



# **Medicare Special Needs Plans Performance Results: Structure & Process Measures Reporting Year 2012**

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## Executive Summary

### Background

This report provides results of measurement of care provided by Special Needs Plans (SNP) to Medicare beneficiaries. Data address Structure & Process (S&P) measures reported in October 2012 and covering SNP information and operations from April 15–October 15, 2012). Structure & Process measures assess internal SNP process and operations that support and affect the quality of care provided by SNPs. This report is the fifth annual report on SNP performance on S&P measures, and provides CMS with a better understanding of how these plans perform on a set of standardized national performance measures.

The Centers for Medicare & Medicaid Services (CMS) required 394 SNPs to submit data related to the S&P measures during this cycle. NCQA assessed SNPs against S&P measures that address the structures, systems and processes in place to address quality of care in the following 6 areas (see Appendix 1 for a list of measures by element and Appendix 2 for technical specifications).

SNP 1: Complex Case Management.

SNP 2: Improving Member Satisfaction.

SNP 3: Clinical Quality Improvement.

SNP 4: Care Transitions.

SNP 5: Institutional SNP Relationship With Facility.

SNP 6: Coordination of Medicare and Medicaid Coverage.

Requirements differed for initial and returning SNPs in 2012. Initial SNPs (i.e., operational as of January 1, 2011, renewed for January 1, 2012; no previous submission of S&P measures) were required to document their performance on the following S&P measures:

- SNP 1, Elements A–H.
- SNP 2, Elements A–C.
- SNP 4, Elements A–F.
- SNP 5, Elements A–C.
- SNP 6, Elements A–E.

Returning SNPs (i.e., operational as of January 1, 2011, renewed for January 1, 2012; and previous submission of the S&P measures) were required to document their performance on the following S&P measures:

- SNP 1, Elements A, B, I–K.
- SNP 2, Element C.
- SNP 3, Element A.
- SNP 4, Elements A–F.
- SNP 5, Elements A–C.
- SNP 6, Elements A–E.

Three hundred ninety-four (394) SNPs met CMS's requirements to be assessed in 2012, 30 fewer than in 2011. After several years of rapid growth, followed by a sharp decline in plan number after 2009, SNP offerings appear to be stabilizing. Although the number of SNP benefit packages declined in 2012, enrollment increased by slightly more than 126,000 beneficiaries from 2011.

Under CMS' direction and approval, NCQA made structural changes and, in some cases, content and scoring changes to some measures, making it difficult to compare results from previous years; thus, only the most recent year's data are presented for many measures. For elements whose requirements did not change from 2011 to 2012, this report provides year-to-year comparison. Changes were made in order to raise performance expectations on certain requirements and also to provide clarification of requirements based on the experience from the previous year's assessment process.

**Measure Framework.** An S&P *measure* is an overall statement of the desired area of performance, accompanied by an explanatory *intent statement*, which states the goals of the measure. Each measure consists of one or more *elements*, which are detailed statements of sub-areas in the measure requirements. Each element comprises *factors* that 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% or higher on each element that composes a measure.***

## Findings

- NCQA saw a wide range of performance within and across S&P measures
- SNPs showed improvement on a majority of elements where requirements remained consistent from 2011 to 2012
- Dual-Eligible SNPs (D-SNPs) comprise a majority of plans and enrollment, thus driving overall performance results
  - 262 of 394 SNPs reporting (66%)
  - 1.12 million enrollees of 1.35 million total SNP members (83%)
- Institutional SNPs (I-SNPs) outperform other SNP types across all measures
  - Smallest number of plans (58), overall enrollment (46,000) and average size (793).
  - 5 organizations account for nearly three-fourths (72%) of the I-SNP plans. One organization has more than 40% of the I-SNPs. Their performance drives overall I-SNP performance.
- Chronic SNPs (C-SNPs) had the lowest performance across all measures
  - There were 74 C-SNPs reporting in 2012 (18 percent of all SNP plans), comprising 13.5 percent of the total population enrolled in SNPs.

Findings regarding each measure are briefly described below.

- Complex Case Management (SNP 1).
  - CMS strengthened the requirements for 2012 by requiring SNPs to provide evidence of implementation of documented processes (e.g., policies and procedures). NCQA also added three new elements for 2012 (SNP 1: I-K) focusing on satisfaction with case management; analyzing effectiveness and identifying opportunities for improvement; and implementing interventions and follow-up evaluation. SNPs had lower performance on these new elements than existing elements; the percentage of plans achieving the national benchmark for each of these elements was 77.9 percent, 47.8 percent and 43.2 percent, respectively.
  - Overall performance was strong for both new and returning SNPs. The majority of plans in 2012 were returning plans.

- Improving Member Satisfaction (SNP 2).

- Returning plans were required to report Element C, which was a new requirement for 2012. Scores were relatively low (52.2 percent of returning plans met the national benchmark).
- New plans were required to report Elements A–C. For Elements A and B, which did not change in 2012, a lower percentage of SNPs met the national benchmark than in 2011: (78.9 percent and 60 percent in 2012 vs. 84.5 percent and 91.6 percent in 2011, for Elements A and B, respectively).

- Clinical Quality Improvement (SNP 3).

- 89.1 percent of SNPs met the national benchmark for this measure, which contains one element and assesses whether the SNP showed statistically significant improvement on at least three SNP-specific HEDIS<sup>®1</sup> measures from 2011 to 2012.

- Care Transitions (SNP 4).

- While overall scores for this measure were lower than the other measures, SNPs showed improvement on 4 of the 6 elements from 2011.
- Analysis of communication and coordination activities (SNP 4: Element C) rose from 39.3 percent in 2011 to 51.9 percent in 2012.
- Many plans are able to show documented processes pertaining to the requirements, but do not provide evidence of implementation of those processes, which are required for the plan to receive full credit.

- Institutional SNP Relationship With Facilities (SNP 5).

- This measure applies only to I-SNPs, which comprise the smallest number of SNP benefit packages (58 of 394). I-SNPs performed well on Elements A and C (80.4 percent met the national benchmark for Element A; 98 percent met the national benchmark for Element C). Scores were lower for Element B (78.4 percent met the national benchmark). Requirements for Elements A and B increased in 2012.

- Coordination of Medicare and Medicaid Coverage (SNP 6).

- D-SNPs have more requirements for this measure than the other two SNP types. For 2012, data source requirements increased to include reports and materials for Elements A and B.
- For elements with no change in requirements, scores increased from 2011.
- D-SNPs and I-SNPs had higher scores than C-SNPs on most requirements.
- Many SNPs did not demonstrate that they conduct network adequacy assessments for both their providers and facilities that accept payment from Medicare and Medicaid
- Approximately three-fourths of the I-SNPs (72.5 percent) and nearly two-thirds of D-SNPs (62.8 percent) met the national benchmark for Element E. Slightly more than half of the C-SNPs (52.9 percent) met the national benchmark. SNPs tended to conduct network adequacy assessments for Medicare network providers, but often did not have such data for Medicaid.
- All three SNP types showed improvement from 2011 (C-SNPs: 50 percent vs. 46.5 percent; I-SNPs: 72.5 percent vs. 66.7 percent; and D-SNPs: 62.8 percent vs. 61.6 percent) on Element E.

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<sup>1</sup> HEDIS is a registered trademark of the National Quality for Committee for Quality Assurance (NCQA).

## **Conclusion**

SNP performance on the S&P measures highlights areas of strong performance as well as areas for improvement. Overall, I-SNPs outperformed the other SNP types on nearly all the measures. D-SNPs comprise the majority of plans and enrollment in the SNP program, so their performance drives aggregate performance in the SNP program. C-SNPs lagged behind the other SNP types on nearly all elements. Some measures and elements had changes to their requirements in 2012 and a year-to-year comparison is not possible. For those elements that remained the same, mainly all of SNP 4: Care Transitions, Elements A and C of SNP 5: Institutional SNP Relationship with Facilities and all elements of SNP 6: Coordination of Medicare and Medicaid, scores are improving. For example, performance on SNP 4: Care Transitions requirements, which did not change from the previous year, showed encouraging improvement by all SNP types across nearly all the required elements.

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## Objectives and Background

### Objectives

This report presents the fifth year of results for SNPs reporting S&P measures. It provides SNP performance in 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.* This information is presented in a separate report delivered to CMS. *Review data submissions on S&P measures, and analyze the results.* S&P measures support evaluation of SNPs in areas (e.g. care transitions, coordination of Medicare and Medicaid) 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 for development of the S&P measures.
- Illustrate SNP performance on the S&P measures and show the percentage of plans that met the national benchmark (i.e., scored above 80 percent) on each element, as well as the percentage of plans that met each factor in each element.
- Provide qualitative and quantitative analyses. For areas where the requirements remain unchanged from 2011 to 2012, provide year-to-year comparison.

### SNP Overview

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

- *Dual-Eligible SNPs (D-SNP)* enroll beneficiaries eligible for Medicare and Medicaid
- *Institutional SNPs (I-SNP)* enroll beneficiaries who 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. SNPs must submit their Model of Care for review and approval by NCQA, based on standards developed by the Secretary of the Department of Health and Human Services.

**Table 1. Key Differences Between SNPs and Standard MA Plans<sup>2</sup>**

Categories	SNPs	MA plans
Enrollment	<ul style="list-style-type: none"> <li>• Must limit enrollment to targeted special needs individuals (i.e., dual eligible beneficiaries, those with specific chronic or disabling conditions, or living in or eligible for residing in an institutional setting).</li> <li>• May target specific subsets of special needs populations (e.g., beneficiaries with congestive heart failure or diabetes).</li> <li>• 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.</li> <li>• One-time passive enrollment of dual-eligibles in 2006 (individuals covered under both Medicare and Medicaid).</li> </ul>	<ul style="list-style-type: none"> <li>• Must be open to all Medicare-eligible beneficiaries.</li> <li>• Lock-in provision for all enrollees with an annual open-enrollment period</li> </ul>
Benefits	<ul style="list-style-type: none"> <li>• Standard MA benefits.</li> <li>• Must offer Part D prescription drug coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Standard MA benefits.</li> <li>• Part D coverage is voluntary.</li> </ul>
Payments	<ul style="list-style-type: none"> <li>• Standard MA geographic payment schedule, with PMPM payments risk-adjusted by hierarchical condition category (HCC) scores.</li> </ul>	
Marketing	<ul style="list-style-type: none"> <li>• May target special needs populations in the market area.</li> <li>• May target specific subsets of special needs populations (on a case-by-case basis) within the market area.</li> </ul>	<ul style="list-style-type: none"> <li>• Must include all Medicare-eligible beneficiaries in the market area.</li> </ul>

The SNP program began with 11 SNPs in 2004 and grew to 702 SNPs by February 2008. Although the number of SNP benefit packages has steadily declined since then (dropping to 447 in 2010; to 424 in 2011; and to 394 in 2012), the total population covered by SNPs increased by approximately 10 percent from 2010 to 2011 and by another 10 percent in 2012 (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 2,892 members to 3,430 members (19 percent) from 2011 to 2012.

Most SNP enrollees are dual-eligible. Enrollment in D-SNPs ranges from 11 to more than 86,000 members. Table 2 illustrates the total submissions for S&P measures during the 2012 data collection period.

<sup>2</sup>CMS. *Special Needs Plans—Fact Sheet & Data Summary*.  
<http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FSNPFACT.pdf>

Table 2. SNP Enrollment as of February 2010, 2011 and 2012<sup>3</sup>

SNP Type and Year	SNPs Required to Report S&P Measures	
	Number of SNPs	Subtotal Enrollment
Chronic or Disabling Condition 2010	115	173,479
Dual-Eligible 2010	272	820,262
Institutional 2010	60	121,849
<b>2010 Total</b>	<b>447</b>	<b>1,115,590</b>
Chronic or Disabling Condition 2011	80	142,708
Dual-Eligible 2011	286	991,423
Institutional 2011	58	92,013
<b>2011 Total</b>	<b>424</b>	<b>1,226,144</b>
Chronic or Disabling Condition 2012	74	182,983
Dual-Eligible 2012	262	1,122,168
Institutional 2012	58	46,412
<b>2012 Total</b>	<b>394</b>	<b>1,351,563</b>

## 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.

### 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.

<sup>3</sup> Enrollment is derived from the monthly SNP Comprehensive Report found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Special-Needs-Plan-SNP-Data.html>

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* because these measures had the lowest performance in the previous year, and required new SNPs to submit all six S&P measures.

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

In 2012, initial and returning SNPs had differing requirements. Initial SNPs were required to report the following measures:

- SNP 1, Elements A–H.
- SNP 2, Elements A–C.
- SNP 4, Elements A–F.
- SNP 5, Elements A–C.
- SNP 6, Elements A–E.

Returning SNPs were required to submit the following S&P measures:

- SNP 1, Elements A, B, I–K.
- SNP 2, Element C.
- SNP 3, Element A.
- SNP 4, Elements A–F.
- SNP 5, Elements A–C.
- SNP 6, Elements A–E.

### **New Submission Date in 2012**

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The submission date for the S&P measures has changed several times since SNPs were first required to report in 2008. It was originally June 30 of the reporting year until 2011, when CMS changed it to February 28, 2011. For 2012, the submission date was October 15.

## Structure & Process Measure Results

### Measure Submission

NCQA analyzed data from the 394 SNP benefit packages required to report for 2012. Data reflect SNP operations for 2011 and 2012 (i.e., SNPs were required to be operational as of January 1, 2011, and renewed for January 1, 2012).

CMS required initial and returning SNPs to report differing elements of the six measures (SNP 1–SNP 6), added data source requirements and scoring for some measures and added four elements (SNP 1, Elements I–K; SNP 2, Element C). CMS increased the requirements for SNP 1; requirements had not changed significantly since they were introduced in 2008, and a large majority of SNPs were achieving the national benchmark in nearly all elements.

Where possible, NCQA compares 2012 scores with 2011 scores. For elements where changes prevent year-to-year comparison, NCQA presents the most recent data only. For these analyses, NCQA established a national benchmark to gauge performance, which is the percentage of plans scoring 80 percent or 100 percent on each element that composes a measure.

### Overall Performance (Table 3)

Table 3 shows performance on all required measures, by element. Each measure comprises elements; each element comprises factors. The number of factors met by a SNP determines an element's score—100 percent indicates the highest level of performance. Shaded cells indicate that the score was not an option for the element.

The *Percentage at 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; a score of 80 percent reflects that nearly all factor-level requirements have been met.

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

- *Complex Case Management (SNP 1)*. The majority of plans in 2012 were returning plans, required to report Elements A, B, I–K. New plans were required to report Elements A–H. Benchmark scores for new plans showed a high percentage of plans achieving the national benchmark, considering that 2012 was their first year of reporting.

Ninety percent of plans met the national benchmark for Elements E and F. All plans met the national benchmark for Element H.

Scores were lower in 2012 than in 2011, particularly for Elements A, B and D. CMS increased reporting requirements for these elements in 2012, which partly accounted for the lower performance. Many plans attempted to receive credit for automatically enrolling all members in complex case management, but did not meet specific requirements. This also contributed to lower scores for many plans.

Elements I–K were new elements. 77.6 percent of plans met the national benchmark for Element I; scores were lower for Elements J and K (47.8 percent and 43.2 percent, respectively). NCQA expects these scores to improve over time as SNPs become more familiar with the requirements and focus attention and efforts to raise their scores.

- *Improving Member Satisfaction (SNP 2)*. Returning plans were required to report Element C, which was a new requirement for 2012. 52.2 percent of returning plans achieved the national benchmark. New plans were required to report Elements A–C. For Elements A and B, which did not change in 2012, a lower percentage of SNPs met the national benchmark than in 2011 (78.9 percent and 60 percent in 2012 vs. 84.5 percent and 91.6 percent in 2011, respectively).

- Clinical Quality Improvement (SNP 3). 89.1 percent of SNPs met the national benchmark for this measure, which contains one element and assesses whether the SNP showed statistically significant improvement on at least three SNP-specific HEDIS measures from 2011 to 2012.
- Care Transitions (SNP 4). While overall scores for this measure were lower than the other measures, there was variation among the elements. SNPs had the highest scores on Element D (79.4 percent met the national benchmark). 51.9 percent of SNPs met the national benchmark for Element C, a large improvement over 2011 (39.3 percent). SNPs also improved on Elements B–E from 2011 to 2012.
- 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 394). I-SNPs scored high on Elements A and C (80.4 percent met the national benchmark for Element A; 98 percent met the national benchmark for Element C). Scores were lower for Element B (78.4 percent met the national benchmark). Requirements for Elements A and B increased in 2012.
- Coordination of Medicare and Medicaid Coverage (SNP 6). D-SNPs have more requirements for this measure than the other two SNP types. Scores ranged from a high of 92.4 percent (Element A) to a low of 62.4 percent (Element E) meeting the national benchmark.

For 2012, CMS strengthened the data source requirements to include reports and materials for Elements A and B in 2012; thus, scores for these elements are not compared with scores from previous years. A lower percentage of SNPs met the national benchmark in 2012 on Element D (71.9 percent vs. 86 percent in 2011), while scores improved for Element E (59.6 percent in 2011 and 62.4 percent in 2012).

**Table 3. Structure and Process Performance of SNPs for Measures Submitted in 2012  
(N = 394)**

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	%
<b>SNP 1: Complex Case Management</b>												
A Identifying Members for Case Management	394	66.8	219	55.6	44	11.2	63	16.0	35	8.9	33	8.4
B Access to Case Management	394	71.1	280	71.1	NA	NA	18	4.6	19	4.8	77	19.5
C Case Management Systems	20	85.0	17	85.0	NA	NA	2	10.0	1	5.0	0	0.0
D Frequency of Member Identification	20	70.0	13	65.0	1	5.0	NA	NA	0	0.0	6	30.0
E Providing Members With Information	20	90.0	16	80.0	2	10.0	NA	NA	0	0.0	2	10.0
F Case Management Assessment Process	20	90.0	18	90.0	0	0.0	1	5.0	0	0.0	1	5.0
G Informing and Educating Practitioners	20	85.0	17	85.0	0	0.0	1	5.0	1	5.0	1	5.0
H Individualized Care Plan	20	100.0	20	100.0	NA	NA	0	0.0	NA	NA	0	0.0
I Satisfaction With Case Management	370	77.6	150	40.5	137	37.0	NA	NA	NA	NA	83	22.4
J Analyzing Effectiveness/Identifying Opportunities**	370	47.8	136	36.8	41	11.1	115	31.1	34	9.2	44	11.9
K Implementing Interventions and Follow-Up Evaluation**	370	43.2	140	37.8	20	5.4	96	25.9	34	9.2	80	21.6
<b>SNP 2: Improving Member Satisfaction</b>												
A Assessment of Member Satisfaction	19	78.9	15	78.9	NA	NA	2	10.5	1	5.3	1	5.3
B Opportunities for Improvement	15	60.0	9	60.0	NA	NA	0	0.0	NA	NA	6	40.0
C Improving Satisfaction	356	52.2	186	52.2	NA	NA	32	9.0	NA	NA	138	38.8
<b>SNP 3: Clinical Quality Improvements</b>												
A Clinical Improvements	312	89.1	261	83.7	17	5.4	NA	NA	21	6.7	13	4.2
<b>SNP 4: Care Transitions</b>												
A Managing Transitions	394	63.7	191	48.5	60	15.2	NA	NA	82	20.8	61	15.5
B Supporting Members Through Transitions	394	73.4	261	66.2	28	7.1	NA	NA	56	14.2	49	12.4
C Analyzing Performance	389	51.9	190	48.8	12	3.1	18	4.6	1	0.3	168	43.2
D Identifying Unplanned Transitions	394	79.4	313	79.4	NA	NA	36	9.1	NA	NA	45	11.4
E Analyzing Transitions	389	51.2	199	51.2	NA	NA	109	28.0	NA	NA	81	20.8
F Reducing Transitions	394	61.4	242	61.4	NA	NA	80	20.3	NA	NA	72	18.3

**Table 3. Structure and Process Performance of SNPs for Measures Submitted in 2012 (N = 394) continued**

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	%
<b>SNP 5: Institutional SNP Relationship With Facility</b>												
A: Monitoring Members' Health Status	51	80.4	41	80.4	NA	NA	0	0.0	NA	NA	10	19.6
B: Monitoring Changes in Members' Health Status	51	78.4	40	78.4	NA	NA	0	0.0	NA	NA	11	21.6
C: Maintaining Members' Health Status	51	98.0	50	98.0	NA	NA	NA	NA	NA	NA	1	2.0
<b>SNP 6: Coordination of Medicare and Medicaid Coverage</b>												
A: Coordination of Benefits for Dual-Eligible Members	262	92.4	239	91.2	3	1.1	NA	NA	17	6.5	3	1.1
B: Administrative Coordination of D-SNPs	262	71.0	186	71.0	NA	NA	27	10.3	NA	NA	49	18.7
C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages	119	89.9	71	59.7	36	30.3	9	7.6	0	0.0	3	2.5
D: Service Coordination	381	71.9	202	53.0	72	18.9	NA	NA	72	18.9	35	9.2
E: Network Adequacy Assessment	380	62.4	230	60.5	7	1.8	78	20.5	18	4.7	47	12.4

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

\*\*For SNP 1, Elements J and K, results for three separate measures are combined. The summary score for the multiline element is the average of element scores across all measures. For reporting purposes, final scores are grouped into 0%, 20%, 50%, 80% and 100% score brackets:

- Scores from 0%–<20% are in the 0% bracket.
- Scores from 20%–<50% are in the 20% bracket.
- Scores from 50%–<80% are in the 50% bracket.
- Scores from 80%–<100% are in the 80% bracket.
- Only scores of 100% are included in the 100% bracket.

**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 4A–C)

SNP 1: *Complex Case Management* requires SNPs to identify, assess and educate members with complex illnesses and for actively coordinating their care. Many SNP members are eligible for case management because many members tend to be more frail or have multiple comorbidities.

Tables 4A–4C show performance on SNP 1 by SNP type, enrollment size, element and factor. The majority of plans in 2012 were returning plans, required to report Elements A, B, I–K. New plans were required to report Elements A–H. Benchmark scores for returning plans, while lower than in 2011, were still relatively high. 90 percent of plans met the national benchmark for Elements E and F. All plans met the national benchmark for Element H.

Scores were lower in 2012 than in 2011, particularly for Elements A, B and D. CMS and NCQA increased reporting requirements for these elements in 2012, which partly accounted for the lower performance. Many

plans attempted to receive credit for automatically enrolling all members in complex case management, but did not meet specific requirements. This also contributed to lower scores for many plans.

Elements I–K were new elements. 77.6 percent of plans met the national benchmark for Element I; scores were lower for Elements J and K (47.8 percent and 43.2 percent, respectively). All SNP types had low benchmark scores on factor two of Element I, analyzing member complaints and inquiries (D-SNPs, 46.0 percent; C-SNPs, 23.5 percent; I-SNPs, 39.3 percent). This is an area SNPs should target for improvement. A main reason for the lower benchmark scores on this requirement is that many SNPs either do not or cannot show how they collect and analyze information related to case management inquiries. These requirements were new for 2012, so SNPs were less familiar with them, which normally results in lower scores. As SNPs become more familiar with the requirements and begin to more fully implement processes and actions to address them, NCQA expects these scores to improve over time.

SNP size was not a factor in overall performance, generally, although SNPs with the smallest enrollments (0–99 members) had higher scores (75.5 percent) for Element A than did the other categories. Conversely, for Elements I–K, the smaller category had the lowest scores (63.9 percent, 38.9 percent and 22.2 percent, respectively), while the largest category had the highest scores (83.2 percent, 58.4 percent and 54.5 percent, respectively). Neither of the two largest categories of SNP plans (1,000–2,499 and  $\geq 2,500$ ) were composed of new SNPs and thus were not required to report Elements C–H. Consequently, a discussion of those elements addresses the performance of new plans only.

A higher percentage of I-SNPs met the national benchmark than either D-SNPs or C-SNPs on all elements of SNP 1, with the exception of Element D and Elements I–K, where a smaller percentage met the national benchmark.

D-SNPs scored highest on Elements D, I–K. C-SNPs did not outperform either of the other SNP types on any elements in SNP 1 and had a lower percentage of plans achieving the national benchmark on 8 of the 11 elements.

**Table 4A. Complex Case Management (SNP 1) Performance on National Benchmarks by SNP Type, by Element 2012**

Elements	National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible National Benchmark	Institutional National Benchmark	Chronic National Benchmark
Number of reporting SNPs by type		<b>262</b>	<b>58</b>	<b>74</b>
A: Identifying Members for Case Management	66.8	58.0	96.6	74.3
B: Access to Case Management	71.1	69.8	79.3	68.9
C: Case Management Systems	85.0	85.7	100.0	81.8
D: Frequency of Member Identification	70.0	85.7	50.0	63.6
E: Providing Members With Information	90.0	100.0	100.0	81.8
F: Case Management Assessment Process	90.0	85.7	100.0	90.9
G: Individualized Care Plan	85.0	71.4	100.0	90.9
H: Informing and Educating Practitioners	100.0	100.0	100.0	100.0
I: Satisfaction With Case Management	77.6	82.3	70.4	64.5
J: Analyzing Effectiveness/Identifying Opportunities **	47.8	53.9	25.9	41.9
K: Implementing Interventions and Follow-Up Evaluation**	43.2	51.6	20.4	29.0

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

\*\*For SNP 1, Elements J and K, results for three separate measures are combined. The summary score for the multiline element is the average of element scores across all measures. For reporting purposes, final scores are grouped into 0%, 20%, 50%, 80% and 100% score brackets:

- Scores from 0%–<20% are in the 0% bracket.
- Scores from 20%–<50% are in the 20% bracket.
- Scores from 50%–<80% are in the 50% bracket.
- Scores from 80%–<100% are in the 80% bracket.
- Only scores of 100% are included in the 100% bracket.

**Table 4B. Complex Case Management (SNP 1) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			49	89	52	103	101
A: Identifying Members for Case Management	394	66.8	75.5	67.4	65.4	60.2	69.3
B: Access to Case Management	394	71.1	71.4	69.7	73.1	72.8	69.3
C: Case Management Systems	20	85.0	88.9	90.0	NA	NA	NA
D: Frequency of Member Identification	20	70.0	77.8	60.0	100.0	NA	NA
E: Providing Members With Information	20	90.0	100.0	80.0	100.0	NA	NA
F: Case Management Assessment Process	20	90.0	100.0	80.0	100.0	NA	NA
G: Individualized Care Plan	20	85.0	100.0	70.0	100.0	NA	NA
H: Informing and Educating Practitioners	20	100.0	100.0	100.0	100.0	NA	NA
I: Satisfaction With Case Management	370	77.6	63.9	77.2	74.5	78.6	83.2
J: Analyzing Effectiveness/Identifying Opportunities**	370	47.8	38.9	41.8	47.1	45.6	58.4
K: Implementing Interventions and Follow-Up Evaluation**	370	43.2	22.2	36.7	45.1	43.7	54.5

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

\*\*For SNP 1, Elements J and K, results for three separate measures are combined. The summary score for the multiline element is the average of element scores across all measures. For reporting purposes, final scores are grouped into 0%, 20%, 50%, 80% and 100% score brackets:

- Scores from 0%–<20% are in the 0% bracket.
- Scores from 20%–<50% are in the 20% bracket.
- Scores from 50%–<80% are in the 50% bracket.
- Scores from 80%–<100% are in the 80% bracket.
- Only scores of 100% are included in the 100% bracket.

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 22 plans with no enrollment data are included in the 0-99 enrollment category.

**Table 4C. Performance on Complex Case Management (SNP 1) by Factor, All SNPs Reporting 2012**

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	394		262		58		74	
<b>Element A: Identifying Members for Case Management</b>								
1. Claim or encounter data	394	68.8	262	63.4	58	96.6	74	66.2
2. Hospital discharge data	394	74.4	262	75.2	58	87.9	74	60.8
3. Pharmacy data	394	66.2	262	59.9	58	94.8	74	66.2
4. Laboratory results	394	49.7	262	40.5	58	77.6	74	60.8
5. Data collected through the UM process, if applicable	394	79.2	262	77.9	58	96.6	74	70.3
6. Data supplied by member or caregiver, if applicable	394	73.4	262	67.2	58	79.3	74	90.5
7. Data supplied by practitioners, if applicable	372	61.3	240	56.3	58	79.3	74	63.5
<b>Element B: Access to Case Management</b>								
1. Health information line referral	271	68.3	199	64.8	37	91.9	35	62.9
2. Disease Management (DM) program referral	394	67.0	262	65.6	58	81.0	74	60.8
3. Discharge planner referral	394	69.5	262	71.8	58	70.7	74	60.8
4. UM referral, if applicable	394	76.1	262	73.7	58	81.0	74	81.1
5. Member or caregiver referral	394	71.3	262	72.5	58	79.3	74	60.8
6. Practitioner referral	394	72.8	262	72.5	58	79.3	74	68.9
7. Other	394	69.3	262	74.8	58	72.4	74	47.3
<b>Element C: Case Management Systems</b>								
1. Evidence-based clinical guidelines or algorithms to conduct assessment and management	20	85.0	7	85.7	2	100.0	11	81.8
2. Automatic documentation of the staff member's identification and date and time on which there was action on the case or interaction with the member	20	100.0	7	100.0	2	100.0	11	100.0
3. Automated prompts for follow-up, as required by the case management plan	20	95.0	7	100.0	2	100.0	11	90.9
<b>Element D: Frequency of Member Identification</b>								
The organization systematically identifies members at least monthly	20	65.0	7	85.7	2	50.0	11	54.5
The organization systematically identifies members at least quarterly	20	5.0	7	0.0	2	0.0	11	9.1
The organization systematically identifies members less frequently than every 6 months	20	30.0	7	14.3	2	50.0	11	36.4
The organization systematically identifies members at least every 6 months	20	0.0	7	0.0	2	0.0	11	0.0
<b>Element E: Providing Members With Information</b>								
1. How to use the services	20	85.0	7	100.0	2	100.0	11	72.7
2. How members become eligible to participate	20	85.0	7	100.0	2	100.0	11	72.7
3. How to opt in or opt out	20	90.0	7	100.0	2	100.0	11	81.8

**Table 4C. Performance on Complex Case Management (SNP 1) by Factor, All SNPs Reporting 2012 *continued***

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
<b>Element F: Case Management Assessment Process</b>								
1. Initial assessment of members' health status, including condition-specific issues	20	95.0	7	100.0	2	100.0	11	90.9
2. Documentation of clinical history, including medications	20	95.0	7	100.0	2	100.0	11	90.9
3. Initial assessment of the activities of daily living	20	95.0	7	100.0	2	100.0	11	90.9
4. Initial assessment of mental health status, including cognitive functions	20	95.0	7	100.0	2	100.0	11	90.9
5. Evaluation of cultural and linguistic needs, preferences or limitations	20	95.0	7	100.0	2	100.0	11	90.9
6. Evaluation of visual and hearing needs, preferences or limitations	20	90.0	7	85.7	2	100.0	11	90.9
7. Evaluation of caregiver resources and involvement	20	95.0	7	100.0	2	100.0	11	90.9
8. Evaluation of available benefits	20	90.0	7	85.7	2	100.0	11	90.9
<b>Element G: Individualized Care Plan</b>								
1. Development of a case management plan, including prioritized goals that consider the member's and caregivers' goals, preferences and desired level of involvement in the case management plan	20	90.0	7	85.7	2	100.0	11	90.9
2. Identification of barriers to meeting their goals or complying with the plan	20	85.0	7	71.4	2	100.0	11	90.9
3. Development of a schedule for follow-up and communication	20	90.0	7	85.7	2	100.0	11	90.9
4. Development and communication of member self-management plans	20	90.0	7	85.7	2	100.0	11	90.9
5. A process to assess member's progress against their case management plans	20	90.0	7	85.7	2	100.0	11	90.9
<b>Element H: Informing and Educating Practitioners</b>								
1. Instructions on the complex case management services and how to use these services	20	100.0	7	100.0	2	100.0	11	100.0
2. How the organization works with a practitioner's patients in the complex case management program	20	100.0	7	100.0	2	100.0	11	100.0
<b>Element I: Satisfaction With Case Management</b>								
1. Obtaining feedback from members	370	69.2	254	72.4	54	70.4	62	54.8
2. Analyzing member complaints and inquiries	322	41.3	215	46.0	51	23.5	56	39.3

**Table 4C. Performance on Complex Case Management (SNP 1) by Factor, All SNPs Reporting 2012 *continued***

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
<b>Element J: Analyzing Effectiveness/Identifying Opportunities*</b>								
1. Identifies three relevant processes or outcomes	370	62.4	254	64.6	54	63.0	62	53.2
2. Uses valid methods that provide quantitative results for three relevant processes or outcomes	370	62.7	254	66.9	54	40.7	62	64.5
3. Sets a performance goal for three relevant processes or outcomes	370	66.8	254	65.7	54	66.7	62	71.0
4. Clearly identifies measure specifications for three relevant processes or outcomes	370	71.4	254	67.7	54	74.1	62	83.9
5. Analyzes results for three relevant processes or outcomes	370	48.1	254	53.5	54	24.1	62	46.8
6. Identifies opportunities for improvement for the three relevant processes or outcomes, if applicable	365	49.9	249	55.8	54	25.9	62	46.8
<b>Element K: Implementing Interventions and Follow-Up Evaluation *</b>								
1. Implemented at least one intervention for each of the three opportunities identified in Element J to improve performance	365	47.1	249	48.6	54	61.1	62	29.0
2. Develops a plan for evaluation of the intervention and remeasurement for all three opportunities identified in Element J	370	48.6	254	57.9	54	25.9	62	30.6

\*SNP1 Elements J and K comprise multiple measures. Plans choose any three measures to have scored against six factors in Element J and two factors in Element K. For reporting purposes, the factor scores (pass/fail) are summarized across all measures the plan chose. A plan that meets a factor across all applicable measures is reported as passing that factor.

### **Performance on SNP 2: Improving Member Satisfaction, All SNPs Reporting (Tables 5A–C)**

*SNP 2: Improving Member Satisfaction* requires that plans systematically assess member satisfaction, identify opportunities for improvement and implement interventions based on those identified opportunities. For the most part, SNPs collect, analyze and identify opportunities for improvement regarding member satisfaction, using complaint and appeal data or CAHPS survey data.

Returning SNPs were required to report Element C and new plans were required to report Elements A–C. 78.9 percent, 60 percent and 52.2 percent of SNPs, respectively, met the national benchmark for these elements. Results for Elements A and B (unchanged from 2011) were lower overall in 2012 (84.4 percent and 91.6 percent in 2011 vs. 78.9 percent and 60 percent in 2012, respectively), which mostly reflects lower performance from the D-SNPs.

I-SNPs outperformed D-SNPs and C-SNPs on all three elements, with large differences in the percentage of I-SNPs that met the national benchmark, compared with D-SNPs and C-SNPs.

The largest SNPs (1,000–2,499; ≥2,500) were all returning SNPs that did not report Elements A and B; thus, it is difficult to compare SNPs by size across the elements. All SNPs were required to report Element C. There is not much variance among smaller, mid-size and larger SNPs; however, the largest category (≥2,500) had the highest percentage of SNPs that met the national benchmark (53.7 percent), while the mid-size SNPs (500–999) scored lowest, with 46.9 percent.

**Table 5A. Improving Member Satisfaction (SNP 2) Performance on National Benchmarks\* by SNP Type, by Element 2012**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
	All SNPs	Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		262	58	74
A: Assessment of Member Satisfaction	78.9	57.1	100.0	90.9
B: Opportunities for Improvement	60.0	40.0	100.0	66.7
C: Improving Satisfaction	52.2	43.1	93.9	54.4

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

**Table 5B. Improving Member Satisfaction (SNP 2) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			49	89	52	103	101
A: Assessment of Member Satisfaction	19	78.9	75.0	80.0	100.0	NA	NA
B: Opportunities for Improvement	15	60.0	66.7	62.5	NA	NA	NA
C: Improving Satisfaction	356	52.2	57.5	53.2	46.9	50.5	53.7

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

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 22 plans with no enrollment data are included in the 0-99 enrollment category.

**Table 5C. Improving Member Satisfaction (SNP 2) by Factor, All SNPs Reporting 2012**

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	Dual	%	N	%
Number of reporting SNPs by type	394		262		58		74	
<b>Element A: Assessment of Member Satisfaction</b>								
1. Identifying the appropriate population and collecting member satisfaction data for all the SNP's operations	19	89.5	7	85.7	1	100.0	11	90.9
2. Drawing appropriate samples from the affected population, if a sample is used	18	88.9	6	83.3	1	100.0	11	90.9
3. Conducting an annual quantitative and qualitative analysis of member satisfaction data	19	84.2	7	57.1	1	100.0	11	100.0
<b>Element B: Opportunities for Improvement</b>								
The organization does not identify any opportunities for improvement	15	40.0	5	60.0	1	0.0	9	33.3
The organization identifies 1 opportunity for improvement	15	0.0	5	0.0	1	0.0	9	0.0
The organization identifies 2 or more opportunities for improvement	15	60.0	5	40.0	1	100.0	9	66.7
<b>Element C: Improving Satisfaction</b>								
1. Implementing interventions	332	57.8	238	49.2	26	88.5	68	76.5
2. Measuring the effectiveness of the interventions	346	52.0	236	43.6	42	92.9	68	55.9

**Performance on SNP 3: Clinical Quality Improvement, All SNPs Reporting (Tables 6A–C)**

SNP 3: *Clinical Quality Improvement* requires plans to show statistically significant improvement on three or more HEDIS measures from the SNP-subset of HEDIS measures. Because this is a change from 2011, year-to-year comparison is not possible.

Dual-eligible SNPs had the highest percentage of plans meeting the national benchmark (93.2 percent vs. 67.6 percent for I-SNPs and 86.8 percent for C-SNPs). I-SNPs had the lowest number of SNPs showing statistically significant improvement, which may be the result of low enrollment, a population with many exceptions (e.g., frailty, age, dementia) to being included in either the numerator or denominator of many of the HEDIS measures, resulting in many I-SNPs not being able to report sufficient data to determine significant improvement.

Larger plans, particularly those with enrollments of more than 1,000 members, had the highest percentage of SNPs that met the national benchmark (92.8 percent and 94.9 percent, respectively) for the two largest size categories.

**Table 6A. Clinical Quality Improvements (SNP 3) Performance on National Benchmarks by SNP Type, by Element 2012**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
	All SNPs	Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		262	58	74
A: Clinical Improvements	89.1	93.2	67.6	86.8

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

**Table 6B. Clinical Quality Improvements (SNP 3) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			49	89	52	103	101
A: Clinical Improvements	312	89.1	75.0	75.8	89.4	92.8	94.9

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

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 22 plans with no enrollment data are included in the 0-99 enrollment category.

**Table 6C. Clinical Quality Improvements (SNP 3) by Factor, All SNPs Reporting 2012**

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	Dual	%	N	%
Number of reporting SNPs by type	394		262		58		74	
The organization demonstrates no clinical improvements	312	4.2	222	1.8	37	16.2	53	5.7
The organization demonstrates 1 clinical improvement	312	6.7	222	5.0	37	16.2	53	7.5
The organization demonstrates 2 clinical improvements	312	5.4	222	6.8	37	5.4	53	0.0
The organization demonstrates 3 clinical improvements	312	83.7	222	86.5	37	62.2	53	86.8

**Performance on SNP 4: Care Transitions, All SNPs Reporting (Tables 7A–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.

Although this measure continues to be a challenging, SNPs showed improvement from 2011 on four of the six elements (Elements B–E). Element C had the largest gains, with 51.9 percent of the SNPs meeting the national benchmark in 2012 vs. 39.3 percent in 2011. Conversely, SNPs showed a large decrease in performance on Element F (61.4 percent in 2012 vs. 80.7 percent in 2011).

I-SNPs outperformed D-SNPs and C-SNPs on Elements B–E, but scored lower on Elements A and F, where scores dropped by 48 percentage points on each element. It is not clear why there was such a large reduction in performance for these elements.

C-SNPs scored the highest on Element A (73 percent), while D-SNPs had the highest scores for Element F (68.3 percent).

The trend at the factor level is consistent with the overall element scoring trend; I-SNPs consistently outperform other SNP types on every factor of Elements B–E. C-SNPs had the highest percentage of SNPs that met the benchmark on Element A. C-SNPs outperformed the other types on Element F, factor 1; D-SNPs scored higher on factor 2.

Plan size does not appear to affect SNP performance on this measure. The I-SNP category, which has the smallest number of benefit packages (58), is dominated by 5 SNP organizations that account for nearly three-quarters (72.4 percent) of the benefit packages (42 of 58). One organization accounts for more than 40 percent of all I-SNP benefit packages (24)—this organization’s performance has a strong effect on the I-SNP category’s overall results.

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### **Additional Performance Details**

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

- *Element A, Managing Transitions.* Most SNPs scored highly in identifying planned transitions in advance (e.g., scheduled surgery, where 75.6 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 (76.9 percent of SNPs met the requirements for Element B, factor 1, 83.8 percent met the requirements for Element B, factor 3).

If documentation inadequately addresses requirements for Element A factors, SNPs do not receive credit for those factors. SNPs must provide documented processes (e.g., policies and procedures) for performing certain activities and must provide reports or materials for evidence that they implement the documented process. In other words, SNPs must demonstrate that they actually do what they say they do. Areas where documentation did not demonstrate that Element A was met were:

- *Implementation:* Some SNPs had policies and procedures for Element A but did not have documentation of implementation. Some policies were too general or the SNP did not demonstrate implementation for transitions to care settings other than to and from the hospital. The measure requires that policies be specific with regard to transition type (e.g., 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 requirement 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 time 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 for all three factors from 2011. 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.<sup>4</sup>

The highest percentage of SNPs meeting the requirements was for factor 3 (81.7 percent met the national benchmark). Some SNPs have scripts for contacting members after discharge, with questions

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<sup>4</sup> 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.

about follow-up physician appointments and about understanding prescribed medications. Many I-SNPs have nurse practitioners conduct in-person follow-up with patients. Because most I-SNP members transition between the hospital and institutional facility where they reside, care coordination and follow-up tends to be more consistent and systematic in I-SNPs, compared with other SNPs.

– *Implementation:* As in Element A, SNPs sometimes have a policy for communicating with members but had no evidence of actual communication. Where members were already identified for case management, communication with the case manager was well documented. Members who are in active case management tend to have a relationship with their case managers and to know to contact them directly if they have questions or issues related to their care.

- *Element C: Analyzing Performance.* Many SNPs had difficulty demonstrating performance for this element, which requires an annual analysis of aggregate performance of managing transitions related to the requirements of Elements A and B. However, in aggregate, SNPs improved performance on this element and on each of the four factors. Only the C-SNPs decreased in performance on three factors from 2011 to 2012.

The average percentage of SNPs meeting the requirements for all factors of Element C is 53.2 percent, with a range from 50.1 percent (factor 1) to 55.6 percent, and 55.5 percent on factors 2 and 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 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 regularly.

- *Element D: Identifying Unplanned Transitions.* Performance on this element was relatively high, and increased from 2011 on both factors. 87.1 percent of SNPs met the national benchmark related to receiving notification from hospitals and 81 percent met the national benchmark related to receiving timely notification from long-term care facilities of member admission. Many SNPs require such notification in their contracts with facilities, which may explain the higher performance.
- *Element E: Analyzing Transitions.* SNP performance on factors 1 and 2 was lower in 2012 than in 2011 for all three SNP types, with the exception of I-SNPs, which scored considerably higher (92.7 percent in 2012 vs. 40 percent in 2011) for factor 1. I-SNPs also had a higher percentage meeting the national benchmark for each factor than D-SNPs or C-SNPs.

SNPs that did not perform well on this element were often 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 (e.g., 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-related adverse events). SNPs must be able to identify such issues if they are going to reduce admissions, particularly unplanned admissions.

- *Element F: Reducing Transitions.* Although SNPs scored well on this element, their scores were lower in 2012 than in 2011. This element requires SNPs to educate at-risk members about preventing unplanned transitions, to coordinate care for these members in order to reduce unplanned transitions and to keep members in the least restrictive setting possible. One reason plans scored lower in 2012 might be that the requirements increased emphasis on SNPs showing a connection between members identified as “at risk” in Element E and coordination and education efforts on behalf of those members in Element F.

**Table 7A. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Type, by Element 2012**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		<b>262</b>	<b>58</b>	<b>74</b>
A: Managing Transitions	63.7	66.4	39.7	73.0
B: Supporting Members Through Transitions	73.4	66.8	96.6	78.4
C: Analyzing Performance	51.9	56.3	61.8	28.8
D: Identifying Unplanned Transitions	79.4	74.8	98.3	81.1
E: Analyzing Transitions	51.2	44.4	72.7	58.9
F: Reducing Transitions	61.4	68.3	37.9	55.4

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

**Table 7B. Care Transitions (SNP 4) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			<b>49</b>	<b>89</b>	<b>52</b>	<b>103</b>	<b>101</b>
A: Managing Transitions	394	63.7	59.2	65.2	73.1	59.2	64.4
B: Supporting Members Through Transitions	394	73.4	77.6	75.3	80.8	71.8	67.3
C: Analyzing Performance	389	51.9	45.5	44.9	55.8	59.2	51.5
D: Identifying Unplanned Transitions	394	79.4	83.7	78.7	71.2	78.6	83.2
E: Analyzing Transitions	389	51.2	45.5	50.6	51.9	55.3	49.5
F: Reducing Transitions	394	61.4	57.1	52.8	57.7	58.3	76.2

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

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 22 plans with no enrollment data are included in the 0-99 enrollment category.

Table 7C. Performance on Care Transitions (SNP 4) by Factor, All SNPs Reporting 2012

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	394		262		58		74	
<b>A: Managing Transitions</b>								
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	394	75.6	262	76.0	58	56.9	74	89.2
2. For planned and unplanned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, sharing the sending setting's care plan with the receiving setting within 1 business day of notification of the transition	394	51.3	262	52.3	58	31.0	74	63.5
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	394	69.8	262	65.3	58	79.3	74	78.4
<b>B: Supporting Members Through Transitions</b>								
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	394	73.9	262	67.6	58	96.6	74	78.4
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	394	69.5	262	61.1	58	96.6	74	78.4
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	394	83.8	262	78.6	58	96.6	74	91.9
<b>C. Analyzing Performance</b>								
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	389	50.1	261	54.4	55	61.8	73	26.0
2. Drawing appropriate samples from the affected population for the transitions specified in factor 1, if a sample is used	383	55.6	256	60.9	54	63.0	73	31.5
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 point in the system within a specified timeframe.	389	51.4	261	55.6	55	61.8	73	28.8
4. Drawing appropriate samples from the affected population for the transitions specified in factor 3, if a sample is used	382	55.5	255	60.8	54	63.0	73	31.5

**Table 7C. Performance on Care Transitions (SNP 4) by Factor, All SNPs Reporting 2012**  
*continued*

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
<b>D: Identifying Unplanned Transitions</b>								
1. Reports of hospital admissions within one business day of admission	394	87.1	262	85.1	58	98.3	74	85.1
2. Reports of admissions to long-term care facility within one business day of admission	394	81.0	262	75.6	58	98.3	74	86.5
<b>E: Analyzing Transitions</b>								
1. Analyzing data at least monthly, to identify individual members at risk of transition	389	64.0	261	53.6	55	92.7	73	79.5
2. Analyzing rates of all member admissions to facilities and ED visits at least annually to identify areas for improvement	389	66.3	261	65.9	55	74.5	73	61.6
<b>F: Reducing Transitions</b>								
1. Coordinating services for members at high risk of having a transition	394	76.9	262	78.6	58	55.2	74	87.8
2. Educating members or responsible parties about transitions and how to prevent unplanned transitions	394	66.2	262	75.6	58	37.9	74	55.4

### Performance on SNP 5: Institutional SNP Relationship With Facility (I-SNPs Only) Reporting (Tables 8A–C)<sup>5</sup>

SNP 5: *Institutional SNP Relationship With Facility* requires I-SNPs to perform certain care management activities for members who reside in institutional facilities and have contracts with the facilities to care for I-SNP members. Because only I-SNPs report this measure, there is no performance comparison with other SNP types. Requirements changed in 2012; thus, there is no year-to-year comparison for this measure.

I-SNPs scored very high (98 percent scored either 100 percent or 80 percent) on Element C, but had more difficulty on Element A (80.4 percent) and Element B (78.4 percent).

Although I-SNPs performed well in general, the smaller SNPs (0–99 members; 100–499 members) had the lowest scores, particularly for Elements A and B. All plans in the two largest enrollment categories met the national benchmark on each element.

At the factor level, a large majority of the I-SNPs (80.4 percent) monitor information about their members' health status at least monthly (Element A). For Element B, NCQA changed the structure of the requirements in 2012 to include "critical factors." For a plan to achieve a score of 50 percent or higher, it must meet requirements for factors 1–3. 98 percent of the plans scored "yes" on factors 2 and 3.

98 percent of the SNPs met the requirement to work with facilities to modify care as needed (Element C), based on triggering events or health status changes (factor 1).

<sup>5</sup> SNP 5 is only applicable to Institutional SNPs. D-SNPs and C-SNPs receive a score of NA. In addition, seven 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 8A. Institutional SNP Relationship With Facility (SNP 5) Performance on National Benchmarks by SNP Type, by Element 2012**

Elements	Percentage at National Benchmark* (%)
	Institutional
Number of reporting SNPs by type	58
A: Monitoring Members' Health Status	80.4
B: Monitoring Changes in Members' Health Status	78.4
C: Maintaining Members' Health Status	98.0

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

**Table 8B. Institutional SNP Relationship With Facility (SNP 5) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			17	16	6	14	5
A: Monitoring Members' Health Status	51	80.4	62.5	80.0	80.0	100.0	100.0
B: Monitoring Changes in Members' Health Status	51	78.4	62.5	73.3	80.0	100.0	100.0
C: Maintaining Members' Health Status	51	98.0	100.0	93.3	100.0	100.0	100.0

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

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 9 I-SNPs with no enrollment data are included in the 0-99 enrollment category.

**Table 8C. 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	
<b>Element A: Monitoring Members' Health Status</b>		
The organization monitors information at least monthly	51	80.4
The organization monitors information at least quarterly	51	0.0
The organization monitors information less often than quarterly	51	19.6
<b>Element B: Monitoring Changes in Members' Health Status</b>		
1. Setting parameters for the types of changes and triggering events contracted facilities must report within 48 hours, 3 calendar days and 4 to 7 calendar days	51	78.4
2. Identifying who will act on that information and should therefore be contacted	51	98.0
3. Identifying how the member's care will be coordinated with appropriate clinicians or the clinical care plan	51	98.0
4. Identifying one monitoring or data collection method it uses to assess changes in all members' health status	51	80.4
<b>Element C: Maintaining Members' Health Status</b>		
The organization works with facilities to modify care as needed	51	98.0
The organization does not work with facilities to modify care as needed	51	2.0

### **Performance on SNP 6: Coordination of Medicare and Medicaid Coverage, All SNPs Reporting (Tables 9A–C)<sup>6</sup>**

*SNP 6: Coordination of Medicare and Medicaid Coverage* contains different elements for different SNP types. This measure has more 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. NCQA added data source requirements for Elements A–C, so year-to-year comparison is not possible.

Coordinating coverage for members who are eligible for both Medicare and Medicaid is a crucial administrative function for SNPs. 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 1.3 million members enrolled in SNPs, 83 percent are in dual-eligible plans. This is slightly higher than the percentage of dual-eligible members in 2011 (81 percent). Many members of chronic and I-SNPs are also dual-eligible. For SNPs to provide the most complete care for dual eligible members, it is crucial that the financial, operational and informational components of their Medicare and Medicaid benefits are aligned.

Although all D-SNPs are required to have CMS approved MIPPA contracts with the State Medicaid agencies in the states where they operate, in many states there is limited integration of benefits, services and funding between the two programs. D-SNPs integrate their Medicare services with some Medicaid acute care services, but the long-term supports and services (paid for by Medicaid) are generally not provided by the SNPs, with the exception of the Fully Integrated Dual Eligible (FIDE) SNPs. These SNPs contract with State Medicaid Agencies to provide and coordinate Medicaid acute and long-term supports and services under a capitated arrangement. S&P measures require D-SNPs to be able to provide a basic level of coordination (financial, operational, and informational), where possible; and, when not possible, to direct members to other resources that will provide the needed information, so they can receive the benefits and services to which they are entitled.

Unlike D-SNPs, C-SNPs and I-SNPs are not required to have contracts with the states, even if they have dual-eligible members in their SNP benefit packages. For those dual-eligible members in C-SNPs or I-SNPs that do not have a formal relationship with their state Medicaid agency, they receive benefits through separate systems (i.e., Medicare and Medicaid). Because of the lack of a formal relationship with the state, these SNPs may not be able to coordinate Medicare and Medicaid coverage and thus are unable to meet some requirements of the measure. These SNPs receive a score of “NA” if they are unable to comply with requirements because of a lack of a formal, contractual relationship with the state.

*Performance by D-SNPs.* D-SNPs performed well on Element A (92.4 percent of plans met the national benchmark) and scored lower on Element B (71 percent met the national benchmark). Both scores are lower than in 2011, but as noted above, NCQA required additional data sources as evidence of implementation of policies and systems.

*Performance by C-SNPs and I-SNPs.* I-SNPs outperformed C-SNPs on Elements D and E, which they are required to report for this measure.

*Performance across SNP type.* I-SNPs outperformed C-SNPs and D-SNPs for these requirements. Both C-SNP (58.8 percent) and D-SNP (71.8 percent) scores were lower than I-SNP scores (80.4 percent).

*Network Adequacy Assessment.* D-SNPs and C-SNPs had a lower percentage of plans meet the national benchmark for Element E. SNPs tended to conduct network adequacy assessments for Medicare network providers, but often did not have such data for Medicaid. Approximately three-fourths of I-SNPs (72.5 percent) and nearly two-thirds of D-SNPs (62.8 percent) met the national benchmark. Slightly more than half of the C-SNPs met the national benchmark (52.9 percent). All three SNP types showed improvement from 2011 (C-

<sup>6</sup> SNP 6, Elements A–B are for D-SNPs only. SNP 6, Element C is for C-SNPs and I-SNPs. For SNP 6, Elements D–E, C-SNPs and I-SNPs with less than 5 percent dual eligible members as of the February 2012 CMS SNP Comprehensive Report are exempt from reporting.

providers, but often did not have such data for Medicaid. Approximately three-fourths of I-SNPs (72.5 percent) and nearly two-thirds of D-SNPs (62.8 percent) met the national benchmark. Slightly more than half of the C-SNPs met the national benchmark (52.9 percent). All three SNP types showed improvement from 2011 (C-SNPs: 50 percent vs. 46.5 percent; I-SNPs: 72.5 percent vs. 66.7 percent; D-SNPs 62.8 percent vs. 61.6 percent).

Size is not a major factor in performance on this measure, with the exception of Element E, where the larger plans' (>500) performance is higher than that of the smaller plans (<500). Overall, the two largest plan categories (1,000–2,499; ≥2,500) outperform smaller plans. For Element E, the smallest plan size category (0–99) had a 28 percentage point difference (42.5 percent vs. 70.7 percent) from the largest category (≥2,500) in the number of plans that met the national benchmark.

**Table 9A. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by SNP Type, by Element 2012**

Elements	Percentage at National Benchmark* (%)	Percentage at National Benchmark* (%) by SNP Type		
		Dual-Eligible	Institutional	Chronic
Number of reporting SNPs by type		262	58	74
A: Coordination of Benefits for Dual-Eligible Members	92.4	92.4	NA	NA
B: Administrative Coordination of D-SNPs	71.0	71.0	NA	NA
C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages	89.9	0.0	86.3	92.6
D: Service Coordination	71.9	72.9	80.4	61.8
E: Network Adequacy Assessment	62.4	62.8	72.5	52.9

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

**Note:** Shaded cells indicate that an element does not apply to the SNP type specified.

**Table 9B. Coordination of Medicare and Medicaid Coverage (SNP 6) Performance on National Benchmarks by SNP Size, by Element, 2012**

Elements	National Benchmark* All SNP Types		Percentage at National Benchmark* (%) by Enrollment Size				
	N	%	0-99	100-499	500-999	1,000-2,499	≥2,500
Number of reporting SNPs by type			49	89	52	103	101
A: Coordination of Benefits for Dual-Eligible Members	262	92.4	84.2	91.1	92.5	93.4	93.9
B: Administrative Coordination of D-SNPs	262	71.0	78.9	64.4	60.0	77.6	72.0
C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages	119	89.9	81.8	90.9	90.0	88.5	100.0
D: Service Coordination	381	71.9	73.2	66.3	72.0	73.5	74.7
E: Network Adequacy Assessment	380	62.4	42.5	57.3	64.0	65.7	70.7

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

**Note:** For privacy reasons, CMS does not publish enrollment data for plans with fewer than 11 members. 22 plans with no enrollment data are included in the 0-99 enrollment category

**Table 9C. Coordination of Medicare and Medicaid Coverage (SNP 6) by Factor, All SNPs Reporting 2012**

Factors	Overall		Dual-Eligible		Institutional		Chronic	
	N	%	N	%	N	%	N	%
Number of reporting SNPs by type	394		262		58		74	
<b>A: Coordination for Dual-Eligible Benefit Packages</b>								
1. Giving members access to staff who can advise them on using both Medicare and Medicaid	262	98.9	262	98.9	NA	NA	NA	NA
2. Giving members clear explanations of benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers	262	91.6	262	91.6	NA	NA	NA	NA
3. Giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program	262	92.0	262	92.0	NA	NA	NA	NA
<b>B: Administrative Coordination of Dual-Eligible Benefit Packages</b>								
1. Using a process to identify changes in members' Medicaid eligibility	262	75.2	262	75.2	NA	NA	NA	NA
2. Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible	260	76.9	260	76.9	NA	NA	NA	NA
<b>C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages</b>								
1. Using a process to identify any changes in members' Medicaid eligibility	119	75.6	0	0.0	51	52.9	68	92.6
2. Informing members about maintaining Medicaid eligibility	119	85.7	0	0.0	51	90.2	68	82.4
3. Giving information to members about benefits they are eligible to receive for both Medicare and Medicaid	119	90.8	0	0.0	51	82.4	68	97.1
4. Giving members access to staff who can advise them on use of both Medicare and Medicaid	119	92.4	0	0.0	51	86.3	68	97.1
<b>D: Service Coordination</b>								
1. Helping members access network providers that participate in both the Medicare and Medicaid programs or providers that accept Medicaid patients	381	69.8	262	70.6	51	80.4	68	58.8
2. Educating providers about coordinating Medicare and Medicaid benefits for which members are eligible and about members' special needs	381	84.8	262	86.6	51	86.3	68	76.5
3. Helping members obtain services funded by either program when assistance is needed	381	61.2	262	68.7	51	25.5	68	58.8
<b>E: Network Adequacy Assessment</b>								
1. Establishes quantifiable and measurable standards for the number of each type of practitioner and provider	380	83.2	261	80.1	51	94.1	68	86.8
2. Establishes quantifiable and measurable standards for the geographic distribution of each type of practitioner and provider	380	84.7	261	84.7	51	80.4	68	88.2
3. Annually analyzes performance against the standards for the number of each type of practitioner and provider	380	61.3	261	61.3	51	72.5	68	52.9
4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner and provider	380	64.2	261	65.1	51	74.5	68	52.9

**Note:** Shaded cells indicate that the factor does not apply to the SNP type specified.

## Data Collection

S&P measures assess systems that support member care management and assess whether SNPs implement desired policies and procedures. SNPs report measures using the Survey Tool component of NCQA's Web-based Interactive Survey System (ISS). 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, including SNP self-assessment of performance and supporting documentation.

Before the 2012 data collection process, NCQA collected data on each SNP benefit package, in accordance with CMS requirements, to determine eligibility for the submission. SNPs were required to be operational as of January 1, 2011, with a renewed contract for 2012. SNPs that had no members as of the April 2012 CMS SNP Comprehensive Report were not required to report for SNP 2, SNP 3 or SNP 4, Elements C and E; they could report "NA" because there were no member data to be analyzed. For the 2012 reporting cycle, CMS moved the submission deadline from February 28 to October 15.

Organizations with multiple (4 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 apply, for select S&P elements. The benefits of a primary entity-level SNP evaluation survey include consistency of findings for affiliated organizations, reduced redundancy in surveys, as well as reduced preparation time for organizations. NCQA uses a similar process to review health plans in its private, voluntary accreditation programs where there is a corporate relationship among multiple sites or affiliated products. Of the 394 SNPs that reported the S&P measures, 220 were from 20 entities that underwent a primary entity review. Thus, a small percentage of organizations have a dominant market share. In fact, 5 organizations have 141 benefit packages, which is more than one-third of the total (36 percent). During the data collection and submission process, NCQA provided technical support for result submission.

## 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 and add documentation. 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 annual update training. NCQA reviews surveyors' education level, 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 request reassessment of elements scored less than 100%. Plans were allowed to submit additional documentation and clarifications.<sup>7</sup> Reassessment occasionally resulted in a higher score for specific elements.

On April 31, 2012, NCQA provided draft SNP-specific results to CMS. NCQA also provided each SNP with its preliminary results. CMS and NCQA incorporated a new feature this year that provided SNPs with an opportunity to resolve issues they felt were not resolved. SNPs could not submit additional documents or challenge scores based on reinterpretation of submitted documentation between NCQA and the SNP. Instead, the focus was on documents the SNP felt demonstrated performance and wanted NCQA to re-review.

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<sup>7</sup>SNPs were only allowed to submit documentation that existed on or before the survey submission date.

## Data Limitations

This analysis described in the body of this report provides a basic understanding of how well SNPs performed in key quality areas. An important limitation in the fifth year of this activity is the change in the S&P measures submission date from February 28 to October 15. Although SNPs had additional time between the 2011 and 2012 submissions, they had to revise their data collection, analysis and reporting cycles to accommodate the change in submission date and required look-back periods. Many SNPs had recently set up their data collection, analysis and evaluation processes to conform to the February time frame, so when the submission date was moved to the middle of October in 2012, they could not obtain the required data and approvals within this new time frame.

In order to ensure that SNPs are not held accountable for compliance with measures before their release, S&P measures reflect performance for six months before the survey submission date. Many plans had recently created documented processes but could not bring their actual operations into compliance with their policies. Future review will have a longer look-back period, which will provide a more robust picture of SNP performance.

D-SNPs make up the largest number of benefit packages (66 percent) and total membership (83 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. Five organizations account for more than one-third (36 percent) of all SNP benefit packages eligible to report in the program in 2012.

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 and receive the same score for specific elements, their grouped results may weight an element's score heavily in one direction. This is particularly true if many benefit packages are 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.

## Future Analyses

The analysis in this report contains the fifth year of S&P measures 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. The following analyses may shed more light on these results:

- 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.
- Comparison of results on the Model of Care and S&P measures results to determine if SNPs are delivering on the promises detailed in their Model of Care and SNP application.
- 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.

## Appendix 1: Summary of S&P Measures

### S&P Evaluation

SNPs are required 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 staff, is similar to NCQA's process of health plan accreditation.

### S&P Measures & Elements

#### SNP 1: Complex Case Management

- Element A: Identifying Members for Case Management
- Element B: Access to Case Management
- Element C: Case Management Systems
- Element D: Frequency of Member Identification
- Element E: Providing Members with Information
- Element F: Case Management Process
- Element G: Individualized Care Plan
- Element H: Informing and Educating Practitioners
- Element I: Satisfaction with Case Management
- Element J: Analyzing Effectiveness/Identifying Opportunities
- Element K: Implementing Interventions and Follow-up Evaluation

#### SNP 2: Improving Member Satisfaction

- Element A: Assessment of Member Satisfaction
- Element B: Opportunities for Improvement
- Element C: Improving Satisfaction

#### SNP 3: Clinical Quality Improvements

- Element A: Clinical Improvements

#### SNP 4: Care Transitions

- Element A: Managing Transitions
- Element B: Supporting Members Through Transitions
- Element C: Analyzing Performance
- Element D: Identifying Unplanned Transitions
- Element E: Analyzing Transitions
- Element F: Reducing Transitions

#### SNP 5: Institutional SNP Relationship with Facility

- Element A: Monitoring Members' Health Status
- Element B: Monitoring Changes in Members' Health Status
- Element C: Maintaining Members' Health Status

#### SNP 6: Coordination of Medicare and Medicaid Coverage

- Element A: Coordination of Benefits for Dual-Eligible Members
- Element B: Administrative Coordination of D-SNPs
- Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages
- Element D: Service Coordination
- Element E: Network Adequacy Assessment

## Summary of Changes for 2012

### SNP 1: Complex Case Management

Element	Description
Elements A, B, D, E, G, H	<ul style="list-style-type: none"> <li>Removed “documented processes” and added “reports/materials” as required data source.</li> </ul>
Element C	<ul style="list-style-type: none"> <li>Deleted language excluding application of guidelines for members who are frail or near the end of life.</li> </ul>
Element F	<ul style="list-style-type: none"> <li><i>New element.</i> Separated Element F (Case Management Process) into two elements F and G. New Element F focuses on initial member assessment.</li> <li>Deleted factor 1 because the right to decline participation or disenroll from case management is covered in Element E.</li> </ul>
Element G	<ul style="list-style-type: none"> <li><i>New element</i> (Individualized Care Plan) focuses on developing an individualized care plan and ongoing assessment for members.</li> </ul>
Element I	<ul style="list-style-type: none"> <li><i>New element</i> measures member satisfaction with the case management program.</li> </ul>
Element J	<ul style="list-style-type: none"> <li><i>New element</i> measures the effectiveness of the case management program and identifies opportunities for improvement.</li> </ul>
Element K	<ul style="list-style-type: none"> <li><i>New element</i> focuses on implementing interventions based on the identified opportunities.</li> </ul>

### SNP 2: Member Satisfaction

Element	Description
Element C	<ul style="list-style-type: none"> <li><i>New element</i> (Implementing Interventions) focuses on implementing interventions based on opportunities for improvement identified in Element B.</li> </ul>

### SNP 3: Clinical Quality Improvement

Element	Description
Element A	<ul style="list-style-type: none"> <li>Requires SNPs to show improvement on three clinical HEDIS measure results when compared with results from the previous reporting year. NCQA assesses any 3 measures from the Effectiveness of Care domain (15 of the 17 HEDIS measures SNPs are required to report come from this domain—only the Board Certification and Plan All-Cause Readmissions measures would not be included) to determine if the SNP has year-over-year improvement.</li> </ul>

### SNP 4: Care Transitions

Element	Description
Element C	<ul style="list-style-type: none"> <li>NCQA clarified language in the explanations to make requirements more explicit.</li> </ul>

### SNP 5: Institutional SNP Relationship With Facility

Element	Description
Element A	<ul style="list-style-type: none"> <li>Changed the time frame for monitoring health status changes from quarterly to monthly.</li> </ul>
Element B	<ul style="list-style-type: none"> <li>Revised scoring to reflect the intent that SNPs must address all 4 factors to receive a score of 100%.</li> <li>Specified factors that must be met to score 50%.</li> </ul>
Elements B, C	<ul style="list-style-type: none"> <li>Added language to extend SNP 5 requirements to assisted living facilities (ALF).</li> </ul>

### SNP 6: Coordination of Medicare and Medicaid Coverage

Element	Description
Element A	<ul style="list-style-type: none"> <li>Eliminated factors 1-3 because the Medicare Improvements for Patients and Providers Act (MIPPA) already establishes these requirements.</li> </ul>
Elements A, B	<ul style="list-style-type: none"> <li>Added “reports/materials” as required data sources.</li> </ul>
Element C	<ul style="list-style-type: none"> <li>Eliminated Element C because it measures contracting status of dual-eligible SNPs (D-SNPs). Pursuant</li> </ul>

	to MIPPA and the Affordable Care Act (ACA), all D-SNPs must have a contract with a State Medicaid agency by January 1, 2013, thereby making Element C redundant.
<b>Element D</b>	<ul style="list-style-type: none"> <li>• Element D is now Element C.</li> <li>• Added “reports/materials” as required data sources.</li> <li>• Revised the language regarding billing and co-payments for dual-eligible members.</li> </ul>
<b>Element E</b>	<ul style="list-style-type: none"> <li>• Element E is now Element D.</li> </ul>
<b>Element F</b>	<ul style="list-style-type: none"> <li>• Element F is now Element E.</li> <li>• Require SNPs to quantify and establish standards for the number of each type of practitioner and provider in the network (factor 1) as well as for the geographic distribution of those practitioners and providers (factor 2).</li> <li>• Require SNPs to analyze network performance against those standards (factors 3 and 4).</li> </ul>

## 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 that had more than 2,800 participants<sup>8</sup> and covered:

- An introduction to SNP Assessment - Created specifically for SNPs and SNP personnel that were new to the SNP assessment program. New SNPs were contacted through targeted telephone and e-mail communication.
- SNP subset of HEDIS measures.
- Interactive Data Submission System (IDSS) for submission of HEDIS results.
- S&P measures.
- ISS (Interactive Survey System) for S&P measures assessment.

In addition, CMS and NCQA held three “open-door forum” conference calls and provided numerous individual and ad hoc consultations. Conference calls allowed SNPs to receive clarification from NCQA’s SNP Assessment Team before data submission.

NCQA provided three surveyor 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; and 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.

SNPs can also submit questions using NCQA’s Web-based Policy Clarification Support (PCS) system and by calling or e-mailing NCQA’s Customer Support staff.

<sup>8</sup> An individual participating in multiple sessions is counted multiple times.