults	0	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0	0.0
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event**	2	0.5
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event**	2	0.5
Controlling High Blood Pressure	7	1.9
Persistence of Beta-Blocker Treatment After a Heart Attack	2	0.5
Osteoporosis Management in Older Women	0	0.0
Antidepressant Medication Management—Acute Phase	6	1.6
Antidepressant Medication Management—Continuation Phase	6	1.6
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge**	4	1.1
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge**	4	1.1
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	0	0.0
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	0	0.0
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	0	0.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	0	0.0
Annual Monitoring for Patients on Persistent Medications—Total Rate***	0	0.0
Medication Reconciliation Post-Discharge**	5	1.4
Care for Older Adults—Advance Care Planning	3	0.8
Care for Older Adults—Medication Review	9	2.4
Care for Older Adults—Functional Status Assessment	4	1.1
Care for Older Adults—Pain Screening	7	1.9
Active Board Certification—Family Medicine	25	6.8
Active Board Certification—Internal Medicine	25	6.8
Active Board Certification—Geriatrics	25	6.8
Active Board Certification—Other Physician Specialists	25	6.8
Potentially Harmful Drug-Disease Interactions in the Elderly—History of Falls	0	0.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia	0	0.0

Measures	DID NOT REPORT CATEGORIES	
	Materially Biased	
	N	%
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure	0	0.0
Potentially Harmful Drug-Disease Interactions in the Elderly— Total Rate***	0	0.0
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	0	0.0
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	0	0.0

** The measure is based on events or a disease or condition; a member with multiple events, diseases or conditions may be counted in the measure multiple times.

***Indicates a summary measure that results from combining the measures above it.

Structure & Process Measure Results

S&P Measure Submission

NCQA analyzed data from the 424 SNP benefit packages required to report for 2011. Data reflect SNP operations for 2010, that is, those SNPs had to be operational as of January 1, 2010, and renewed for January 1, 2011. CMS and NCQA required all SNPs to report all six measures (SNP 1–SNP 6) for 2011. NCQA made structural changes and, in some cases, content and scoring-related changes to some measures, making it difficult to compare results from previous years, so we present the most recent data only. For these analyses, we established a national benchmark to gauge performance, which is the percentage of plans scoring 80 percent or 100 percent on each element that makes up the measures.

Overall Performance (Table 12)

This table shows performance on all required measures, by element. Each measure is comprised of elements; each element contains factors. The number of factors that the SNP meets determines an element's score—where 100 percent indicates the highest level of performance on the factors. The national benchmark column shows the percentage of SNPs that received a score of 100 percent or 80 percent for that element. A plan that receives a score of 100 percent has met all the factor-level requirements for that element, while a score of 80 percent reflects a plan that has met nearly all of the factor-level requirements.

- **NCQA saw a wide range of performance within and across S&P measures.**

- *Complex Case Management (SNP 1)*. SNPs performed consistently well on this measure. On average, 97 percent of SNPs scored at the national benchmark on four of seven elements (Element A: Identifying Members for Case Management; Element B: Access to Case Management; Element D: Frequency of Member Identification; Element F: Case Management Process), and 84 percent scored at the national benchmark on two elements (Element C: Case Management Systems; Element G: Informing and Educating Practitioners). The notable exception was Element E: Providing Members with Information, where 69.3 percent scored at the national benchmark.
- *Improving Member Satisfaction (SNP 2)*. For the most part, SNPs collect, analyze and identify opportunities for improvement regarding member satisfaction, using complaint and appeal data or CAHPS survey data. For the two elements in this measure, 84.5 percent and 91.6 percent of SNPs met the national benchmark, respectively.
- *Clinical Quality Improvement (SNP 3)*. 96.9 percent of SNPs achieved the national benchmark for this measure, which contains one element.
- *Care Transitions (SNP 4)*. While overall scores for this measure were lower than the other measures, there was variation among the elements: SNPs did best on Element F: Reducing Transitions, where 80.7 percent met the benchmark. 39.3 percent of SNPs met the national benchmark score for Element C: Analyzing Performance, while 63.4 percent met the benchmark for Element B: Supporting Members Through Transitions. For Element D: Identifying Unplanned Transitions, 77.4 percent of SNPs met the benchmark.
- *Institutional SNP Relationship With Facilities (SNP 5)*. This measure applies only to I-SNPs, which compose the smallest number of SNP benefit packages (58 of 424). I-SNPs performed well on two elements (Element A: Monitoring Members' Health Status and Element C: Maintaining Members' Health Status), where 96.2 percent of the I-SNPs met the national benchmark for both elements. Scores were lower for Element B: Monitoring Changes in Members' Health Status, with 76.9 percent of I-SNPs achieving the national benchmark.
- *Coordination of Medicare and Medicaid Coverage (SNP 6)*. D-SNPs have more rigorous requirements for this measure than the other two SNP types. Scores ranged from a high of 97.6 percent of SNPs meeting the benchmark for Element A: Coordination of Benefits for Dual-Eligible Members, which is for D-SNPs only to a low of 59.6 percent meeting the benchmark on Element F: Network Adequacy Assessment.

Table 12. Structure and Process Performance of SNPs for Measures Submitted in 2011
(N = 424)

Element	Total SNPs Eligible for Measure	Percentage at National 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	424	99.5	417	98.3	5	1.2	1	0.2	0	0.0	1	0.2
B Access to Case Management	424	97.2	412	97.2			5	1.2	2	0.5	5	1.2
C Case Management Systems	424	81.4	345	81.4			35	8.3	15	3.5	29	6.8
D Frequency of Member Identification	424	96.0	380	89.6	27	6.4			0	0.0	17	4.0
E Providing Members With Information	424	69.3	257	60.6	37	8.7			48	11.3	82	19.3
F Case Management Process	424	96.9	370	87.3	41	9.7	5	1.2	7	1.7	1	0.2
G Informing and Educating Practitioners	424	86.8	368	86.8			17	4.0			39	9.2
SNP 2: Improving Member Satisfaction												
A Assessment of Member Satisfaction	412	84.5	348	84.5			31	7.5	5	1.2	28	6.8
B Opportunities for Improvement	364	91.2	332	91.2			4	1.1			28	7.7
SNP 3: Clinical Quality Improvements												
A Relevance to Members	416	96.9	399	95.9	4	1.0			6	1.4	7	1.7
SNP 4: Care Transitions												
A Managing Transitions	424	76.4	268	63.2	56	13.2			58	13.7	42	9.9
B Supporting Members Through Transitions	424	63.4	258	60.8	11	2.6			53	12.5	102	24.1
C Analyzing Performance	412	39.3	159	38.6	3	0.7	53	12.9	18	4.4	179	43.4
D Identifying Unplanned Transitions	424	77.4	328	77.4			19	4.5			77	18.2
E Analyzing Transitions	412	46.4	191	46.4			156	37.9			65	15.8
F Reducing Transitions	424	80.7	342	80.7			27	6.4			55	13.0
SNP 5: Institutional SNP Relationship With Facility												
A Monitoring Members' Health Status	52	96.2	50	96.2							2	3.8
B Monitoring Changes in Members' Health Status	52	76.9	40	76.9	0	0.0			0	0.0	12	23.1
C Maintaining Members' Health Status	52	96.2	50	96.2							2	3.8

Element	Total SNPs Eligible for Measure	Percentage at National 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 for Dual-Eligible Benefit Packages	286	97.6	267	93.4	12	4.2	1	0.3	0	0.0	6	2.1
B Administrative Coordination of Dual-Eligible Benefit Packages	286	82.9	237	82.9			28	9.8			21	7.3
C Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	279	91.8	256	91.8							23	8.2
D Administrative Coordination for Chronic Condition and Institutional Benefit Packages	121	91.7	109	90.1	2	1.7	2	1.7	1	0.8	7	5.8
E Service Coordination	407	86.0	310	76.2	40	9.8			25	6.1	32	7.9
F Network Adequacy Assessment	403	59.6	240	59.6							163	40.4

* The National Benchmark is the percentage 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 an option for the element.

Performance on SNP 1: Complex Case Management, All SNPs Reporting (Tables 13A–C)

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 frailer or have multiple comorbidities.

Tables 13A–C show performance on *SNP 1: Complex Case Management* by SNP type, enrollment size element and factor. SNPs performed consistently well on this measure. On average, 97 percent of SNPs met the national benchmark on four of seven elements (Element A: Identifying Members for Case Management; Element B: Access to Case Management; Element D: Frequency of Member Identification; Element F: Case Management Process), and 84 percent met the national benchmark on two elements (Element C: Case Management Systems; Element G: Informing and Educating Practitioners). The notable exception was Element E: Providing Members with Information, where 69.3 percent met the national benchmark.

SNP size generally was not a factor in overall performance, although SNPs with smaller enrollments (0–99 members and 100–499 members) had lower scores for Element C: Case Management Systems, which requires SNPs to have electronic case management systems that use evidence-based guidelines and provide automated prompts for follow-up with members based on their case management plans. For this element, 81.4 percent of the plans met the national benchmark, however, a lower percentage (72.5 and 77.2 percentage, respectively) of the smaller SNPs met the benchmark.

Table 13A. Complex Case Management (SNP 1) Performance on National Benchmarks by SNP Type, by Element, 2011

Elements	Percentage at National Benchmark* (%) All SNPs	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		286	58	80
A Identifying Members for Case Management	99.5	99.3	100.0	100.0
B Access to Case Management	97.2	97.6	100.0	93.8
C Case Management Systems	81.4	81.1	79.3	83.8
D Frequency of Member Identification	96.0	94.8	100.0	97.5
E Providing Members With Information	69.3	70.6	48.3	80.0
F Case Management Process	96.9	97.9	98.3	92.5
G Informing and Educating Practitioners	86.8	86.4	96.6	81.3

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

Table 13B. Complex Case Management (SNP 1) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-599	1,000-2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
A Identifying Members for Case Management	424	99.5	100.0	100.0	100.0	100.0	98.0
B Access to Case Management	424	97.2	100.0	97.0	96.8	97.2	96.0
C Case Management Systems	424	81.4	72.5	77.2	82.3	84.9	85.1
D Frequency of Member Identification	424	96.0	98.0	100.0	96.8	94.3	93.1
E Providing Members With Information	424	69.3	76.5	70.3	72.6	60.4	72.3
F Case Management Process	424	96.9	96.1	95.0	100.0	98.1	96.0
G Informing and Educating Practitioners	424	86.8	82.4	83.2	91.9	90.6	86.1

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

Table 13 C. Performance on Complex Case Management (SNP 1) by Factor, All SNPs Reporting, 2011

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	424		286		58		80	
Element A: Identifying Members for Case Management								
1. Claim or encounter data	424	99.3	286	99.3	58	100.0	80	98.8
2. Hospital discharge data	424	99.5	286	99.7	58	100.0	80	98.8
3. Pharmacy data	424	98.8	286	99.0	58	98.3	80	98.8
4. Laboratory results	424	78.8	286	72.0	58	91.4	80	93.8
5. Data collected through the UM process, if applicable	416	98.6	278	99.3	58	100.0	80	95.0
Element B: Access to Case Management								
1. Health information line referral	277	79.4	200	79.0	39	87.2	38	73.7
2. Disease Management program referral	424	88.9	286	89.5	58	98.3	80	80.0
3. Discharge planner referral	424	97.4	286	97.6	58	100.0	80	95.0
4. UM referral, if applicable	420	97.9	282	98.6	58	100.0	80	93.8
5. Member self-referral	424	98.6	286	99.7	58	100.0	80	93.8
6. Practitioner referral	424	98.8	286	99.7	58	100.0	80	95.0
7. Other	424	94.8	286	96.5	58	84.5	80	96.3
Element C: Case Management Systems								
1. Evidence-based clinical guidelines or algorithms to conduct assessment and management	424	86.8	286	85.0	58	98.3	80	85.0
2. Automatic documentation of the staff member's identification and date and time action on the case or interaction with the member occurred	424	89.9	286	91.6	58	82.8	80	88.8
3. Automated prompts for follow-up, as required by the case management plan	424	87.5	286	88.8	58	81.0	80	87.5

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Element D: Frequency of Member Identification								
1. The organization systematically identifies members at least monthly	424	89.6	286	86.7	58	100.0	80	92.5
2. The organization systematically identifies members at least quarterly	424	6.4	286	8.0	58	0.0	80	5.0
3. The organization systematically identifies members less frequently than every 6 months	424	4.0	286	5.2	58	0.0	80	2.5
4. The organization systematically identifies members every 6 months	424	0.0	286	0.0	58	0.0	80	0.0
Element E: Providing Members With Information								
1. How to use the services	424	68.6	286	70.6	58	43.1	80	80.0
2. How members become eligible to participate	424	75.9	286	72.0	58	86.2	80	82.5
3. How to opt in or opt out	399	63.9	273	67.4	47	23.4	79	75.9
Element F: Case Management Process								
1. Members' right to decline participation or disenroll from case management programs and services offered by the organization	424	91.5	286	94.4	58	75.9	80	92.5
2. Initial assessment of members' health status, including condition-specific issues	424	98.3	286	99.3	58	100.0	80	93.8
3. Documentation of clinical history, including medications	424	98.3	286	99.3	58	100.0	80	93.8
4. Initial assessment of the activities of daily living	424	98.1	286	99.0	58	100.0	80	93.8
5. Initial assessment of mental health status, including cognitive functions	424	95.0	286	97.9	58	84.5	80	92.5
6. Initial assessment of life-planning activities	424	96.9	286	98.3	58	98.3	80	91.3
7. Evaluation of cultural and linguistic needs, preferences or limitations	424	94.1	286	95.8	58	100.0	80	83.8
8. Evaluation of visual and hearing needs, preferences or limitations	424	89.9	286	88.8	58	96.6	80	88.8
9. Evaluation of caregiver resources and involvement	424	97.6	286	98.6	58	98.3	80	93.8
10. Evaluation of available benefits	424	93.4	286	95.1	58	87.9	80	91.3
11. 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	424	94.6	286	94.8	58	98.3	80	91.3
12. Identification of barriers to meeting goals or complying with the plan	424	97.4	286	97.9	58	98.3	80	95.0
13. Development of a schedule for follow-up and communication with members	424	95.3	286	94.1	58	100.0	80	96.3
14. Development and communication of member self-management plans	424	95.5	286	95.8	58	98.3	80	92.5
15. A process to assess their progress against case management plans	424	94.6	286	93.7	58	98.3	80	95.0
Element G: Informing and Educating Practitioners								
1. Instructions on how to use services	424	87.0	286	86.7	58	96.6	80	81.3
2. How the organization works with a practitioner's patients in the program	424	90.6	286	90.9	58	96.6	80	85.0

Performance on SNP 2: Improving Member Satisfaction, All SNPs Reporting (Tables 14A–C)

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. For the most part, SNPs collect, analyze and identify opportunities for improvement regarding member satisfaction, using complaint and appeal data or CAHPS survey data. The percentage of SNPs meeting the national benchmarks for the two elements in this measure were 84.5 percent and 91.6 percent, respectively.

D-SNPs and I-SNPs outperformed C-SNPs, with at least 10 percent more SNPs scoring meeting the national benchmark. Further, at the factor level, the C-SNPs had lower scores for Element A, factor 3: Collecting Valid Data, which includes analysis of member satisfaction scores. Not surprisingly, C-SNPs also scored lower on identifying two or more opportunities for improvement, which is related to the data analysis in factor 3 of SNP 2, Element A.

The smallest SNPs (0–99 members) also had lower scores than the other enrollment categories. For Element A: Assessment of Member Satisfaction, the percentage of plans in the 0–99 enrollment category that met the national benchmark was approximately 10 percentage points lower than the other categories. For Element B: Opportunities for Improvement, the percentage of plans meeting the benchmark was 8.9 percentage points lower than the next lowest category (1,000–2,499 members).

Table 14A. Improving Member Satisfaction (SNP 2) Performance on National Benchmarks by SNP Type, by Element, 2011**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		286	58	80
A Assessment of Member Satisfaction	84.5	86.2	88.0	75.9
B Opportunities for Improvement	91.2	92.1	100.0	81.8

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

** SNPs with no enrollment as of the December 2010 CMS SNP Comprehensive Report were exempt from reporting this measure.

Table 14B. Improving Member Satisfaction (SNP 2) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0–99	100–499	500–599	1,000–2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
A Assessment of Member Satisfaction	412	84.5	75.6	84.2	85.5	85.8	86.1
B Opportunities for Improvement	364	91.2	81.8	91.7	92.9	90.7	93.5

Table 14C. Improving Member Satisfaction (SNP 2) by Factor, All SNPs Reporting, 2011

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	Dual	%	N	%
Number of reporting SNPs by type	424		286		N		80	
Element A: Assessment of Member Satisfaction								
1. Identifying the appropriate population	412	92.0	283	93.3	50	88.0	79	89.9
2. Drawing appropriate samples from the affected population, if a sample is used	408	93.1	281	94.7	50	88.0	77	90.9
3. Collecting valid data	412	84.5	283	86.2	50	88.0	79	75.9
Element B: Opportunities for Improvement								
1. The organization does not identify any opportunities for improvement	362	7.2	253	5.9	44	0.0	65	16.9
2. The organization identifies one opportunity for improvement	362	1.1	253	1.6	44	0.0	65	0.0
3. The organization identifies 2 or more opportunities for improvement	362	91.7	253	92.5	44	100.0	65	83.1

Performance on SNP 3: Clinical Quality Improvement, All SNPs Reporting (Tables 15A–C)

SNP 3: Clinical Quality Improvement requires that plans identify clinical issues relevant to their members, such as osteoporosis or prevention of falls. Performance on this element was high across SNP type and by enrollment category. The smallest SNPs (0–99 members) had the lowest scores, approximately 10 percentage points below the next enrollment category, with 86.7 percent of plans meeting the benchmark (which is still high performance).

Table 15A. Clinical Quality Improvements (SNP 3) Performance on National Benchmarks by SNP Type, by Element, 2011**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type			
		All SNPs	Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type			286	58	80
Element A. Relevance to members	96.9		97.2	98.1	94.9

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

** SNPs with no enrollment as of the December 2010 CMS SNP Comprehensive Report were exempt from reporting this measure.

Table 15B. Clinical Quality Improvements (SNP 3) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-599	1,000-2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
Element A. Relevance to Members	416	96.9	86.7	96.0	100.0	97.2	100.0

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

Table 15C. Clinical Quality Improvements (SNP 3) by Factor, All SNPs Reporting, 2011

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	Dual	%	N	%
Number of reporting SNPs by type	424		286		N		80	
1. The organization does not select measures that are relevant to the membership	416	1.7	283	1.1	54	1.9	79	3.8
2. The organization selects 1 measure that is relevant to the membership	416	1.4	283	1.8	54	0.0	79	1.3
3. The organization selects 2 measures that are relevant to the membership	416	1.0	283	0.7	54	1.9	79	1.3
4. The organization selects 3 measures that are relevant to the membership	416	95.9	283	96.5	54	96.3	79	93.7

Performance on SNP 4: Care Transitions, All SNPs Reporting (Tables 16A-C)

SNP 4: Care Transitions requires SNPs to identify planned and unplanned transitions of care, coordinate patient transitions across care settings and act to reduce or prevent unnecessary transitions for at-risk members. 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 measure plans' care transition processes. The measure draws from the work of Eric Coleman, MD, whose Care Transitions ProgramSM demonstrates how to improve care transitions using transition coaches.

This measure proved the most challenging of the six S&P measures for the SNPs. The highest percentage of plans meeting the benchmark score for any of the six elements was 80.7 percent (Element F). Although overall scores for this measure were lower than the other measures, there was variation among the elements: 39.3 percent of the SNPs met the national benchmark on Element C, while 63.4 percent met it for Element B, and 77.4 percent met it for Element D.

The I-SNPs outperformed the D-SNPs and C-SNPs on five of the six elements. For Element B, the percentage of I-SNPs that met the benchmark was 30.6 percentage points and 20.4 percentage points higher than the D-SNPs and C-SNPs respectively. For Element C, the percentage of I-SNPs that met the benchmark was nearly 20 points higher than either D-SNPs or C-SNPs.

At the factor level, the trend is consistent with the overall element scoring trend, with the I-SNPs consistently outperforming the other SNP types on every factor of every element, with the exception of the two factors in Element F: Reducing Transitions (coordinating services for members at high risk of having and transition; educating members or responsible parties about transitions and how to prevent unplanned transitions).

It should be noted that the I-SNP category, which has the smallest number of benefit packages (58) is dominated by a handful of SNP organizations that account for the majority of the benefit packages. In fact, one organization accounts for approximately 40 percent of all the I-SNP benefit packages. Thus, this organization's performance has a strong effect on the overall results for the I-SNP category.

Additional Performance Details

NCQA staff also noted the following patterns in SNP performance on SNP 4.

Element A, Managing Transitions. SNPs improved performance on this element, compared with 2010, increasing their score on factor 1 (identifying planned transitions) and factor 3 (notifying members' practitioner of a transition). While it may be difficult to determine actual causality, one of the main reasons for the improvement may be the result of removing the analysis requirements from the element. In 2010, the analysis requirement was part of Elements A and B (factor 4). The SNPs had consistently lower performance on the analysis factor (factor 4) in 2010. Further, the SNPs had lower performance for the analysis requirements in 2011 (Element C). Thus, it is reasonable to conclude that removing the analysis requirements from Elements A and B in 2011 had some positive effect on the improved performance.

One area where most SNPs scored highly was in identifying planned transitions in advance, such as scheduled surgery, where 86.3 percent of SNPs met the requirements for that factor. In addition, SNPs that automatically enroll a hospitalized member in case management did well on systematic processes that increased coordination after transitions. Specifically, 85.1 percent of SNPs met the requirements for factor 1 (coordinating services for members at high risk of having a transition) of Element F (Reducing Transitions), and 75.2 percent of the SNPs met the requirements for factor 3 (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) of Element B (Supporting members through transitions).

If SNPs do not provide adequate documentation that addresses the requirements for the factors of Element A, they do not receive credit for those factors. SNPs must provide documented processes (e.g., policies and procedures) detailing what and how they perform certain activities, and they must also provide reports or materials that demonstrate evidence of implementation of their processes. That is, they must demonstrate that they actually do what they say they do. Areas where SNPs' documentation did not demonstrate that Element A was met:

- *Implementation:* Some SNPs had policies for Element A but did not have documentation that the policies were implemented. Also, some policies were too general, or the SNP could not demonstrate evidence of implementation for transitions to care settings other than to and from the hospital. The measure 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 meets 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.

Element B, Supporting Members Through Transitions. SNPs improved their scores slightly for factors 1 and 2, compared to last year, but scores for factor 3 decreased by slightly less than 9 percentage points. 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.⁵

The highest percentage of SNPs meeting the requirements 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 I-SNPs have their employed nurse practitioners conduct in-person follow-up with patients. Since most I-SNP members transition between the hospital and institutional facility where they reside, care coordination and follow tends to be more consistent and systematic in I-SNPs as compared to other SNPs.

As noted for Element A, some improvement may be the result of removing the analysis requirements from the element. A difficult area for SNPs was:

- *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.

Element C: Analyzing Performance. Many SNPs had difficulty demonstrating performance for this element, which requires the SNP to conduct an annual analysis of its aggregate performance of managing transitions related to the requirements in Elements A and B. The average percentage of SNPs meeting the requirements for all the factors of Element C is 46.6 percent, with a range from 40.8 percent (factor 1) to 50.4 percent (factors 2 & 4). 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. Many SNPs have data collection systems in place to collect and analyze performance data on care transitions, as required for Element C, but did not begin data collection or analysis activities in time to report for 2011.⁶

Element D: 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 E: Analyzing Transitions. SNPs tended to have mixed results with this element, scoring lower than they did in 2010 for factor 1, but higher for factor 2. SNPs that did not perform well on this element often were unable to show analysis or to identify opportunities for improvement based on analysis. Some SNPs analyzed data only for members enrolled in case management rather than for the entire population, as required. Element E 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 members 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 readmissions (e.g., CHF, COPD, medication adverse events). SNPs must be able to identify such issues if they are to reduce admissions, particularly unplanned admissions.

Element F: Reducing Transitions. This is a new element for 2011 based on factors 2 and 3 of Element E from the 2010 S&P measures. SNPs scored well on this element, which requires SNPs to educate at-risk members about preventing unplanned transitions and coordinate care for these members in order to reduce

⁵ According to research by Eric Coleman, supporting members through the transition process—particularly hospital discharge—can have a positive effect on health outcomes and help contain costs.

⁶ The 2011 submission deadline was moved to February 2011 from a previous deadline of June 30, as it was in prior years. Many SNPs did not have sufficient time to revise their procedures and/or systems as a result of this change in the submission deadlines.

unplanned transitions and keep members in the least restrictive setting possible. Plans generally have educational programs to address specific diseases and conditions.

Table 16A. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Type, by Element, 2011

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		286	58	80
A Managing Transitions	76.4	73.8	87.9	77.5
B Supporting Members Through Transitions	63.4	57.3	87.9	67.5
C Analyzing Performance**	39.3	36.7	56.0	38.0
D Identifying Unplanned Transitions	77.4	76.6	93.1	68.8
E Analyzing Transitions**	46.4	43.8	30.0	65.8
F Reducing Transitions	80.7	79.0	86.2	82.5

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

**SNPs with no enrollment as of the December 2010 CMS SNP Comprehensive Report were exempt from reporting this measure.

Table 16B. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0–99	100–499	500–599	1,000–2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
A Managing Transitions	424	76.4	74.5	76.2	71.0	83.0	74.3
B Supporting Members Through Transitions	424	63.4	66.7	65.3	62.9	66.0	57.4
C Analyzing Performance	412	39.3	29.3	41.6	32.3	42.5	42.6
D Identifying Unplanned Transitions	424	77.4	74.5	74.3	82.3	82.1	74.3
E Analyzing Transitions	412	46.4	46.3	45.5	45.2	37.7	56.4
F Reducing Transitions	424	80.7	74.5	73.3	77.4	86.8	87.1

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

Table 16C. Performance on Care Transitions (SNP 4) by Factor, All SNPs Reporting, 2011

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	424		286		58		80	
A: Managing Transitions								
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	424	86.3	286	87.1	58	87.9	80	82.5
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	424	67.2	286	61.2	58	87.9	80	73.8
3. For planned and unplanned transitions from any setting to any other setting, notifying the patient's usual practitioner of the transition within a specified timeframe	424	76.2	286	73.4	58	87.9	80	77.5
B: Supporting Members Through Transitions								
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	424	63.4	286	57.3	58	87.9	80	67.5
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 within a specified timeframe	424	61.6	286	54.5	58	87.9	80	67.5
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 within a specified timeframe	424	75.2	286	72.7	58	89.7	80	73.8

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
C: Analyzing Performance								
1. For all transitions, conducting an analysis annually of its aggregate performance: identifying that a planned transition is going to occur; sharing the sending setting's care plan with the receiving setting within one business day of notification of planned and unplanned transitions; and notifying the member's usual practitioner of planned and unplanned transitions within a specified timeframe	412	40.8	283	38.5	50	58.0	79	38.0
2. Drawing appropriate samples from the affected population for the transitions specified in factor 1, if a sample is used	411	50.4	283	45.2	50	66.0	78	59.0
3. For all transitions, conducting an analysis annually of its aggregate performance: communicating with the member or responsible party about the care transition process within a specified timeframe; communicating with the member or responsible party about changes to the member's health status and plan of care within a specified timeframe; and 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 within a specified timeframe.	412	44.9	283	45.2	50	56.0	79	36.7
4. Drawing appropriate samples from the affected population for the transitions specified in factor 3, if a sample is used	411	50.4	283	45.6	50	64.0	78	59.0
D: Identifying Unplanned Transitions								
1. Reports of hospital admissions within one business day of admission	424	81.8	286	81.1	58	94.8	80	75.0
2. Reports of admissions to long-term care facility within one business day of admission	424	77.4	286	76.6	58	93.1	80	68.8
E: Analyzing Transitions								
1. Analyzing data at least monthly, to identify individual members at risk of transition	412	61.7	283	58.7	50	40.0	79	86.1
2. Analyzing rates of all member admissions to facilities and ED visits at least annually to identify areas for improvement	412	68.9	283	67.5	50	82.0	79	65.8
F: Reducing Transitions								
1. Coordinating services for members at high risk of having a transition	424	85.1	286	84.6	58	86.2	80	86.3
2. Educating members or responsible parties about transitions and how to prevent unplanned transitions	424	82.5	286	80.4	58	86.2	80	87.5

Performance on SNP 5: Institutional SNP Relationship With Facility (I-SNPs only) Reporting (Tables 17A–C)⁷

SNP 5: Institutional SNP Relationship With Facility requires I-SNPs to perform certain care management activities for those members who reside in institutional facilities and have contracts with the facilities to do so. Because only I-SNPs report this measure, there is no performance comparison with the other SNP types. I-SNPs scored very high (96.2 percent scored either 100 or 80 percent) on Element A: Monitoring Members' Health Status and on Element C: Monitoring Changes in Members' Health Status, and had more difficulty on Element B: Maintaining Members' Health Status, where 76.9 percent of the SNPs met the benchmark.

While I-SNPs performed well in general, the smaller SNPs (0–99 members; 100–499 members) had the lowest scores, particularly for Element B.

Table 17A. Institutional SNP Relationship With Facility (SNP 5) Performance on National Benchmarks by Element, 2011

Elements	Percentage at National Benchmark* (%)
	Institutional
Number of reporting SNPs by type	58
A Monitoring Members' Health Status	96.2
B Monitoring Changes in Members' Health Status	76.9
C Maintaining Members' Health Status	96.2

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

Table 17B. Institutional SNP Relationship With Facility (SNP 5) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark*		Percentage at National Benchmark* (%) by Enrollment Size				
	I-SNPs						
	N	%	0–99	100–499	500–599	1,000–2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
A Monitoring Members' Health Status	52	96.2	94.4	92.3	100.0	100.0	100.0
B Monitoring Changes in Members' Health Status	52	76.9	61.1	69.2	83.3	100.0	100.0
C Maintaining Members' Health Status	52	96.2	94.4	100.0	100.0	92.3	100.0

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

⁷ SNP 5 is only applicable to Institutional SNPs. D-SNPs and C-SNPs receive a score of NA. In addition, six I-SNPs were exempted from reporting this measure because their model of care was for members that reside at home or in a community-based setting, and the measure addresses care in an institutional-facility setting and the relationship between the SNP and the facility. NCQA is exploring developing measures to address I-SNP members that reside in a home or community-based setting.

Table 17C. Institutional SNP Relationship With Facility (SNP 5) by Factor, 2011 (SNP 5 Applies to I-SNPs only)

Factors	Institutional	
	N	%
Number of reporting SNPs by type	58	
Element A: Monitoring Members' Health Status		
1. The organization monitors information at least quarterly	52	96.2
2. The organization monitors information less often than quarterly	52	3.8
Element B: Monitoring Changes in Members' Health Status		
1. The organization collects the information within 48 hours of the change in health status	52	76.9
2. The organization collects the information within 49–72 hours of the change in health status	52	0.0
3. The organization receives the information within 4–7 days of the change in health status	52	0.0
4. The organization does not require notification or receives the information more than a week after the change in health status	52	23.1
Element C: Maintaining Members' Health Status		
1. The organization works with facilities to modify care as needed	52	96.2
2. The organization does not work with facilities to modify care as needed	52	3.8

Performance on SNP 6: Coordination of Medicare and Medicaid Coverage, All SNPs Reporting (Tables 18A–C)⁸

SNP 6: Coordination of Medicare and Medicaid Coverage contains different elements for different SNP types. It is important to note that this measure has more demanding requirements for D-SNPs, which are required by law to enroll only dual-eligible members and thus must have additional systems in place to coordinate Medicare and Medicaid benefits.

- *Performance by D-SNPs.* Elements A–C apply only to D-SNPs, which performed well on Element A: Coordination of Benefits for Dual-Eligible Members (97.6 percent of plans met the benchmark) and Element C: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages (91.8 percent met the benchmark). D-SNPs scored lower on Element B: Administrative Coordination of Dual-Eligible Benefit Package (82.9 percent met the benchmark), which requires plans to have a process to identify changes in members' Medicaid eligibility and coordinate adjudication of Medicare and Medicaid claims for which they are contractually responsible.
- *Performance by C-SNPs and I-SNPs.* I-SNPs outperformed C-SNPs on all the elements they are required to report for this measure.
- *Performance across SNP type.* All SNP types must report Element E: Service Coordination and the new Element F: Network Adequacy Assessment). I-SNPs outperformed C-SNPs (whose scores were significantly lower) and D-SNPs for these requirements.

⁸ SNP 6, Elements A–C are for D-SNPs only. SNP 6, Element D is for C-SNPs and I-SNPs. For SNP 6, Elements D–F, C-SNPs and I-SNPs with less than 5 percent dual eligible members as of the December 2010 CMS SNP Comprehensive Report are exempt from reporting.

- *Network Adequacy Assessment.* All SNP types had a lower percentage of plans meet the national benchmark for Element F, which requires SNPs to assess network adequacy for Medicare and Medicaid providers. SNPs tended to conduct solid network adequacy assessments for Medicare network providers, but often did not have such data for Medicaid. Approximately two-thirds of the I-SNPs (66.7 percent) and D-SNPs (61.6 percent) scored at the national benchmark level. For C-SNPs, less than half the plans achieved the benchmark (46.5 percent).

Coordinating coverage for 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; Medicaid is a state-federal program with coverage that varies from state to state. Of the more than one million members enrolled in SNPs, 81 percent are in dual-eligible plans. Many members of chronic and I-SNPs are dual-eligible also. In order for SNPs to be able to provide the most complete care for dual eligible members, it is crucial to align the financial, operational and informational components of their Medicare and Medicaid benefits. Many D-SNPs do not have formal contracts with the Medicaid agencies in which they operate, thus limiting the integration of benefits and services between the two programs. Despite this lack of formal coordination, the S&P measures require the D-SNPs to be able to provide a basic level of coordination, (financial, operational, and informational) where possible, and when not, to direct their members to other resources that will provide the needed information so they can receive the benefits and services for which they are entitled.

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. There are additional elements that require higher levels of coordination for D-SNPs. The following provides a high-level overview of SNP 6 requirements.

**Elements A–C
apply to D-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.

The Medicare Improvement and Patient Protection Act (MIPPA) and the Affordable Care Act (ACA) have provisions that will require all D-SNPs to obtain contracts with state Medicaid agencies to coordinate Medicare and Medicaid benefits.

Element D

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

This element applies only to C-SNPs and I-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.

Element F

- Element F: Network Adequacy Assessment

This element applies to all SNPs. SNPs must provide an analysis of their Medicare and Medicaid provider networks to ensure sufficient access to providers that accept both programs. C-SNPs and I-SNPs must have at least 5 percent dual-eligible members or they receive a score of “NA” for this element.

“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 18A. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by SNP Type, by Element, 2011

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		286	58	80
A Coordination for Dual-Eligible Benefit Packages	97.6	97.6	0.0**	0.0**
B Administrative Coordination of Dual-Eligible Benefit Packages	82.9	82.9	0.0**	0.0**
C Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	91.8	91.8	0.0*	0.0**
D Administrative Coordination for Chronic Condition and Institutional Benefit Packages	91.7	0.0**	95.9	88.9
E Service Coordination	86.0	86.0	98.0	77.8
F Network Adequacy Assessment	59.6	61.6	66.7	46.5

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

**Shaded cells denote that element does not apply to that SNP type.

Table 18B. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by SNP Size, by Element, 2011

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-599	1,000-2,499	≥2,500
Number of reporting SNPs by type			51	101	62	106	101
A Coordination for Dual-Eligible Benefit Packages	286	97.6	94.4	100.0	97.9	96.3	97.6
B Administrative Coordination of Dual-Eligible Benefit Packages	286	82.9	83.3	73.2	77.1	84.0	91.5
C Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages	279	91.8	88.2	88.9	93.5	88.8	96.3
D Administrative Coordination for Chronic Condition and Institutional Benefit Packages	121	91.7	91.7	88.6	91.7	95.7	94.4
E Service Coordination	407	86.0	83.3	84.0	86.7	85.6	89.0
F Network Adequacy Assessment	403	59.6	32.5	57.6	56.7	67.3	65.7

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

Table 18C. Coordination of Medicare and Medicaid Coverage (SNP 6) by Factor, All SNPs Reporting, 2011

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	424		286		58		80	
A: Coordination for Dual-Eligible Benefit Packages								
1. Giving prospective members information about benefits they are eligible to receive from both programs	286	95.1	286	95.1	0*	0.0*	0.0*	0.0*
2. Informing members about maintaining their Medicaid eligibility	286	97.2	286	97.2	0*	0.0*	0.0*	0.0*
3. Providing information to members about benefits they are eligible to receive from both programs	286	97.9	286	97.9	0*	0.0*	0.0*	0.0*
4. Giving members access to staff who can advise them on using both Medicare and Medicaid	286	97.6	286	97.6	0*	0.0*	0.0*	0.0*
5. Giving members clear explanations of benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers	286	97.9	286	97.9	0*	0.0*	0.0*	0.0*
6. Giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program	286	97.9	286	97.9	0*	0.0*	0.0*	0.0*
B: Administrative Coordination of Dual-Eligible Benefit Packages								
1. Using a process to identify changes in members' Medicaid eligibility	286	92.0	286	92.0	0*	0.0*	0.0*	0.0*
2. Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible	282	83.3	282	83.3	0*	0.0*	0.0*	0.0*
C: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages								
1. Organization either has or is working toward an agreement with state Medicaid agency	279	92.1	279	92.1	0*	0.0*	0.0*	0.0*
2. Organization does not have and is not working toward an agreement	279	7.9	279	7.9	0*	0.0*	0.0*	0.0*

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
D: Administrative Coordination for Chronic Condition and Institutional Benefit Packages								
1. Giving prospective members information about benefits they are eligible to receive from both programs	119	92.4	0*	0.0*	49	98.0	70	88.6
2. Informing members about maintaining their Medicaid eligibility	119	93.3	0*	0.0*	49	100.0	70	88.6
3. Providing information to members about benefits they are eligible to receive from both programs	119	91.6	0*	0.0*	49	95.9	70	88.6
4. Giving members access to staff who can advise them on using both Medicare and Medicaid	119	91.6	0*	0.0*	49	93.9	70	90.0
E: Service Coordination								
1. Helping members access network providers that participate in both the Medicare and Medicaid programs or providers that accept Medicaid patients	405	86.4	286	87.1	49	95.9	70	77.1
2. Educating providers about coordinating Medicare and Medicaid benefits for which members are eligible and about members' special needs	405	84.7	286	85.3	49	98.0	70	72.9
3. Helping members obtain services funded by either program when assistance is needed	405	83.0	286	81.5	49	98.0	70	78.6
F: Network Adequacy Assessment								
1. The organization assesses the adequacy of its network at least semiannually	401	59.9	284	61.6	48	66.7	69	47.8
2. The organization assesses the adequacy of its network less often than semiannually	401	40.1	284	38.4	48	33.3	69	52.2

*Shaded cells denote that factor does not apply to that SNP type.

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 2011 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, 2010, with a renewed contract for 2011. SNPs that had no members as of the December 2010 CMS SNP Comprehensive Report were not required to report for *SNP 2: Improving Member Satisfaction* and *SNP 3: Clinical Quality Improvement*; *SNP 4: Care Transitions*, Elements C and E—they could report "NA" because there were no data to be analyzed. With CMS approval, for the 2011 reporting cycle, NCQA moved the submission deadline from June 30 to February 28.

Organizations with multiple (four or more) SNPs that used centralized policies, procedures and systems (e.g., case management assessment systems or complaint and appeal processes) were allowed to undergo primary entity review. This review allows eligible SNPs to provide centralized results, when centralized processes applied. Of the 424 SNPs that reported the S&P measures, 243 were from 33 entities that underwent a primary entity review. During the data collection and submission process, NCQA provided technical support for result submission.

NCQA sent regular reminders that Survey Tools were due by February 28, 2011, and also included this message at each training session, at the open-door forums and on the NCQA Web site. After the deadline, NCQA contacted SNPs (by e-mail and follow-up telephone call) that had not submitted a Survey Tool. NCQA achieved a 100 percent submission rate within 72 hours of the submission deadline.

Additional technical assistance was provided for plans that lost or forgot their password or that had difficulty uploading information to the ISS server.

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 experience 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-five 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 to reassess elements where they scored less than 100%. Plans were allowed to submit additional documentation and clarifications.⁹ Reassessment occasionally resulted in higher scores.

On August 31, 2011, NCQA provided final SNP-specific results to CMS. Those results form the basis of this report.

⁹SNPs were only allowed to submit documentation that existed on or before the survey submission date.

Data Limitations

This analysis provides a basic understanding of how well SNPs performed in key quality areas described in the body of this report. An important limitation that remains in the fourth year of this activity is having limited results from small plans. Analysis is affected by the presence of small SNPs. As of February 2010, CMS identified 424 SNPs, 55 of which had fewer than 30 beneficiaries and were not required to report HEDIS because of their small enrollment. This is a slight reduction from the 66 SNPs not required to report HEDIS in 2010.

To provide a complete picture of the SNP environment, analyses systematically distinguished aggregate program performance from benefit package performance. Program-level analysis includes data from all SNP submissions, regardless of size, to generate a complete picture of the SNP program.

HEDIS reporting guidelines also have a size limitation: they require a minimum denominator of 30 for each measure. With a smaller number, the reliability and stability of rates for individual plans are below statistically acceptable levels. Some SNPs did not have 30 members for any individual measure, although they had more than 30 members; therefore, NCQA could not include those SNPs in the analysis that compares results of individual SNPs (benefit package performance). NCQA includes results by measure of all SNPs in the overall program performance, regardless of size. The limitation in number of SNPs that could report any measure was less of a limitation in 2011 than in previous years.

An important limitation in the fourth year of this activity is the limited look-back period created by the change in the submission date, from June 30 to February 28 for the S&P measures. SNPs were required to submit new information, particularly for the analysis requirements, less than a year after submitting similar information for the 2010 assessment. Many SNPs had set up their data collection, analysis and evaluation processes to conform to the June 30 time frame, so when the submission date was moved to the end of February of the same year for 2011, many SNPs were not able to obtain the required data and approvals within this new time frame. So that an organization is not held accountable for compliance with measures before their release, S&P measures reflect performance for three months prior to the survey submission date. Many plans had recently created documented processes and could not bring their actual operations in compliance with their policies. Future review will have a longer look-back period, which will provide a more robust picture of SNP performance.

It is important to note, D-SNPs make up the largest number of benefit packages (more than 66 percent) and total membership (80 percent), so their performance as a group drives overall SNP performance. Several organizations compose a large percentage of plans in the SNP program, and their performance may also have an effect on overall SNP performance—this is especially true for I-SNPs, where several organizations have the majority of plans and members, including one organization that accounts for more than 40 percent of the I-SNP benefit packages.

Finally, plans that submit using the primary entity review also have an impact on overall SNP performance. Because multiple plans that submit the same documentation for the S&P measures are linked together and receive the same score for specific elements, their individual results, when grouped together, may weight an element's score heavily in one direction. This is particularly true if there are a large number of benefit packages associated with the primary entity. The larger the number of linked benefit packages, the greater the influence on the overall results and the S&P national benchmark results for those elements.

HEDIS Exclusions for Nonacute Admissions

All HEDIS measures that SNPs are required to report apply to I-SNPs. The exclusions in specific HEDIS measures for members admitted to nonacute inpatient facilities probably has a disproportionate impact on I-SNPs compared to other types of plans. Two measures have optional exclusions; two have non-optional exclusions for members who are admitted to nonacute inpatient facilities. These exclusions apply to all SNP types and also apply to MA, commercial and Medicaid HEDIS.

- *Controlling High Blood Pressure*. Optional exclusion of members who had admission to a nonacute inpatient setting.
- *Persistence of Beta-Blocker Treatment*. Exclude members who were hospitalized for AMI but transferred directly to nonacute care facilities for any diagnosis.
- *Follow-Up After Hospitalization for Mental Illness*. Exclude members who are discharged to nonacute care facilities after being hospitalized for mental illness.
- *Annual Monitoring for Patients on Persistent Medications*. Optional exclusion of members who had acute or nonacute inpatient stays.

All submissions were reviewed by HEDIS Compliance Auditors, even if the outcome was that there were no people in the measure denominator after the exclusion. Results for I-SNPs indicate that there were members living in the community (I-SNP members must be at risk for institutionalization but not necessarily institutionalized) or that some SNPs chose not to implement the optional exclusions.

Next Steps

The analysis in this report contains the fourth year of HEDIS results specifically focused on SNPs. Further analysis of the data, and additional data in future years, will provide a more robust picture of the quality of care provided by SNPs. Further analysis can also provide a better understanding of differences in the beneficiary populations of SNPs and other MA plans, how those may affect performance and how SNPs improve quality of care over time. With additional support from CMS, the following analyses may shed further light on these results.

- Analysis of results for the SNP and MA programs informed by demographic and health characteristics of their 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 of HEDIS results and S&P measure results.
- Reports from SNP beneficiaries on their experiences, through SNP-specific results on the CAHPS survey and the 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.

APPENDICES

Appendix 1: HEDIS Background

About HEDIS

HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of the performance of health plans. The HEDIS measurement set is sponsored, supported and maintained by NCQA. Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes. NCQA Certified HEDIS Compliance Auditors verify all results using a process designed by NCQA. SNPs can use HEDIS performance data to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement and provide a set of measurement standards that allow comparison with other plans. Data allow identification of performance gaps and establishment of realistic targets for improvement.

The development of a HEDIS measure involves multiple steps; each potential measure is refined and evaluated at several points in the process. The Committee on Performance Measurement (CPM) oversees the evolution of the measurement set. NCQA operates Measurement Advisory Panels (MAP) that provide the clinical and technical expert knowledge required to develop measures for particular clinical areas or specific populations, and HEDIS Expert Panels and a Technical Advisory Group offer invaluable assistance through feedback on new measure specifications. Measures are released for a 30-day Public Comment period before being included in HEDIS.

Measure Selection

With guidance from the Geriatric MAP, NCQA recommended to CMS a subset of HEDIS measures to be reported by SNPs. Starting with measures reported by MA plans at the contract level, the subset was then defined by one of the following qualities:

1. An upper age limit above 75 years of age because measures with an upper age limit below 75 would exclude many SNP beneficiaries, *or*
2. Measures focus on overall health management rather than on one disease or condition, and are therefore appropriate for a population with multiple comorbid conditions.

SNPs reported the following measures in HEDIS 2011. (Note: HEDIS 2011 results are reported in 2011 and primarily cover services delivered in 2010) See Appendix Four for technical specifications for these measures.

- *Colorectal Cancer Screening*
- *Glaucoma Screening in Older Adults*
- *Care for 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*
- *Annual Monitoring for Patients on Persistent Medications*
- *Medication Reconciliation Post-Discharge*
- *Potentially Harmful Drug-Disease Interactions in the Elderly**

- *Use of High-Risk Medications in the Elderly**
- *Osteoporosis Management in Older Women*
- *Antidepressant Medication Management*
- *Follow-Up After Hospitalization for Mental Illness*
- *Board Certification*
- *Plan All-Cause Readmission*

*Lower rate indicates better performance

Data Collection & Validation Process

To submit HEDIS measures, SNPs used NCQA's Web-based Interactive Data Submission System, which has extensive data validation checks. Before the submission process, NCQA collected SNP benefit package profile data to determine reporting eligibility. HEDIS measures were reported by SNPs with an enrollment of ≥ 30 members as of CMS' February 2010 SNP Comprehensive Report, which has enrollment figures for mid-January 2010.

Before data were submitted to NCQA, every SNP benefit package submission underwent a HEDIS Compliance Audit™. The NCQA HEDIS Compliance Audit is a two-part program that consists of an overall assessment of information systems capabilities (IS standards), followed by an evaluation of a plan's ability to comply with HEDIS specifications (HD standards). NCQA Certified Auditors reviewed systems, policies and procedures, and final data results, ensuring that measures were correctly calculated and reported.

Appendix 2: Structure & Process Measures Background

Anatomy of an S&P Measure

S&P measures evaluate how well SNPs perform in key 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 that are met by a plan. NCQA and CMS agreed to set the national benchmark element score at 80%. Refer to Table 12 for a list of the measures, elements and factors evaluated for 2011.

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. Because some SNPs had not reported SNP 1–3 since the initial start of the program in 2008 or since 2009, it was time to require a second round of reporting on SNP 1–3. SNP 4 and SNP 6, in particular, warranted a third year of reporting. For 2011, CMS required all returning SNPs to report SNP 1–3 and SNP 4–6. Thus for a majority of SNPs participating in the MA program, we now have two full years of data on SNP 1–3 and three years of data on SNP 4–6. SNPs new to the program for FY 2011 were required to report all measures (SNP 1–6).

SNP 4: Care Transitions. Expectations for *SNP 4: Care Transitions* are higher and more specific in 2011 than they were in 2010. NCQA removed the analysis requirements (factor 4) from Elements A and B, and made them one element (Element C: Analyzing Performance). Although content did not change, this resulted in more stringency and a stronger emphasis on analysis requirements for 2011. Previously, analysis factors were worth 25 percent of the score for Elements A and B; analyses are worth 100 percent of the score for Element C.

NCQA made a similar change to Element E from 2010. For 2011, we split this element into two separate elements, taking factors three and four, which focus on educating at-risk members about reducing transitions and coordinating services for those members, and making a new Element F: Reducing Transitions. Again, NCQA did not change the requirements, but added emphasis to their importance.

To accommodate these changes, we renumbered other elements of SNP 4, but content remains the same. Identifying Unplanned Transitions is now Element D.

SNP 6: Coordination of Medicare and Medicaid Coverage: NCQA split Element E into two elements: Element E: Service Coordination and Element F: Network Adequacy Assessment. Element E focuses on helping members obtain access to needed providers and services, regardless of payer; Element F focuses on ensuring that members have access to providers that accept Medicare and Medicaid payments. This is a change in how the elements are organized, not a content change, but by making the network adequacy assessment its own element, NCQA increased the scoring rigor for this requirement.

Support for the Evaluation Process

NCQA implemented a support strategy that focused on educating SNPs about the measures, data collection and data submission tools. Support included 16 training sessions with more than 1,600 participants that covered the following topics.

- Introduction to NCQA and SNP Assessment (addresses how NCQA creates HEDIS and S&P measures, and how we collect and measure data in a broad overview)
- SNP Subset of HEDIS Measures
- Interactive Data Submission System (IDSS) (for HEDIS results)
- S&P Measures
- Interactive Survey System (ISS) (for S&P results)

NCQA created the introduction program above specifically for SNPs that were new to NCQA or to the SNP Assessment Program, and directly targeted those plans with telephone and e-mail contacts.

NCQA also held three “open-door forum” conference calls, presented at stakeholder and industry conferences and provided numerous individual and ad-hoc consultations. The “open-door forum” conference calls allowed SNPs to ask questions and get clarifications from NCQA’s SNP Assessment Team prior to data submission. Additionally for surveyors, NCQA provided three training sessions on evaluating S&P measures (one all-day, in-person session and two Webinar sessions) and weekly calls.

NCQA continually provided information to SNPs through e-mail reminders and updates to the NCQA Web site, which includes frequently asked questions (FAQ) and policy updates. NCQA also continually engaged key industry stakeholders, such as the SNP Alliance, America’s Health Insurance Plans, Blue Cross Blue Shield Association, and the Association for Community Affiliated Plans. Additionally, SNPs could submit questions using NCQA’s Web-based Policy Clarification Support (PCS) system and by calling or e-mailing NCQA’s Customer Support staff.

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, and approval by the NCQA Committee on Performance Measurement (HEDIS measures). 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.

- 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 (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 2011, based on the 2010 assessment and the reporting process. Refer to Appendix 4 for S&P measure technical specifications.