Effective February 6, 2009

Special Needs Plans
Structure & Process Measures

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

SNP 1: Complex Case Management

The organization coordinates services for members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services and coordinates their care

Element A: Identifying Members for Case Management

The organization uses the following data sources to analyze the health status of members.

1. **Claim or encounter data**
2. **Hospital discharge data**
3. **Pharmacy data**
4. **Laboratory results**
5. **Data collected through the utilization management (UM) process, if applicable.**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Case management is the coordination of care and services provided to members to facilitate appropriate delivery of care and services. The organization implements case management for members.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Distinguishing features of case management

- Degree and complexity of illness or condition is typically severe
- Level of management necessary is typically intensive
- Amount of resources required for member to regain optimal health or improved functionality is typically extensive

This element requires the organization to develop criteria for proactive identification of

eligible members using available data systems. The organization may use the clinical data sources to which it has access (directly or through a vendor) to identify members; it may not have access to data if a service is carved out by a purchaser (e.g., administrative services accounts). The organization may use predictive modeling software for this function.

The organization specifies the criteria it uses to determine appropriate members for complex case management. Although NCQA does not prescribe the criteria the organization must use, the intent of this element is to give members with a variety of complex conditions the opportunity to participate in complex case management. The criteria used to determine eligibility for complex case management should not be determined by one specific condition or previous enrollment in condition-specific care management programs.

The organization uses the clinical data sources to which it has access (directly or through a vendor) to analyze members' health status. The organization receives a score of 100% if it maintains its entire member population in case management. The organization must submit documentation showing that it provides ongoing case management to its entire member population.

Exception

Factor 5 is NA if the organization does not conduct UM activities.

Examples

Data captured through UM processes

- Precertification data
- Concurrent review data
- Prior authorization data
- Hospital admission data

Element B: Access to Case Management

The organization has multiple avenues for members to be considered for case management services, including:

1. **Health information line referral**
2. **Disease management (DM) program referral**
3. **Discharge planner referral**
4. **UM referral, if applicable**
5. **Member self-referral**
6. **Practitioner referral**
7. **Other.**

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	No scoring option	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review SNP benefit package

Look-back *For Initial Surveys:* NCQA looks for evidence of completion of the required activities

period during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Members who experience a critical event or diagnosis should receive timely case management services. Multiple referral avenues can minimize the time between when a member's need is identified and when the member receives services. Case managers can help members navigate the care system and obtain necessary services in an optimal setting. For factor 3, the organization is not required to have discharge planners on staff if it works with the hospital discharge planners to ensure that appropriate referrals are made.

Member self-referral and practitioner referral allow the organization to consider members for entry to case management programs. The organization may demonstrate that it provides a means for member self-referral or practitioner referral by communicating the availability of programs and contact information (e.g., telephone numbers) to members and practitioners. The organization may communicate this information using printed materials or on its Web site. For factor 7, the organization must indicate the avenue for referral.

The organization receives a score of 100% if it maintains its entire member population in case management. The organization must submit documentation showing that it provides ongoing case management to its entire member population.

Organizations are encouraged to use existing data from institutional settings to consider institutionalized members for case management.

Exceptions

Factor 1 is NA if the organization does not have a health information line.

Factor 4 is NA if the organization does not conduct UM activities.

Examples For factor 7, other sources may include:

- Family members and caregivers
- Ancillary providers
- Behavioral health/substance abuse specialists
- Pharmacists
- Specialty programs
- Disability programs
- Community resources
- Medication therapy management (MTM) programs
- Social workers

Element C: Case Management Systems

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management**
2. **Automatic documentation of the staff member's identification and the date and time on which there was action on the case or interaction with the member**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets no

factors				factors

Data source Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

The organization facilitates case management by providing the necessary tools and information to help staff do their jobs effectively. The systems to support case management use algorithmic logic scripts or other prompts to guide care managers through assessment and ongoing management of members. The clinical aspects of the algorithms used to generate these prompts or scripts are evidence based, when available. Evidenced-based guidelines are available from various sources, including The National Guideline Clearinghouse (www.guideline.gov) and medical and behavioral health specialty societies.

Factor 1 requires the organization to provide documentation that references the specific clinical evidence used to develop the assessment and management systems. The organization may exclude from the application of guidelines members who are frail or near the end of life, given the smaller body of evidence for these populations.

Systems include automated features that provide accurate documentation for each entry; recording actions or interaction with members, practitioners or providers; and automatic date, time and user (user ID or name) stamps. To facilitate care planning and management, the system includes features to set prompts and reminders for next steps or follow-up contact.

NCQA reviews the organization's documented process and systems. The organization may provide access to the case management system or reports showing system operations.

Documentation

To demonstrate performance on this element, the organization must provide documentation that includes screen shots of the system showing the function specified.

Element D: Frequency of Member Identification

The organization systematically identifies members who qualify for case management.

Scoring

100%	80%	50%	20%	0%
The organization systematically identifies members at least monthly	The organization systematically identifies members at least quarterly	No scoring option	The organization systematically identifies members at least every 6 months	The organization systematically identifies members less frequently than every 6 months

Data source Documented process, Reports

Scope of review SNP Benefit Package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Given the dynamic nature of clinical data, an organization that uses these data with greater frequency has the greatest opportunity to identify members who may benefit most from case management programs.

The organization receives a score of 100% if it maintains its entire member population in case management. The organization must submit documentation showing that it provides ongoing case management to its entire member population.

Element E: Providing Members With Information

The organization provides eligible members with the following case management program information in writing AND in-person or by telephone:

1. **How to use the services**
2. **How members become eligible to participate**
3. **How to opt in or opt out.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Materials

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Eligible members are members who have been identified as eligible for program participation.

Organizations often provide members with written program information immediately after enrollment in the case management program or after member identification for participation in the program; they may communicate introductory information in a letter, e-mail, notification of a Web site, other written medium and through in-person/telephone contact. If the organization provides program information by telephone, NCQA reviews the written scripts or outlines used in the process.

If the organization auto-enrolls all members into a case management program, it may provide written materials about available benefits—including case management—upon enrollment to satisfy the written component of this requirement. The organization must follow-up with members in-person or by telephone to give them pertinent information about its case management program.

Opt in is the process whereby eligible members choose to receive services and participate in the program. **Opt out** is the process whereby eligible members elect not

to receive services in order to decline participation in the program. Members are assumed to be in the program unless they opt out.

The organization receives credit for factor 2 if it maintains its entire member population in case management. The organization must submit documentation showing that it provides ongoing case management to its entire member population.

Exception

Factor 3 is NA if the organization is required by states or others to provide case management to all members.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes that describe the process for notifying members and (2) materials provided to members.

Element F: Case Management Process

The organization's case management procedures address the following with members:

1. **Their right to decline participation or disenroll from case management programs and services offered by the organization**
2. **Initial assessment of their health status, including condition-specific issues**
3. **Documentation of their clinical history, including medications**
4. **Initial assessment of activities of daily living**
5. **Initial assessment of their mental health status, including cognitive functions**
6. **Initial assessment of life-planning activities**
7. **Evaluation of their cultural and linguistic needs, preferences or limitations**
8. **Evaluation of their caregiver resources**
9. **Evaluation of their available benefits**
10. **Development of a case management plan, including long-term and short-term goals that take into account the patients' or responsible party's goals and preferences**
11. **Identification of barriers to meeting their goals or complying with the plan**
12. **Development of a schedule for follow-up and communication**
13. **Development and communication of their self-management plans**
14. **A process to assess their progress against case management plans.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 14 factors	The organization meets 11-13 factors	The organization meets 6-10 factors	The organization meets 3-5 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

SNPs that completed the survey in 2008 are exempt from completing this element in 2009.

A process to assess the needs of each member requiring case management is essential for developing an effective case management plan.

Health status

During initial assessment, care managers evaluate members' health status specific to identified health conditions and likely comorbidities (e.g., heart disease, for members with diabetes).

Clinical history

Case managers document members' clinical history, including disease onset; key events such as acute phases; and inpatient stays, treatment history and current and past medications.

Activities of daily living

Case management procedures evaluate members' functional status related to five activities of daily living: eating, bathing, walking, toileting, transferring.

Mental health status

Initial assessment includes an evaluation of the member's mental health status, including psychosocial factors and cognitive functions, such as the ability to communicate, understand instructions and process information about their illness.

Life planning

Assessment addresses life planning issues such as wills, living wills or advance directives and health care powers of attorney. Although life planning activities may not be appropriate for some members in complex case management, the case manager or other member of the care team must assess whether or not life planning is appropriate with the member or caregiver.

Cultural and linguistic needs, preferences or limitations

The case management plan includes an assessment of cultural and linguistic needs, preferences or limitations.

Caregiver resources

Initial assessment evaluates caregiver resources such as family involvement in and decision making about the care plan.

Benefits

The case management plan includes an assessment of members' eligibility for health benefits and other pertinent financial information regarding benefits.

Individualized case management plan and goals

The case management plan is individualized to a member's specific needs and identifies the following.

- Short- and long-term goals
- Time frame for reevaluation
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfers
- Collaborative approaches to be used, including family participation

Barriers

Case management procedures address any issue that may be an obstacle to the member receiving or participating in the case management plan. A barrier analysis includes issues such as language or literacy, lack of or limited access to reliable transportation, a member's lack of understanding of the condition, a member's lack of motivation, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairments and psychological impairment.

Follow-up schedule

The case management plan includes a schedule for follow-up that includes, but is not limited to, counseling, disease management referrals, education and self-management support. Follow-up activities include specific dates on which the case manager will follow up with the member.

Development and communication of self-management plans
Self-management activities are those performed by members to help them manage their health.

In complex case management, development and communication of the self-management plan refers to the instructions or materials provided to members or their caregivers to help them manage their condition. These activities are designed to help members care for themselves, where appropriate. Self-management activities are components of the care plan and do not require a separate plan or specific format.

Self-management activities could include, but are not limited to, members:

- Maintaining a prescribed diet
- Charting daily readings (e.g., weight, blood sugar)
- Changing a wound dressing as directed.

Assessing progress

The case management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. The case management process includes reassessing and adjusting the care plan and its goals, as needed.

Examples

A cultural needs, preferences or limitations assessment addresses:

- Health care treatments or procedures that are religiously or spiritually discouraged or not allowed
- Family traditions related to illness, death and dying

A barrier assessment includes examining the member's:

- Understanding of the condition and treatment
- Desire to participate in the case management plan
- Belief that their participating will improve their health
- Financial or transportation limitations that may hinder participation in care
- Mental and physical capacity to participate in care.

Element G: Informing and Educating Practitioners

The organization provides practitioners with written information about the program that includes the following:

1. Instructions on how to use services

2. How the organization works with a practitioner's patients in the program.

Scoring

100%	80%	50%	20%	0%
The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets not meet either factor

Data source Materials, Documented Process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

The organization must have a documented process for providing practitioners with information that includes instructions on how to use the services. The organization may provide a timeline showing when it provides practitioners with information or notice of where information is located.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes that describe its process for notifying practitioners and (2) materials provided to practitioners.

Examples **Instructions on how to use the services for the following issues**

Monitoring

- The member's self-management of the condition
- Preventive health issues
- Relevant medical test results
- Mental health issues

Managing

- Comorbidities
- Lifestyle issues
- Medication

SNP 2: Improving Member Satisfaction

The organization assesses and improves member satisfaction.

Intent

The organization monitors member satisfaction with its services and identifies areas for improvement.

Element A: Assessment of Member Satisfaction

The organization assesses member satisfaction by:

1. **Identifying the appropriate population**
2. **Drawing appropriate samples from the affected population, if a sample is used**
3. **Collecting valid data.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Reports

Scope of review SNPs benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Complaint categories

At a minimum, the organization must aggregate samples of member complaints and appeals by reason, showing rates related to the total member population. The organization must collect and report complaints and appeals relating to at least the following major categories

- Quality of Care
- Access
- Attitude and Service
- Billing and Financial Issues

Data collection

Reasons used and data collected must be sufficiently detailed for the organization to identify areas of dissatisfaction on which it can act. If the organization uses a sample of complaints for analysis, it must accurately describe the universe and the sampling methodology. Complaint data may come from medical necessity and benefit appeals or other issues of dissatisfaction.

Data collection must involve accurately and consistently coded complaints. The organization may aggregate complaints by practitioner or practitioner group; it may also analyze complaint data by specialty areas, such as behavioral health.

NCQA evaluates the appropriateness of the population sampling methodology (if applicable), the categories of reasons used and the reports.

The data used to analyze member satisfaction should be recent and relevant to the SNP population; data collected 12 months prior to the beginning of the look-back period is not valid.

Self-reported data

The organization may use self-reported data from members, such as member

satisfaction with practitioner availability. Organizations may use existing surveys, such as CAHPS®, to meet the factors in lieu of complaints and appeals data. However, this does not include CAHPS disenrollment surveys which are insufficient to demonstrate performance against the requirements of this element. While data analysis for this element is generally required to be specific to the SNP population, CAHPS survey results may be for the Medicare population as a whole.

Exception

An organization with no members as of the start of the look-back period is exempt from completing this element.

Examples

Conducting data collection to assess member satisfaction

The organization collected all complaint data for the previous year and grouped them into the following four categories.

- Quality of Care
- Access
- Attitude and Service (customer service availability and attitude)
- Billing and Financial Issues (marketing and sales practices, benefits provided)

The following rates were the results for the past year.

Category	2008
Quality of Care	1,462/4.50
Access	1,075/3.31
Attitude/Service	946/2.91
Billing/Financial	817/2.51
Total	4,300/13.26

Complaint rates were calculated by percentage of the total for each category.

Category	2008
Quality of Care	34%
Access	25%
Attitude/Service	22%
Billing/Financial	19%

Element B: Opportunities for Improvement

The organization identifies opportunities for improvement.

Scoring

100%	80%	50%	20%	0%
The organization identifies 2 or more opportunities for improvement	No scoring option	The organization identifies 1 opportunity for improvement	No scoring option	The organization does not identify any opportunities for improvement

Data source Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

Identifying opportunities for improvement

The organization must identify as many opportunities as possible, based on the analysis documented in Element A, and prioritize them based on its analysis and their significance to members and must indicate how it chose these opportunities for improvement. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues.

Exceptions

This element is NA if the organization's analysis does not result in opportunities for improvement. NCQA evaluates whether this conclusion is reasonable, given assessment results. An organization with no members as of the start of the look-back period is exempt from completing this element.

Examples

Identifying opportunities for improvement

- Identify the need for access to Spanish-speaking and Chinese-speaking practitioners in areas where there is a large number of members who speak those languages and where the organization has received complaints
- Identify Customer Services Department staffing needs based on complaints
- Identify need for practitioner training on how to communicate with non-English-speaking patients
- Identify need for practitioner training on how to communicate with persons with cognitive impairments and their representatives

Element C: Improving Satisfaction

The organization works to improve member satisfaction by:

1. **Implementing interventions**
2. **Developing a plan for evaluation of the intervention.**

Scoring

100%	80%	50%	20%	0%
The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

Data source Reports, Documented Processes

Scope of review SNP benefit package.

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that are completing the survey for the first time in 2009 are exempt from completing this element.*

Implementing interventions

For at least one of the opportunities identified in Element B, the organization must describe its reasons for taking (or not taking) action. The organization may identify and implement opportunities other than the ones identified in Element B if it provides documentation demonstrating that the opportunity resulted from analysis of member satisfaction data in accordance with Element A. NCQA reviews improvement efforts implemented by the organization to assess their likelihood of making a positive impact. NCQA also evaluates whether or not correlation exists between interventions and specifically identified barriers to improvement, or to the causes of not meeting the requirement.

Annual assessment

The organization develops plans for follow-up assessments of member satisfaction to determine the impact of interventions. The follow-up assessments may be performed as part of annual assessments of member satisfaction, but the organization may not use member satisfaction data generated before the intervention was implemented.

Exceptions

Factor 2 is NA if the organization's analysis does not result in opportunities for improvement (Element B). NCQA evaluates whether this conclusion is reasonable, given assessment results. An organization with no members as of the start of the look-back period is exempt from completing this element.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes demonstrating the evaluation plans and (2) reports demonstrating the implementation of the intervention.

Examples

Actions

- Recruit practitioners who provide primary care services to the geographic areas where the access analysis has found that the member-to-practitioner ratio is below the standard
- Recruit Spanish-speaking and Chinese-speaking practitioners in areas where there is a large number of members who speak those languages and where the organization has received complaints

- Analyze Member Services staffing needs and increase staff, if appropriate
- Train Member Services staff in communication skills
- Recruit Spanish-speaking and Chinese-speaking Member Services staff
- Develop and implement a program to assist practitioners on how to communicate with non-English-speaking patients
- The organization decided to focus its attention on recruiting practitioners providing primary care with appropriate language skills to the service area where the language issues are the greatest, to help with access and communication issues

SNP 3: Clinical Quality Improvements

The organization demonstrates improvements in the clinical care of members.

Intent

The organization continually works to improve the quality of care for its members.

Element A: Relevance to Members

The organization selects three measures to assess performance and identify clinical improvements that are likely to have an impact on its membership.

Scoring

100%	80%	50%	20%	0%
The organization selects 3 measures that are relevant to the member-ship	The organization selects 2 measures that are relevant to the member-ship	No scoring option	The organization selects 1 measure that is relevant to the membership	The organization does not select measures that are relevant to the member-ship

Data source Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that completed the survey in 2008 are exempt from completing this element in 2009.*

The organization must demonstrate that each of the three clinical issues is relevant to its membership; service-oriented issues and measures do not meet the intent of this element. Meaningful clinical issues may involve a high volume of patients or may address conditions entailing a high degree of risk for patients. The organization should identify high-volume and high-risk aspects of care on an ongoing basis in order to set priorities for its Quality Improvement efforts.

Issues that involve only reducing utilization, such as decreasing the rate of hospitalizations, do not meet the element, but the data may be a starting point to identify quality issues. When justified by the organization's data, examples of

appropriate clinical issues could be the management of asthma in primary care or appropriate therapy after heart attack. Organizations may use HEDIS® measures to meet the element.

Exception

An organization with no members as of the start of the look-back period is exempt from completing this element.

Examples

Clinical issues may include acute conditions (e.g., myocardial infarctions, urinary tract infections, pneumonia) and chronic conditions (e.g., diabetes, hypertension, asthma, COPD, depression).

The following do not meet the intent of a clinical measure.

- the percentage of members an organization enrolls in a DM program
- process measures regarding the implementation of a clinical data system
- prevalence of a condition

Element B: Clinical Measurement Activities

Using valid methodology, the organization works to improve clinical issues by:

1. **Collecting data appropriate for the clinical issues**
2. **Analyzing the collected data**
3. **Identifying opportunities for improvement and deciding which to pursue.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation *SNPs that are completing the survey for the first time in 2009 are exempt from completing this element.*

Using valid methodology

Although the organization is not required to use specific methods, such as controlled studies, it must ensure that the methods it uses produce reliable and meaningful findings. Regardless of the methodology selected, the organization must explain all aspects of the measurement method used. NCQA evaluates how the organization identified the population to be studied, the data sources and data collection methods and the sampling techniques if sampling was used. Although most clinical QIAs begin with an identified population of members, some may use practitioners or events as the unit of measure.

The organization must note any limitations (e.g., incomplete claims data, missing treatment records or inaccurate coding) in the methodology.

NCQA evaluates any limitations in the methodology and verifies whether the organization identified the limitations in its analysis.

The data used to analyze clinical quality should be recent and relevant to the SNP population; data collected 12 months prior to the beginning of the look-back period are not valid.

Quantitative analysis

Analysis of findings must include a first-level, quantitative analysis of the data, including a comparison of results with the goal or benchmark and past performance, if a previous measurement was performed. Tests of statistical significance are not required, but may be useful when analyzing trends.

Staff members or other individuals who are specialists in data analysis often develop or help develop first-level analyses. Analyses must go beyond data display and simple reporting of results.

Qualitative data analysis

The purpose of the second phase of analysis is to identify reasons for results and potential barriers to improvement. This is especially important when results do not meet the goal or benchmark identified by the organization.

The second phase of analysis is critical to developing effective interventions. It must include staff members who understand processes of care and potential barriers to improvement. This multidisciplinary group must have the opportunity to review the data analysis thoroughly.

Before developing an action plan that addresses the organization's specific needs, these groups may need to collect further data from practitioners or members. Barriers to data collection are not considered barriers to improvement. NCQA evaluates evidence of both statistical analysis and analysis of causes associated with each measure.

Identifying opportunities

The organization establishes an explicit, quantifiable performance goal or benchmark for each measure.

A **performance goal** is the desired level of achievement that the organization sets for itself as its standard of care.

A **benchmark** is the measure of best performance external to the organization for a specific measure.

The benchmark may be taken from the industry best-practice or from the best performance within a corporate structure or specific geographical area.

As processes for delivering clinical care continue to improve, performance goals move toward optimal performance levels. The organization must designate a specific rate as a goal or benchmark, not merely state that it has a goal of improving a rate.

Exception

An organization with no members as of the start of the look-back period is exempt from completing this element.

Examples

Goals vs. benchmarks

The following illustrates the difference between a goal and a benchmark. The organization's *performance goal* for ambulatory follow-up for members hospitalized for mental illness might be 50 percent, whereas a *benchmark* is based on the best performance of organizations nationally and might be considerably higher.

Causal analysis

If the organization wants to improve its rate of ambulatory follow-up for members hospitalized for mental illness, the group analyzing this issue might determine that any or all of the following are causes of a lower than optimal rate of follow-up.

- Significant numbers of practitioners are unaware that they must schedule follow-up appointments for all hospitalized patients, or hospitalized patients are unaware of the importance of keeping their follow-up appointments
- Appointments with psychiatrists are in short supply in the organization or participating practitioners are not appropriately geographically dispersed to serve the whole member population

SNP 4: Care Transitions

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

Intent

The organization makes a special effort to coordinate care when members move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety.

Element A: Managing Transitions

The organization facilitates safe transitions by either conducting or assigning to providers the following tasks and monitoring system performance:

1. **For planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, identifying that a planned transition is going to happen**
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 one business day of notification of the transition**
3. **For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process**
4. **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**
5. **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**
6. **For planned and unplanned transitions from any setting to any other setting, notifying the patient's usual practitioner of the transition**
7. **For all transitions, conducting an analysis of the organization's aggregate performance on the above aspects of managing transitions at least annually.**

Scoring

100%	80%	50%	20%	0%
The organization meets 6-7 factors	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Reports, Documented process, Materials

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objectives of managing transitions

Older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly

coordinated. Problems include conflicting recommendations regarding chronic disease self-management, confusing medication regimens with a high potential for error and duplication, lack of follow-up care and inadequate preparation for receiving care at the next healthcare setting.

The organization must work actively to see that transitions are coordinated. A transition in care setting may be either planned or unplanned. For planned transitions, such as elective surgery or a decision to enter a long-term care facility, the organization should ensure that members have support prior to and after the transition.

Responsibility for planned transitions involves all activities in factors 1-6. For unplanned transitions, such as an emergency leading to a hospital admission from the emergency department (ED), the organization must react quickly. Responsibility for unplanned transitions involves at least factors 2 -6, including supporting and educating the member and responsible parties and helping them transition to—or remain within—the least restrictive setting of care. For factors 3-6 the organizations documented processes must specify a timeframe for completion of the activities.

Methods of managing transitions

The organization takes steps to coordinate aspects of transitions to avoid potential adverse outcomes. It may do so either by conducting the activities itself, by monitoring providers and practitioners who complete the activities or by working together with providers and practitioners.

The organization may identify the need for a member to make a transition to a new care setting by monitoring all members through risk assessment, UM and case management.

Some organizations conduct transition activities as part of case management. In this case, the organization may submit documentation for transition monitoring and oversight for members in case management. If not all members are in case management, the organization must show documentation of managing transitions for members not in case management.

Definitions

- **Transition:** Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery**.**
- **Care setting:** The provider or place from which the member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for the member's medical care. Settings include:
    1. Home (the designated practitioner in the home setting is the usual source of care or usual practitioner)
    2. Home health care
    3. Acute care
    4. Skilled nursing facility
    5. Custodial nursing facility
    6. Rehabilitation facility.

- **Care plan:** A set of information about the patient that facilitates communication, collaboration and continuity of care across settings. The organization sets parameters for the types of information that should be communicated between settings in a care plan. The care plan should be tailored to each individual and take patient health status into consideration. The care plan may contain, and is

not limited to, both medical and non-medical information (e.g. a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for all professional care providers or practitioners and informal care providers).

Both the sending and the receiving settings should have a care plan, and the receiving setting should receive the sending setting's care plan.

- **Usual setting:** The setting where the member receives care on a regular basis; this may be the member's home or a residential care facility.
- **Usual practitioner or usual source of care:** The practitioner who most frequently provides care to the member.
- **Receiving setting:** The setting responsible for the member's care after a transition. For members who transition to home, the receiving setting is the member's usual source of care.
- **Sending setting:** The setting responsible for the member's care before a transition. For members who transition from home, the sending setting is the member's usual source of care.
- **Transition process:** The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.
- **Aggregate performance:** The extent to which the organization and providers succeeded in performing functions needed to manage transitions. The organization should collect performance data for factors 1 through 6. This may be part of a quality improvement process.

Transitions covered by this element

The first three factors, which are transition tasks, apply to at least two specific types of transitions: *to* an acute care hospital and *from* an acute care hospital.

The remaining factors, which are three transition tasks and analysis of implementation of the processes, apply to all types of transitions, from any of the above settings to another setting.

In each case, communication between settings includes communication with and between practitioners responsible for the member's medical care.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials as examples of carrying out the processes.

Examples

Documented process

- Policies and procedures for supporting members' moves between care settings, including items to be completed by each care setting
- Policies and procedures for communicating with members or responsible parties.

Reports

- Formats for reports used to identify planned transitions, changes in member health status and hospitalizations ordered by providers
- Report showing aggregate analysis of transition task performance

Materials

- Job description for positions responsible for guiding members through

transitions

- Information prepared for members experiencing transitions
- Briefing materials for practitioners regarding their responsibilities during members' transitions.

Element B: Identifying Unplanned Transitions

The organization identifies transitions by reviewing the following for facilities in its network:

1. **Reports of hospital admissions within one business day of admission**
2. **Reports of admissions to long-term care facilities within one business day of admission.**

Scoring

100%	80%	50%	20%	0%
The organization meets both factors	No scoring option	The organization meets 1 factor	No scoring option	The organization does not meet either factor

Data source Reports, Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objectives

The organization establishes and documents procedures with network facilities for identifying members who experience unplanned transitions such as a sudden hospitalization. The objective is to allow either the organization or the member's usual practitioner to manage the transition (e.g. providing the treating practitioner with an accurate list of the member's medications). Based on the documented process and on established relationships with facilities, the organization can obtain reports within specified timeframes. Reporting may come to the organization through UM or another standard reporting process.

Reporting method

Reports may come to the organization either from the facilities themselves or from the organization's staff who regularly see members at hospitals and long-term care facilities.

Documentation

To demonstrate performance on this element, the organization must provide both (1) documented processes and (2) reports as examples of carrying out the processes.

Examples

Documented process

- Procedures for reporting by contracted facilities, including the organization's time frame for receiving reports
- Procedures for organization staff to report on members' transitions.

Reports

- Format or shell of daily admissions reports from hospitals
- Format or shell of daily admissions reports from long-term care facilities
- Format or shell of organization staff notification of member transitions, based on organization staff visits to facilities or organization staff contact regular contact with facility staff.

Element C: Reducing Transitions

The organization minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by:

1. **Analyzing data at least monthly, to identify individual members at risk of transition**
2. **Coordinating services for members at high risk of having a transition**
3. **Educating members or responsible parties about transitions and how to prevent unplanned transitions**
4. **Analyzing rates of all member admissions to facilities and ED visits at least annually to identify areas for improvement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Reports, Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Overall coordination

This element measures how the organization works proactively with its providers, practitioners and members to prevent avoidable transitions for individuals, and its assessment of how well it prevents avoidable transitions across its population.

Regardless of who actually performs each of the factors, the organization is responsible for seeing that it is done. Some organizations carry out these functions as part of case management, and enroll any member at risk of a transition in case management. Some organizations assign to factors 2 3 to providers and practitioners.

Identifying members at risk

To minimize avoidable and unplanned transitions, the organization monitors information on all members and identifies those who are at risk of experiencing a problem that could lead to a change in health status and a transition. The organization may use reports from its own staff and from a variety of data sources, such as data from claims, UM or provider reports. The information that the organization collects for case management (SNP 1: Complex Case Management, Elements A, B and D) meets this factor if the organization analyzes information on all members with the same frequency as it does for case management, to predict possible transitions for individual members.

The organization's procedures should identify potential problems like the following.

- Report from a case manager that a member has had a fall at home or that the family caregiver is ill
- Claims showing a change in the pattern of physician visits, or several visits in a short period of time, or new diagnoses
- Claims showing that a member is taking two drugs that have a potentially dangerous interaction or is taking drugs not recommended for the elderly
- Claims showing that a member is not receiving necessary monitoring for blood-thinning medication

The more frequently the organization receives reports or analyzes data, the better it can respond to a health issue before the issue results in an admission or change in level of care.

Coordinating care

Coordinating care to reduce transitions may be a function of the organization's case management process or it may be handled separately. Regardless of the method it uses, the organization maintains special procedures, beyond ongoing case management, for acting promptly to reduce and manage transitions. The organization works with members (or their responsible parties) and with providers and practitioners to stabilize the member's conditions and to manage care in the least restrictive setting.

Some examples of coordinating care include:

- Contacting an at-risk member or the responsible party, determining whether home health care would prevent a hospital admission and ordering the service directly
- Contacting a member's physician to alert him/her about the potential for adverse drug events based on the member's drug claims
- Intervening to help a member receive the necessary monitoring for blood-thinning medications.

Educating members

As part of identifying and coordinating care to prevent potential problems , the organization educates at-risk members or responsible parties about how to maintain health and remain in the least restrictive setting. Some organizations contaci the at-risk members or their providers and practitioners; some contact all members annually, whether or not they are at risk, with information about potential problems and how to avoid them.

Analyzing population-based data

In addition to identifying and acting on potential problems, the organization monitors its overall processes by analyzing admission rates for the entire population at least annually and determining actions to take to reduce potentially avoidable or unplanned transitions.

Analysis includes patterns of both planned and unplanned admissions, readmissions, ED visits and repeat ED visits and admissions to both participating and non-participating facilities.

Least restrictive setting

The **least restrictive setting** is the setting that best aligns with a member's preferences while being clinically appropriate to manage a condition and medical needs. The least restrictive setting allows the patient the most control while remaining safe.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports as examples of carrying out the processes.

Examples

Documented process

- Procedures for case managers to contact at-risk members to assess needs and arrange appropriate services
- Procedures for either ordering needed services or working with providers and practitioners to order them

Reports

- Format or shell of reports that identify high-risk patients using claims data or other data
- Format or shell of reports that show predictive modeling to assign members a risk score
- Reports on overall rates of admissions and ED visits, and analysis of root causes and opportunities for improvement

SNP 5: Institutional SNP Relationship With Facility

The organization has ongoing communication with facilities to monitor members' needs and the services provided to them.

Intent

The organization continuously works with its contracted nursing facilities to make sure that its members are receiving comprehensive quality care in the least restrictive setting.

Element A: Monitoring Members' Health Status

At least quarterly, the organization monitors information on all members' health status from its contracted facilities.

Scoring

100%	80%	50%	20%	0%
The organization monitors information at least quarterly	No scoring option	No scoring option	No scoring option	The organization monitors information less often than quarterly

Data source Documented process, Reports, Materials

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objectives of monitoring members' health status

An institutional SNP must be in constant communication with contracted facilities in order to effectively monitor and manage the health of its members. Frequent communication allows the plan, or the designated practitioner ordering care for a

member to be aware of the member's health status and care plan. Communication should include information that may indicate a change in health status, or no health change and should occur at least quarterly. The organization might monitor high risk members more often than quarterly.

Member information content

Member status reports may include, but are not limited to, functional status, medication regimen, self-reported health status and reports of falls, socialization and depression. If data collected for case management includes these issues, it can meet this element.

Monitoring methods

The organization may take any approach to monitoring its members, including the following examples.

1. Systematic data collection from facilities, in the form of updated health status information derived from CMS-specified Minimum Data Set (MDS) data, or from other reports specified by the organization
2. Reports from organization staff who visit members
3. Oversight of facility monitoring of members' health status and reporting to treating practitioners.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials as examples of carrying out the processes.

Exception

This element is not applicable (NA) for Chronic condition and Dual-eligible benefit packages.

Examples

Documented process

- Procedures for network facilities to provide ongoing updates on member health
- Contracts or agreements with facilities covering their responsibility for monitoring and reporting on members

Reports

- Format or shell of reports of staff visits to facilities to collect member health status information
- Format or shell of reports from facilities on members' health status

Materials

- Facility briefing materials

Element B: Monitoring Changes in Members' Health Status

The organization requires network institutions to respond to changes in members' health status by notifying the organization or the treating practitioner within 24-48 hours of the change.

Scoring

100%	80%	50%	20%	0%
The	The	No scoring	The	The

organization collects the information within 48 hours of the change in health status	organization collects the information within 49 - 72 hours of the change in health status	option	organization receives the information within 4 – 7 days of the change in health status	organization does not require notification or receives the information more than a week after the change in health status

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objectives of monitoring health status changes

To enable the organization or treating practitioners to intervene with members in a timely fashion, the organization sets parameters for:

1. The types of changes or triggering events that contracted facilities or the organization staff should report
2. Who will act on the information and therefore should be contacted (i.e. either specific organization staff or treating practitioner, whoever will act on the information)
3. The time frame for reporting. The requirement is that reports be within 24-48 hours of the event. The organization may override this requirement with either shorter or longer time frames for particular changes that require them.

For example, the organization may require that a network facility report a patient's fall to the treating practitioner within 2 hours of the fall. In another example, it may require that staff visiting a member should report to her manager in the organization the members' loss of weight within 48 hours of determining it. There may be other, more specific parameters based on the member's condition. The time requirement set for each parameter should be prompt enough to allow the facility, the treating practitioner and/or the organization, as applicable, to respond.

Monitoring methods

The organization may take any of the approaches below to monitor its members for significant changes and must include all members through at least one data collection process.

1. Reports to the organization from facilities to the organization. This can take the form of updates to the CMS-specified Minimum Data Set (MDS) data, which CMS requires after a change, or other reports or calls as specified by the organization.
2. Reports from organization staff who visit the members.
3. Oversight of facility monitoring of member health status and reporting changes in the required time to treating practitioners rather than to the organization.
4. Any combination of the processes above.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials as examples of carrying out the processes.

Exception

This element is NA for Chronic condition and Dual-eligible benefit packages.

Examples

When facility staff notes a decrease in a member's weight, they notify the organization or the treating practitioner in the time frame specified. This allows a practitioner to see the patient soon enough to determine possible causes for weight loss and to modify the plan of care accordingly.

Documented process

- Procedures for network facility to provide notification of member health based on specific triggers
- Contracts or agreements with facilities covering their responsibilities for reporting members health changes to the organization or to treating practitioners

Reports

- Format or shell of reports of member health change reports from staff visits to members
- Format or shell of member health change reports from facilities

Materials

- Facility briefing materials

Element C: Maintaining Members' Health Status

Based on its information on members' health status, the organization works with the treating facilities and practitioners to modify care and minimize further declines in health status.

Scoring

100%	80%	50%	20%	0%
The organization works with facilities to modify care as needed	No scoring option	No scoring option	No scoring option	The organization does not work with facilities to modify care as needed

Data source Documented process, Materials

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objectives of modifying care

The organization uses the information outlined in Elements A and B to identify at-risk members in facilities. It works with the facilities and with treating practitioners to respond promptly to all triggering events and changes in health status by arranging for the necessary care and adjusting members' care plans.

Methods of providing care

Organizations rely on facilities for these functions to differing degrees, and thus have different models that include, but are not limited to the following.

1. Facility oversight: The organization monitors to see that the facility and the

treating practitioner modify and carry out the member's care plan, as necessitated by the triggering event.

2. Staff practitioners: The organization's staff practitioners visit members and order modifications in care, to be provided by the facility.
3. Other: The organization may have a model that includes features of these two models but does not follow either one specifically.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) materials as examples of carrying out the processes.

Exception

This element is NA for Chronic condition and Dual-eligible benefit packages.

Examples

Documented process

- Policies and procedures for how the organization and facilities respond to triggering events and changes in health status.
- Contracts or agreements with facilities covering the facilities' responsibilities for changing care plans

Materials

- Facility briefing materials
- Job descriptions for staff who visit members in facilities.

SNP 6: Coordination of Medicare and Medicaid Coverage

The organization coordinates Medicare and Medicaid benefits and services for members.

Intent

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

Element A: Administrative Coordination for Dual-Eligible Benefit Packages

The organization coordinates Medicare and Medicaid benefits by:

1. **Giving prospective members information about benefits they are eligible to receive from both programs**
2. **Using a process to identify changes in members' Medicaid eligibility**
3. **Informing members about maintaining their Medicaid eligibility**
4. **Providing information to members about benefits they are eligible to receive from both programs**
5. **Giving members access to staff who can advise them on using both Medicare and Medicaid**
6. **Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible**
7. **Giving members clear explanations of benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers**
8. **Giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 8 factors	The organization meets 7 factors	The organization meets 6 factors	The organization meets 5 factors	The organization meets 0-4 factors

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Administrative functions

This element addresses the administrative functions involved in providing Medicare and Medicaid benefits for dual-eligible SNP members (i.e., marketing, eligibility, beneficiary information, claims processing, cost sharing, claims adjudication, grievances and appeals).

Objectives of coordinating administration

Though the desired goal for coordination is that dual-eligible members receive through their SNP a single program that combines Medicare and Medicaid benefits transparently, achieving complete integration of the two programs involves decisions beyond the organization's control. At this time, regulations of CMS and some state Medicaid agencies may put this goal beyond the organization's control; therefore, this element requires the organization to coordinate administrative functions for Medicare and Medicaid benefits and to provide dual-eligible members with comprehensive information on both sets of benefits.

Prospective members

The organization provides marketing materials specifically designed for dual-eligible members, combining information about Medicare and Medicaid benefits. The organization may provide members and prospective members with written materials or contact them in person or by telephone. If the organization contacts members by telephone, NCQA reviews the written scripts or outlines used.

Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members' specific benefit plans, including cost sharing, if any.

Medicaid eligibility

The organization receives information on changes in Medicaid eligibility, which may come from monthly reports on all Medicaid-eligible members or from another source. Changes to Medicaid eligibility involve gaining and losing Medicaid eligibility, and the organization monitors both kinds of change. The organization may help members or refer them to state personnel to maintain Medicaid eligibility. It provides assistance, as appropriate, including during the Medicaid reapplication process, for members who have lost eligibility.

Coordinated information

Descriptions of member benefits include Medicare and Medicaid benefits and cover the details of each member's specific benefit package, including cost sharing. Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members' specific benefit plans. The organization must provide contact information for someone within the organization whom the member can call, as an alternative to written documents.

Staff who can advise on Medicare and Medicaid

The organization has staff who can respond to questions about Medicare benefits and can either respond or refer members to the appropriate state personnel for Medicaid questions, including the level of cost sharing, if any. A member or responsible party can speak with a designated organization representative who knows the Medicare benefits, knows state resources for Medicaid information, knows the organization's network and can guide the member or responsible party in understanding and using benefits.

Coordinating adjudication of claims and explanation of benefits and grievance and appeal procedures

The organization adjudicates all Medicare claims and Medicaid claims for services it administers under a contract with the state Medicaid agency. For other Medicaid services, the organization helps members understand the state's adjudication of claims submitted by providers. If the organization does not have a contract to administer Medicaid-paid services, it nevertheless maintains the capability to help members understand the benefits they are entitled to, their cost sharing and their rights. Cost sharing and grievance and appeal procedures can be confusing for members, especially the frail and disabled. Where Medicare and Medicaid each pay part of the same claims, the organization makes the results from both programs easily understood for members. This includes helping members understand their appeal rights, upon request.

Exceptions

This element is NA for Chronic condition and Institutional benefit packages.

Examples

The organization may provide any one of the three kinds of data sources for each factor. The following are examples; there may be other kinds of documentation:

Documented process

- Job descriptions for staff who help members with coordination of both sets of benefits
- Procedures used to determine changes in members' Medicaid eligibility

Materials

- Sample marketing materials provided to prospective members
- Sample benefit summaries provided to members
- Instructions on where to reapply for Medicaid, which are sent to members or to responsible parties
- Job descriptions for staff who help members with eligibility, benefits and claims for both Medicare and Medicaid
- Scripts or guidelines for staff who help members with eligibility, benefits and claims for both Medicare and Medicaid

Reports

- Format or shell of reports on Medicaid eligibility used by the organization

Element B: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages

The organization maintains a documented relationship with the state Medicaid agency to foster coordinated care, by having or working toward a contract or agreement for administering any part of the Medicaid benefit package.

Scoring

100%	80%	50%	20%	0%
The organization either has or is working toward an agreement with state Medicaid agency	No scoring option	No scoring option	No scoring option	The organization does not have and is not working toward an agreement

Data source Reports, Materials, Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation The status of the organization's coordination with the state Medicaid agency may be:

- Established and operating under an agreement, which may take the form of a memorandum of agreement (MOA), a memorandum of understanding (MOU) or a contract
- In the process of development, which the organization may document with a letter or proposal sent to the state, showing an ongoing effort to establish a relationship with the state. Whatever the type of documentation, it should be dated within the previous 12 months.

This element assesses whether plans are progressing toward establishing contracts with the state Medicaid agency, as required by MIPPA beginning in 2010.

Coordination with the state should encompass administration of some part of Medicaid benefits

The interim final rule for the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) has the following requirements.

- Effective January 1, 2010, MA organizations offering new dual-eligible SNPs must have a contract with the state Medicaid agency
- MA organizations offering existing dual-eligible SNPs may continue to operate without a contract through 2010 as long as they meet other statutory requirements

Exceptions

The element is NA if the organization is in a state that does not enter into agreements with SNPs or if the state agency refuses to enter into an agreement with the organization. To document the state's refusal or inability to enter into agreements, the organization must provide a letter from the state or legislation or regulations that indicate the state currently cannot enter into agreements, or proposed legislation documenting that the state is progressing towards agreements.

This element is NA for Chronic condition and Institutional benefit packages.

Examples

The organization may provide one document from any of the three kinds of data sources, such as the following.

Documented process

- Contracts or agreements with the state Medicaid agency covering administration or benefits
- Procedures for administering Medicaid benefits, where the procedures reflect an ongoing process

Reports

- Written notification of a scheduled meeting with the state to discuss contracting within the past 12 months
- Written notice from the state acknowledging receipt of, or action on, the organization's proposal for contracting to administer Medicaid benefits within the past 12 months

Materials

- Instructional materials from the state Medicaid agency on how to administer benefits

Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages

The organization coordinates Medicare and Medicaid benefits for chronic and institutional SNP members by:

1. Using a process to identify any changes in members' Medicaid eligibility

2. Informing members about maintaining Medicaid eligibility

3. Giving information to members about benefits they are eligible to receive for both Medicare and Medicaid

4. Giving members access to staff who can advise them on use of both Medicare and Medicaid

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source

Documented process, Materials, Reports

Scope of review

SNP benefit package

Look-back period

For Initial Surveys: NCQA looks for evidence of completion of the required activities the 3three months prior to the survey date.

Explanation

Objectives of coordinating administration

There are many dual-eligible members in chronic condition and institutional SNPs. For these members, the organization coordinates benefits from Medicaid and Medicare, similar to dual-eligible SNPs.

The organization has documented processes for administrative coordination across Medicare and Medicaid benefits. Though the goal is for dual-eligible members to have

a single program that combines Medicare and Medicaid benefits transparently, achieving complete integration of the two programs depends on decisions beyond the organization's control. At this time, regulations of CMS and some state Medicaid agencies may be beyond the organization's control; therefore, this element requires the organization to coordinate administrative functions for Medicare and Medicaid benefits and to provide dual-eligible members with comprehensive information on both sets of benefits.

Methods for coordinating administration

The organization may accomplish coordination by carrying out the functions itself or by arranging for affiliated providers to carry them out. For example, the institutions may be the entities that perform all of these functions for institutionalized members, rather than the organization. Processes may reflect the fact that, for institutionalized members, Medicaid status is not likely to change and does not require frequent updating.

Medicaid eligibility

The organization receives information on changes in Medicaid eligibility, which may come from monthly reports on all Medicaid-eligible members or from another source. Changes to Medicaid eligibility involve gaining and losing Medicaid eligibility, and the organization monitors both kinds of change. The organization may help members or refer them to state personnel to maintain Medicaid eligibility. It provides assistance, as appropriate, including during the Medicaid reapplication process, for members who have lost eligibility.

Coordinated information

Descriptions of member benefits include Medicare and Medicaid benefits and cover the details of each member's specific benefit package, including cost sharing. Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members' specific benefit plans. The organization must provide contact information for someone within the organization whom the member can call, as an alternative to written documents.

Staff who can advise on Medicare and Medicaid

The organization has staff who can respond to questions about Medicare benefits and can either respond or refer members to the appropriate state personnel for Medicaid questions, including the level of cost sharing, if any. A member or responsible party can speak with a designated organization representative who knows the Medicare benefits, knows state resources for Medicaid information, knows the organization's network and can guide the member or responsible party in understanding and using benefits.

Exception

This element is NA for Dual-eligible benefit packages and Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. The organization must provide documentation demonstrating this.

Examples

The organization may provide any of the three kinds of data sources, such as the following.

Documented process

- Job descriptions for staff who assist members with coordination of both sets of benefits
- Procedures used to verify changes in members' Medicaid eligibility.

Materials

- Sample benefit summaries provided to members
- Instructions sent to members or to responsible parties that explain where to reapply for Medicaid
- Job descriptions for staff who help members with eligibility and benefits information for Medicare and Medicaid
- Scripts or guidelines for staff who help members with eligibility and benefits information for both Medicare and Medicaid.

Reports

- File layouts for reports on Medicaid-eligible members or for members losing or gaining Medicaid eligibility

Element D: Service Coordination

The organization coordinates delivery of services covered by Medicare and Medicaid through the following.

1. **Helping members access network providers that participate in both the Medicare and Medicaid programs or providers that accept Medicaid patients**
2. **Educating providers about coordinating Medicare and Medicaid benefits for which members are eligible and about members' special needs**
3. **Educating members about both kinds of benefits for which they are eligible**
4. **Helping members obtain services funded by either program when assistance is needed**
5. **Assessing adequacy of the network for providing member access at least semiannually**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objective of coordinating services

The organization facilitates coordination of services covered by Medicare and Medicaid. The goal is that services are specific to member needs and are provided seamlessly, whether they are reimbursed by Medicare or Medicaid.

Methods of coordinating services

The organization is responsible for maintaining an adequate network and for educating network practitioners and providers about their role in coordinating services. For the other functions in this element, the organization may coordinate services in different ways. It may carry out the functions itself, or it may arrange for affiliated providers to perform them. For example, with institutionalized members, the facilities may be the entities that educate members about benefits and arrange for services, rather than the organization.

For some benefit packages of all types, the organization's staff practitioners may order needed services and the affiliated providers may arrange for the services by carrying out the orders. Many SNPs assign to network practitioners the responsibility for arranging services funded under either program.

Providing access

To avoid creating financial barriers for dual-eligible members, the organization may work with providers in a variety of ways, depending on members' Medicaid benefits. Medicare benefits are fairly standard throughout the country; Medicaid benefits vary by state and by type of eligibility; and organizations' agreements with state Medicaid agencies vary. Therefore, to meet the intent of factor 1, the organization should include providers in its network and publish a directory for members, so that:

- All members have access to providers that accept Medicare for services paid only by Medicare
- Dual-eligible members have access to providers who accept Medicaid for services paid only by Medicaid
- For services that are reimbursed by both Medicare and Medicaid for dual-eligible members, such as physicians' services for which Medicaid pays the Medicare copayment, the organization requires that physicians in the network do one of the following:
  - Accept both Medicare and Medicaid payment and do not bill patients more than any co-payment required by the state, ***or***
  - If only accepting Medicare, do not balance-bill dual-eligible members for copayments paid by Medicaid
- For institutional benefit packages, the provider directory may be designed for use by the member's responsible party or by institution staff

Educating providers and members

When members need services, the organization alerts them and their providers to the full range of benefits and services for which they are eligible, including their responsibility for cost-sharing, if any, and their right to reimbursement by both programs. The organization may do this for members by providing materials or by counseling members by telephone or in person.

The organization may educate providers about members and their benefits using briefing materials, interactive Web information or personal contact. Whatever the mode of education, the organization briefs providers on any allowable copayments for SNP members and on the special need to coordinate services for dual-eligible SNP members. The organization informs providers who is responsible (the provider or the organization) for coordinating services covered by both Medicare and Medicaid.

Arranging for services

The organization may arrange services by contracting with providers, by working directly with facilities, by referring members to non-contracted providers, by assisting members in scheduling services or by directly providing the services.

Assessing adequacy of the network

Dual-eligible members of any SNP may not gain access to care when providers do not accept their Medicaid coverage. To assess whether dual-eligible members have access to care, the organization regularly monitors indicators of access, and adds providers to serve its membership across kinds of coverage, geography, cultural and linguistic needs and health needs, as needed.

Exception

This element is NA for Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. The organization must provide documentation demonstrating this.

Examples

The organization may provide any of the three kinds of data sources, such as the following.

Documented process

- Policies and procedures for arranging services for members
- For organizations that rely upon affiliated providers, policies and procedures, or sample briefing materials for institutions or other provider organizations that show the functions for which the provider organization is responsible, rather than the organization.

Materials

- The provider directory, procedures or briefing materials that show the organization's rules for providers treating members
- Sample provider manuals, recruitment material, briefing materials or fax blasts
- Sample benefit summaries

Reports

- Reports on access indicators, such as percentage of in-network and out-of-network use; rate of ED use compared to norms for the area; or member surveys of satisfaction with access

SNP Structure & Process Measures

Appendix A: Glossary

accessibility	The extent to which a patient can obtain available services when they are needed. "Services" refers to both telephone and access and ease of scheduling an appointment, if applicable.
CAHPS®	A set of standardized surveys that measure patient satisfaction with the experience of care. CAHPS is sponsored by the Agency for Health Care Research and Quality (AHRQ).
case management	The process for identifying covered persons with specific health care needs in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum member outcome.
category	A logical group of standards. Within the standards is a hierarchy of organization. The category is the highest level of the hierarchy. Within each category are standards, elements and factors.
chronic care	Management of diseases or conditions that are usually of slow progress and long continuance and require ongoing care (e.g., hypertension, asthma, diabetes).
clinical practice guidelines	Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Usually evidence based.
complex case management	Coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
continuity of care	A process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of the disease process.
criteria	Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific health care decisions, services and outcomes.
customer service	The administrative systems that enroll members, provide information on using an organization's services, respond to member concerns and help members access clinical services. Examples of customer service systems include, but are not limited to, enrollment, member information services, appointments and telephone systems.
delegation	A formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.
discharge planning	Comprehensive evaluation of a member's health needs to arrange for appropriate care following discharge from an institutional clinical care setting.
DM	Disease management. A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions.
DM program	A disease or condition-specific package of ongoing services and assistance laid out by the organization including interventions and education.

documented process	Policies and procedures, process flow charts, protocols and other mechanisms that describe the actual methodology used by the organization to complete a task.
element	The component of a Structure & Process measure that is scored and provides details about performance expectations. NCQA evaluates each element within a standard to determine the degree to which the organization has met the requirements within the standard.
factor	A scored item within an element. For example, an element may require the organization to demonstrate that a specific document includes four items. Each item is a factor.
grievance	A term commonly used to describe requests for an organization to change a decision.
HEDIS®	Health care Effectiveness Data and Information Set. A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans.
intervention	A planned and defined action taken to increase the probability that desired outcomes will occur. Interventions provide the implementation of content developed to aid patients or practitioners manage health and disease. Interventions may include phone calls, e-mails, mailings, coaching, home visits, advice, reminders, tools, use of biometric devices.
materials	Prepared materials or content that the organization provides to its members and practitioners, including written communication, Web sites, scripts, brochures, reviews and clinical guidelines.
medical management systems	Systems designed to ensure that members receive appropriate health care services. Medical management systems include, but are not limited to, UM, quality improvement, case management and complaint and resolution.
medical necessity	Determinations on decisions that are or which could be considered covered benefits, including determinations for covered medical benefits as defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or not covered, depending on the circumstances.
member	A person insured or otherwise provided coverage by a health plan.
monitor	A periodic or ongoing activity to determine opportunities for improvement or the effectiveness of interventions.
opt in	The process in which eligible patients must affirmatively choose to receive services and participate in a program. Also referred to as “active” or “voluntary” participation.
opt out	The process in which eligible patients must elect not to receive services in order to decline participation in a program. Also referred to as passive participation or the engagement method.
overutilization	Providing clinical services that are not clearly indicated or providing services in either excessive amounts or in a higher-level setting than is required.

patient identification	The process by which an organization uses specific criteria, often condition-specific, to determine eligible individuals for a specific program or set of services. Accurate patient identification is considered the starting point of an effective case management program.
patient participation rate	The percentage of eligible patients involved with a program, regardless of their level of involvement with the program. The patient participation rate varies by participation process (active vs. passive).
patient safety	An organization's capability (systems, organization, processes) for measuring and preventing medical errors and otherwise protecting its members.
PCP	Primary care practitioner. A physician or other qualified practitioner who provides primary care services and manages routine health care needs.
performance goal	A desired level of achievement of standards of care or service. Goals may be expressed as desired minimum performance levels (thresholds), industry-best performance (benchmarks) or the permitted variance from the standard. Performance goals are usually not static, but change as performance improves or as the standard of care is refined.
performance measure	A quantifiable measure to assess how well an organization carries out specific functions or processes.
policies and procedures	A documented process that describes a course of action, including the methods in which actions are carried out and staff responsible for them, employed to meet the organization's objectives and guide decision making.
practice	One physician or a group of physicians at a single geographic location who practice together. "Practicing together" means that, for all the physicians in a practice: • The single site is the location of practice for at least the majority of their clinical time • The nonphysician staff follow the same procedures and protocols • Medical records—whether paper or electronic—for all patients treated at the practice site are available to and shared by all physicians as appropriate • The same systems—electronic (computers) and paper—and procedures support clinical and administrative functions: scheduling time, treating patients, ordering services, prescribing, keeping medical records and follow-up.
practice site	An office or facility where one or more practitioners provide care or services.
practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.
preventive health services	Health care services designed for prevention and early detection of illness in asymptomatic people, generally including routine physical examinations, tests and immunizations.
primary care	The level of care that encompasses routine care of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis.

provider	An institution or organization that provides services for an organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services, but recognizes that a "provider directory" generally includes both providers and practitioners, and the inclusive definition is the more common usage of "provider."
push messaging	Messages using telephone, short message service (SMS) messages, e-mail, multimedia messaging, cell broadcast, picture messages and automated surveys with the intent of providing health care information.
QA	Quality assurance. A formal set of activities to review and safeguard the quality of care and services provided. QA includes quality assessment and implementation of corrective actions to address any deficiencies identified in the quality of care and services provided to individuals or populations.
quality assessment	Measurement and evaluation of the success of care and services offered to individuals, groups or populations.
QI	Quality improvement. Implementation of corrective actions based on the assessment of results aimed at addressing identified deficiencies and improving outcome.
quality of care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
records or files	Actual UM denial files or credentialing files that show direct evidence of action or compliance with an element.
reports	Aggregated sources of evidence of action or compliance with an element, including management reports; key indicator reports; summary reports from member reviews; system output giving information like number of member appeals; minutes; and other documentation of actions that the organization has taken.
SNP	Special Needs Plan, created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual eligibles and beneficiaries with severe or disabling chronic conditions. An SNP benefit package may be a stand-alone Medicare Advantage (MA) contract or a benefit package within a larger MA contract. SNPs submit Structure & Process measures and HEDIS measures at the benefit package level.
stratification	Using data (e.g., claims, survey or lab) to place patients into general categories of prioritization for resources or services. Organizations often conduct stratification in conjunction with an individual patient assessment. Stratification systems are dynamic processes and a patient's stratification may change according to changes in status with respect to any factor. The frequency of patient restratification may vary.
systematic identification	Use of a rules-based, consistent, population-based process to identify all members eligible as the organization defines eligibility for the program.

UM	Utilization management. The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.
underutilization	Failure to provide appropriate or indicated services, or provision of an inadequate quantity or lower level of services than required.
utilization review	A formal evaluation (prospective/pre-service, concurrent or retrospective/ post-service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.