

Special Needs Plans Structure & Process Measures



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

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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
6. Data supplied by member or caregiver, if applicable
7. Data supplied by practitioners, if applicable

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

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation **Complex case management** is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system 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 complex 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. Each factor represents a source of data files, not a referral source (i.e., a data file of member reported information, not an individual member requesting to be in case management); the latter is covered in the Element B. To meet the intent of the factors in this element, an organization's documentation must specifically reference and describe the use of at least six individual data sources to identify members for complex case management. In addition, descriptions of the use of hospital discharge data in a plan's documentation for factor 2 must be separate and distinct from the use of UM data.

The organization uses the clinical data sources to which it has access (directly or through a vendor) to analyze members' health status and 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 limiting eligibility for complex case management to one complex condition or to members already enrolled in an organization's disease management program as this does not meet the intent of this element.

Data supplied by member or caregiver

The organization uses self-reported data, such as health risk assessments, or data provided by a caregiver to identify members. Caregiver refers to a family member or other individual who provides support to the member; who is directly involved in the care of the member and who is involved in the decision making about the member's care plan (to some extent). The member usually is dependent on these individuals for help in coping with a serious health condition or disability over a long period of time.

Data from practitioners

The organization uses data provided by practitioners, such as electronic health record data, if available.

Auto enrollment into Complex Case Management

The organization receives a score of 100% if it enrolls and maintains its entire member population in the complex case management program. In addition, an organization's documentation must show that all members receive complex case management services consisting of: a comprehensive assessment of his or her condition; the determination of available benefits and resources; the development and implementation of an individualized case management plan with performance goals, monitoring and follow-up. The organization must submit documentation showing that it provides ongoing case management that includes each of the previously mentioned functions to its entire member population.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it uses the required data sources to identify members eligible for case management and may provide (2) documented processes that describe the process it uses to do so.

Exceptions

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

Factor 7 is NA if the organization does not have access to this type of data.

Examples

Data captured through UM processes

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

Reports

- Report tracking members' prescription drug usage
- Monthly report documenting hospital discharge data
- Claims and UM reports showing members identified for case management
- Lab data showing members identified for case management services

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 or caregiver 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

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation 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.

Each factor represents a referral source not a data file; the latter is covered in Element A. To meet the intent of the factors in this element, an organization's documentation must specifically reference and describe the use of at least five of seven required sources from which it accepts referrals for complex case management.

Element B does not require an organization to enroll every member referred for complex case management services; the organization must however demonstrate that it considers each referral for enrollment.

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

Health information line referral: A health information line is a dedicated telephone line members can call to obtain answers to a broad range of health-related questions that arise outside of a health care visit. A health information line can help members:

- determine whether to seek care
- determine what level of care is most appropriate for their condition
- with medication questions

- apply self-care prior to a health care visit.

For factor 1, a plan's documentation needs to indicate whether or not it: 1) has a health information line and 2) accepts referrals to complex case management from it.

Discharge planner referral

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. In addition, descriptions of the use of referrals from hospital discharge planners in an organization's documentation for factor 3 must be separate and distinct from UM staff referrals.

Member and practitioner referral

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.

Other referral sources

For factor 7, the organization must indicate the avenue for referral.

Auto enrollment into Complex Case Management

The organization receives a score of 100% if it enrolls and maintains its entire member population in the complex case management program. In addition, such an organization's documentation must show that all members receive complex case management services consisting of: a comprehensive assessment of his or her condition; the determination of available benefits and resources; the development and implementation of an individualized case management plan with performance goals, monitoring and follow-up. The organization must submit documentation showing that it provides ongoing case management that includes each of the previously mentioned functions to its entire member population.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it accepts referrals to identify members eligible for case management and may provide (2) documented processes that describe the process it uses to do so.

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

Other complex case management referral sources

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

Reports

- Health information line tracking log
- Report on disease management referrals
- Reports showing members discharge planners referred for case management
- Member self-referral reports
- Reports showing practitioner referral into case management services
- DM reports showing members recommended for case management

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 factors | No scoring option | The organization meets 2 factors | The organization meets 1 factor | The organization meets 0 factors |

Data source Documented process, Reports

Scope of review SNP benefit package - SNPs that completed the survey in 2011 are exempt from completing this element in 2012.

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation 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. Evidence-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.

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 to assess performance with this element. Factor 1 requires the organization to submit a documented process or a training manual that lists the name of specific evidence based clinical guidelines and describes their use within its case management system. Screenshots are not required for factor 1 but plans may choose to supply them.

Conversely, the organization must provide screenshots that show the automatic documentation features and automatic prompts for follow-up specified by factor 2 and 3, or access to the case management system or reports showing the required functionality in system operations. The organization does not need to submit a documented process however to meet the intent of factors 2 and 3.

Documentation

To demonstrate performance on this element, the organization must provide (1)

documented processes that describe how the systems are used for factor 1 and (2) documentation that includes screen shots of the system showing the function specified for factors 2 and 3.

Exception

This element is NA for SNPs undergoing a returning survey in 2012.

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 Reports

Scope of review SNP benefit package - *SNPs that completed the survey in 2011 are exempt from completing this element in 2012.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation NCQA reviews the organization’s reports for evidence of the systematic identification of members in case management and the frequency of member identification for case management.

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.

Auto enrollment into complex case management

The organization receives a score of 100% if it enrolls and maintains its entire member population in the complex case management program. In addition, such an organization’s documentation must show that all members receive complex case management services consisting of: a comprehensive assessment of his or her condition; the determination of available benefits and resources; the development and implementation of an individualized case management plan with performance goals, monitoring and follow-up. The organization must submit documentation showing that it provides ongoing case management that includes each of the previously mentioned functions to its entire member population.

Documentation

To demonstrate performance on this element, the organization must provide (1)

reports showing that it systematically identifies members eligible for complex case management within the specified timeframe.

Exception

This element is NA for SNPs undergoing a returning survey in 2012.

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 0 factors |

Data source Materials

Scope of review SNP benefit package - *SNPs that completed the survey in 2011 are exempt from completing this element in 2012.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation 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. To meet the intent of any of the factors an organization must submit materials showing it explicitly notified members verbally and in writing of the specified information for NCQA's review.

Factor 3 requires an organization to provide information to members on how they can participate in the 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.

Auto enrollment into complex case management

The organization receives credit for factor 2 if it enrolls and maintains its entire member population in the complex case management program. In addition, such an organization's documentation must show that all members receive complex case management services consisting of: a comprehensive assessment of his or her condition; the determination of available benefits and resources; the development and implementation of an individualized case management plan with performance goals, monitoring and follow-up. The organization must submit documentation showing that it provides ongoing case management that includes each of the previously mentioned functions to its entire member population.

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 for factors 1 and 3. The organization must also follow-up with members in-person or by telephone to give them pertinent information about its case management program to satisfy these factors.

Documentation

To demonstrate performance on this element, the organization must submit materials containing written information and detailed scripts or outlines showing it notified members in writing and in-person or by telephone of the program information required for each factor.

Exceptions

Factor 3 is NA if the organization operates in a state that requires it to provide case management to all members.

In addition, based on its care model, an Institutional SNP itself may, for example, require its members to remain in case management as a condition of their membership in the plan. In this instance, a member that wants to opt-out of case management must disenroll from the SNP. Whether it is the SNP, state or others, the organization must submit documentation demonstrating that it is required to provide case management to all members, to substantiate an NA score for factor 3.

This element is NA for SNPs undergoing a returning survey in 2012.

Examples

Materials may include:

- Scripts for the organization's staff to contact members by telephone and notify them about the case management program
- Sections of member handbooks that contain descriptions of the case management program
- Brochures the organization sends to members that detail how the case management program works and the specified information
- Welcome letters introducing the program and case manager to eligible members
- Copies of initial health assessment tools complete with prompts for the organization's staff to ask members if they agree to participate and prompts for them to share information on the program and eligibility with the member.

Element F: Case Management Assessment Process

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

1. Initial assessment of their health status, including condition-specific issues
2. Documentation of their clinical history, including medications
3. Initial assessment of activities of daily living
4. Initial assessment of their mental health status, including cognitive functions
5. Evaluation of their cultural and linguistic needs, preferences or limitations
6. Evaluation of visual and hearing needs, preferences or limitations
7. Evaluation of their caregiver resources and involvement
8. Evaluation of their available benefits

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|--------------------------------------|----------------------------------|------------------------------------|------------------------------------|------------------------------------|
| | The organization meets all 8 factors | The organization meets 7 factors | The organization meets 5-6 factors | The organization meets 3-4 factors | The organization meets 0-2 factors |

Data source Documented process, Reports

Scope of review SNP benefit package - *SNPs that completed the survey in 2011 are exempt from completing this element in 2012.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation The case management notes must clearly describe the assessment results for each factor, even if the factor is not applicable to the member. This means that the documentation must include why the factor is not applicable.

A process to assess the needs of each member requiring case management is essential for developing an effective case management plan. The organization must have written policies and procedures for the processes to manage complex cases. At a minimum it must include all of the factors listed in this element, even if all of the factors are not appropriate for an individual member.

Complex case management program content includes all information and interventions that the organization directs for a member or provider to improve health care delivery and management and promote quality, cost-effective outcomes. This information is available to other providers involved in the member's care.

Health status

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

Clinical history

The complex case management procedures document the member's clinical history, including disease onset; key events such as acute phases; and inpatient stays, treatment history and current and past medications including schedules and dosages. Treatment history refers to the therapies or procedures used to care for a member's identified health conditions and comorbidities. This may include such treatment or procedures as surgery, physical therapy and radiation treatment. Treatment history should go back at least to the onset of the condition that qualified the member for complex case management.

Activities of daily living

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

Mental health and cognitive status

During initial assessment the organization evaluates 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. An organization that only submits documentation describing its process for conducting depression screening will not meet the intent of this factor since its evidence does not also contain an assessment of the member's cognitive status.

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. These could include those covered by the organization as well as providers of benefits and services carved-out by the purchaser or supplementing those for which the organization has been contracted such as community mental health, disease management organizations, palliative care programs and other national or community resources.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and may provide reports or materials showing it carries out the processes for each factor.

Exception

This element is NA for SNPs undergoing a returning survey in 2012.

Examples

Activities of daily living

- Grooming
- Dressing
- Bathing
- Toileting
- Eating

Instrumental activities of daily living

- Laundry
- Light housekeeping
- Shopping
- Meal preparation
- Using the telephone
- Managing money
- Managing medications

Cognitive functioning assessment

- Alert/oriented able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g., on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Cultural needs and preferences

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.

Caregiver assessment

- Member is independent and does not need caregiver assistance
- Caregiver currently provides assistance
- Caregiver needs training, supportive services
- Caregiver is not likely to provide assistance
- Unclear if caregiver will provide assistance
- Assistance needed but no caregiver available

Source: Lorig, K., *Patient Education, A Practical Approach* (Thousand Oaks, CA: Sage Publications, 2001) 186-192.

Reports

- Report showing the initial assessment activities conducted for each member

Materials

- Scripts used to perform initial assessments
- Screenshot or print version of assessment tool or case management checklist

Element G: Individualized Care Plan

The organization's case management program includes the following with members:

1. **Development of a case management plan, including prioritized goals that consider the member's and caregivers' goals, preferences and desired level of involvement in the case management plan**
2. **Identification of barriers to meeting their goals or complying with the plan**
3. **Development of a schedule for follow-up and communication**
4. **Development and communication of their self-management plans**
5. **A process to assess their progress against case management plans.**

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|--------------------------------------|----------------------------------|----------------------------------|------------------------------------|----------------------------------|
| | The organization meets all 5 factors | The organization meets 4 factors | The organization meets 3 factors | The organization meets 1-2 factors | The organization meets 0 factors |

Data source Documented process, Reports, Materials

Scope of review SNP benefit package - *SNPs that completed the survey in 2011 are exempt from completing this element in 2012.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation **Individualized case management plan and goals**

The organization uses information from several sources including the complex case management assessment process to develop a comprehensive care plan for each member. Case management plans contain information on problems to be addressed in the program that may involve:

- medical, nursing or behavioral health needs (i.e., rehabilitation, pain management or depression)
- treatment support (i.e., dietary needs during specific therapies);
- areas of risk for members or worsening symptoms;
- uncontrolled chronic conditions;
- educational needs regarding a disease process and self-management activities;
- trends identified by plan data i.e., inconsistent medication refills or the lack of adherence to a medication regimen;
- functional limitations or
- missed preventive services.

Care plans include detailed descriptions of all the actions or interventions the case management team takes with members to address their medical, behavioral, functional, self-management and support needs, along with the expected duration of each one. The case management plan is personalized to a member's specific needs and identifies the following.

- Prioritized 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

The organization's prioritized goals for a member's situation or condition must be determined and documented by the case management team. Prioritized goals consider member and caregiver needs and preferences. Prioritized goals may be documented in any order as long as the order of priority is clear.

Members' preferences may include: care in accordance with advanced directives or their desires to maintain their independence and current daily activities or remain in their own home.

Evaluating member social needs and personal preferences can drive activities, supports and case management service. Understanding these areas can be useful when creating individualized and person centered case management plans. Social and practical needs can include transportation, shelter and food. Personal preferences can include values and areas of interest such as religious affiliations.

Referrals to resources

Depending on their conditions and results of the case management assessment, members may benefit from referral to available resources as part of benefits. The organization's case managers facilitate member referral to other healthcare organizations, when appropriate.

Barriers

Complex 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. The health plan must document that issues of barriers were assessed, even if no barriers were identified.

Follow-up schedule

The case management plan includes a schedule for follow-up that encompasses, but is not limited to, counseling, disease management referrals, education and self-management support.

The organization's documented processes specify when and how a case manager will follow up with a member after facilitating a referral to a health resource (e.g., a phone call to the participant confirming that the participant contacted the health resource organization). The organization's processes may specify that follow-up is not applicable in all situations.

Development and communication of self-management plans

Self-management activities are those performed by members to help them manage their health.

Self-management plans are activities undertaken by members to help them manage their condition, and are based on instructions or materials provided to them or to their

caregivers. 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.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials containing examples of redacted care plans that show it carries out the processes for each factor.

Exception

This element is NA for SNPs undergoing a returning survey in 2012.

Examples

Barrier assessment

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.

Self-management activities

Self management could include ensuring the member can perform the following:

- Activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)
- Instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances)
- Medication administration (e.g., oral, inhaled or injectable)
- Medical procedures/ treatments (e.g., changing wound dressing)
- Management of equipment (including oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)

Reports

- Report tracking their progress against case management plans

Materials

- Redacted self-management plans

Element H: Informing and Educating Practitioners

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

1. Instructions on the complex case management services and how to use these services
2. How the organization works with a practitioner’s patients in the complex case management 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 does not meet either factor |

Data source Materials

Scope of review SNP benefit package - SNPs that completed the survey in 2011 are exempt from completing this element in 2012.

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation The organization must provide practitioners with information that includes instructions on how to use the complex case management services and how case managers work with the practitioner’s patients enrolled in program. The organization may provide examples of how it educates practitioners about information specified by factors 1 and 2 which may include a timeline showing when it provides practitioners with information or notice of where information is located. In addition, its materials may include information contained in the provider manual or on a provider Web portal.

Documentation

To demonstrate performance on this element, the organization must provide (1) materials it distributes to practitioners for each factor.

Exception

This element is NA for SNPs undergoing a returning survey in 2012.

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

Materials

- Practitioner newsletter with articles describing the case management program, how case managers work with the practitioner’s patients and how to use the services
- Informational document organization provides to practitioner to encourage eligible members to participate in case management
- Letter to practitioner on case management services or updates and how it would benefit members

Element I: Satisfaction With Case Management

At least annually, the organization evaluates satisfaction with its complex case management program by:

1. Obtaining feedback from members
2. Analyzing member complaints and inquiries.

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

Data source Reports

Scope of review SNP benefit package - *SNPs that are completing the survey for the first time in 2012 are exempt from completing this element.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation This element applies to all programs that were presented in Elements A and B.

Member feedback can include information about the overall program, program staff, the usefulness of the information disseminated by the organization and members’ ability to adhere to recommendations. The organization obtains feedback from members by conducting focus groups or satisfaction surveys, and systematically analyzes the feedback it collects at least annually. The intent is that the organization receives feedback from a broad sample of members, not only those who contact the organization to share feedback. Satisfaction surveys may be conducted across multiple benefit packages; however, the results must be stratified at the benefit package level for analysis and determination of actions.

Feedback must be specific to the complex case management programs being evaluated. CAHPS and other general survey questions do not meet the intent of this element.

The organization analyzes complaints and inquiries to identify opportunities to improve satisfaction with its complex case management program. Analysis considers quantitative and qualitative data to identify patterns of member comments.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it evaluates member satisfaction with the complex case management program and may provide (2) documented processes that describe the process it uses to do so.

Exceptions

An organization with no members as of the start of the look-back period is exempt from completing this element. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

This element is NA for SNPs undergoing an initial survey in 2012.

Examples None.

Element J: Analyzing Effectiveness/Identifying Opportunities

The organization annually measures the effectiveness of its complex case management program using three measures. For each measure, the organization:

1. Identifies a relevant process or outcome
2. Uses valid methods that provide quantitative results
3. Sets a performance goal
4. Clearly identifies measure specifications
5. Analyzes results
6. Identifies opportunities for improvement, if applicable

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

Data source Reports

Scope of review SNP benefit package - *SNPs that are completing the survey for the first time in 2012 are exempt from completing this element.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation This element applies to all programs that were presented in Elements A and B.

NCQA scores this element for each of the three measures, with the final element score determined by averaging the scores for the measures.

Relevant process or outcome

The organization selects measures or processes that have significant and demonstrable bearing on the entire complex case management population or a defined portion or subset of the complex case management population, so appropriate interventions would result in significant improvement for the population. Measures must be relevant to the target population, although the target population or condition does not need to be of a significant size or percentage of the total complex case management population.

Because inclusion criteria for complex case management programs vary from program to program, participation rates cannot be consistently measured and are not measures of effectiveness.

If measuring health status using the SF-12[®] or SF-36[®], and given that these tools are designed to facilitate the assessment of health status on physical and mental dimensions of care, organizations may use the results for two measures of effectiveness--one each for physical and mental health functioning.

Valid methods and quantitative results

Measurement of case management effectiveness includes the use of quantitative information derived from valid methodology. NCQA considers the following criteria when evaluating a measure's validity:

- Numerator and denominator
- Sampling methodology
- Sample size calculation
- Measurement periods and seasonality effects

Performance goal

The organization establishes an explicit, quantifiable performance goal for each measure. A performance goal is the desired level of achievement that the organization sets for itself. The organization may base its goal on external benchmarks, which are known levels of best performance.

Analysis

Analysis of findings includes a comparison of results against goals and an analysis of the causes of any deficiencies (if appropriate). Analysis must go beyond data display or simple reporting of results.

Identifying opportunities for improvement

The organization uses qualitative and quantitative analysis to prioritize opportunities to improve. The opportunities may be different each time the organization measures and analyzes the data.

Comparability

The intent of this element is to establish a basis for sound outcomes measurement while acknowledging that different programs have widely varying population bases, enrollment methods and data access.

The organization may use three patient experience measures to meet this element; however, the three measures may not all be satisfaction with the case management program operations, such as satisfaction with the frequency of contact or satisfaction with the case manager. Examples of other measures of patient experience include improved quality of life, pain management and health status.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it evaluates the effectiveness of the complex case management program and may provide (2) documented processes that describe the process it uses to do so.

Exceptions

Factor 6 is NA if no opportunities for improvement are identified by the organization, based on its analysis of results. The organization continues to remeasure to determine performance.

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

completing this element. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

This element is NA for SNPs undergoing an initial survey in 2012.

Examples

- Measures of effectiveness for chronic conditions based on HEDIS, with specifications adapted to draw a denominator from the case management population only (e.g., controlling high blood pressure, persistence of beta blocker treatment after heart attack).
- Measures for care of chronic conditions based on National Quality Forum (NQF) measures, with specifications adapted to draw a denominator from the complex case management population at the plan level (e.g., angiotensin converting enzyme [ACE] inhibitor use in people with heart failure).
- Health status (e.g., SF-36[®] or SF-12[®] results).
- Satisfaction with complex case management services.
- Use of service measures for specific populations for which there is consensus that an increase or decrease represents improvement (e.g., inpatient days/1,000; emergency department visits, admissions/1,000; medication compliance; total cost per member per month [PMPM]).
- Readmission rates.
- Measures of ambulatory-care-sensitive admission, which are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or severe disease.

Element K: Implementing Interventions and Follow-Up Evaluation

Based on the results of its measurement and analysis of complex case management effectiveness, the organization:

1. Implemented at least one intervention for all three opportunities identified in Element J to improve performance
2. Develops a plan for evaluation of the intervention and remeasurement.

| 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

Scope of review SNP benefit package - SNPs that are completing the survey for the first time in 2012 are exempt from completing this element.

Look-back period

NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation

The organization implements at least one intervention that addresses three opportunities identified in SNP 1 Element J.

NCQA scores this element for each of the three measures, with the final element score determined by averaging the scores for the measures.

It develops plan for a follow-up evaluation to determine the effectiveness of the interventions and remeasurement, using methods consistent with initial measurements.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it implements interventions to improve the effectiveness of the complex case management program and has a plan to evaluate the impact of these interventions. The organization may also provide (2) documented processes that describe the process it uses to do so.

Exceptions

Factors 1 and 2 are NA if no opportunities for improvement are identified; but the organization must develop and implement a remeasurement plan to receive credit for the remeasurement component of factor 2.

An organization with no members as of the start of the look-back period is exempt from completing this element. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

This element is NA for SNPs undergoing an initial survey in 2012.

Examples

None.

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 and collecting member satisfaction data for all the SNP's operations
2. Drawing appropriate samples from the affected population, if a sample is used
3. Conducting an annual quantitative and qualitative analysis of member satisfaction 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 0 factors |

Data source Documented process, Reports

Scope of review SNP benefit package - *SNPs that completed the survey in 2011 are exempt from completing this element in 2012.*

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation This element requires an organization to assess member satisfaction across its entire operations. *As a result, a SNP that submits an analysis of member satisfaction data that is limited to a specific program it provides to members like case management, will not meet the intent of the element.*

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

SNP 2: Improving Member Satisfaction

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. In addition, NCQA scores factor 2 “yes” (not NA) for an organization that analyzes satisfaction data for its entire population and does not use a sample.

The data used to analyze member satisfaction should be recent and relevant to the SNP population; data collected more than 12 months prior to the beginning of the look-back period cannot be used to demonstrate performance against this element.

Self-reported data

The organization may use self-reported data from members, such as member satisfaction with practitioner availability. Organizations may use an analysis of existing surveys, such as CAHPS[®], to meet the factors in lieu of complaints and appeals data. 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.

Analysis

Whether the organization uses complaint and appeal data, CAHPS results or another member satisfaction survey, its documentation must include evidence of an analysis of report findings. Element A requires an organization’s documentation to show: 1) data collected; 2) sampling methodology (if any); 3) a quantitative analysis and a qualitative analysis. These analyses must go beyond data display or simple reporting of results by CAHPS vendors or others.

An organization’s analysis for this element must be specific to the SNP benefit package; an organization that has multiple SNPs can present an aggregated analysis of performance across all of its plan benefit packages, as long as the organization breaks out the data and results for each individual plan benefit package in the report.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports showing it carries out the processes for each factor.

Exceptions

An organization with no members as of the start of the look-back period is exempt from completing this element. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

This element is NA for SNPs undergoing a returning survey in 2012.

Examples

Appeal Types

- Quality of Care
 - Appeals for denials and underutilized services
- Access
 - Appeals for denials of out-of network practitioners caused by access issues such as lack of Spanish speaking doctors or appointment availability
- Attitude and Service
 - Appeals for denials when the primary care practitioner will not refer a patient to a specialist
- Billing/Financial
 - Appeals for denials of out-of-network services where members are balanced billed

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 | 2012 |
|-------------------|--------------------|
| 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 | 2012 |
|-------------------|------|
| 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 Documented Process, Reports

Scope of review SNP benefit package - SNPs that completed the survey in 2011 are exempt from completing this element in 2012.

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation Identifying opportunities for improvement

The organization must identify as many opportunities as possible, based on the analysis documented in Element A, 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.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports showing it carries out the processes for each factor.

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. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

This element is NA for SNPs undergoing a returning survey in 2012.

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 members
- Identify need for practitioner training on how to communicate with members with cognitive impairments and their representatives.

Element C: Improving Satisfaction

The organization works to improve member satisfaction by:

1. Implementing interventions
2. Measuring the effectiveness of the interventions.

| | | | | | |
|----------------|-------------------------------------|-------------------|---------------------------------|-------------------|--|
| 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 NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation **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.

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.

Measuring effectiveness

The methodology used to evaluate the effectiveness of interventions must assess whether the interventions had the desired effect. NCQA makes the following determinations.

- Whether the measurement of effectiveness is commensurate with the interventions
- Whether enough time has elapsed since the organization implemented interventions to evaluate their effectiveness

SNP 2: Improving Member Satisfaction

The organization's evaluation must be in measurable terms and may include remeasurement against the original goal or a targeted, intermediate measurement of specific interventions. Element C does not require the organization to demonstrate improvements have occurred.

Submitting a QIP to address a CAP pertaining to complaints and appeals

An organization that received a request for a CAP for an issue pertaining to member satisfaction with its operations for which it initiated a QIP to address these issues after October 15, 2011, may submit it to demonstrate performance with factors 1 and 2 of this element. The QIP must show that the organization performed an analysis of complaint and appeal data and identified at least 2 or more opportunities for improvement which it prioritized, implemented actions and evaluated the effectiveness of the actions at least annually. In other words, this QIP must show that it meets the intent of the requirements in Elements A, B and C of this measure.

Documentation

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

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. The organization must provide information on its enrollment and NCQA will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

Examples

Actions for factor 1

- 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 members
- 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 improvement in the clinical care of members.

Intent

The organization measures quality of clinical care and demonstrates improvements that positively affect the clinical quality of care that members receive.

Element A: Clinical Improvements

The organization demonstrates three clinical improvements, each of which is statistically significant improvement in one audited HEDIS clinical measure

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|---|---|-------------------|--|--|
| | The organization demonstrates 3 clinical improvements | The organization demonstrates 2 clinical improvements | No scoring option | The organization demonstrates 1 clinical improvement | the organization demonstrates no clinical improvements |

Data source Reports

Scope of review SNP benefit package - *SNPs that are completing the survey for the first time in 2012 are exempt from completing this element.*

Look-back period NCQA evaluates from the baseline period up to the current year

Explanation **Evaluation process**

NCQA examines the organization's reported HEDIS measures to determine if there are at least three significant improvements for any of the measures in the effectiveness of care domain. To determine significant improvement, NCQA compares the baseline measurement to the most recent measurement using the statistically based process described in *Significant improvements in HEDIS measures*, below.

NCQA uses the previous year's HEDIS submission for rate comparisons. NCQA uses the same baseline to assess results for the previous year and current year. For example, if the organization's survey submission date is October 15, 2012 the current submission is HEDIS 2012 and the baseline is HEDIS 2011. The organization will be initially scored against the HEDIS 2011 data. If the previous year's data is not available, NCQA will use the current year data as the baseline and the plan will receive a not applicable score.

Significant improvements in HEDIS measures

Significant improvements are those that achieve precalculated-effect sizes. The precalculated effect sizes shown below are statistically based, consistent with HEDIS specifications.

Calculating the baseline rate

Using HEDIS data submissions, NCQA compares the organization's current HEDIS rates to the rates reported in the SNP's previous year HEDIS submission (baseline),

SNP 3: Clinical Quality Improvements

provided that the same methodology has been used (hybrid or administrative method).

If the organization changes methodology for collecting HEDIS data from one year to the next, NCQA uses a decision table to calculate the appropriate methodology combinations and applicable baseline determinations.

NCQA considers results significant and counts them as an improvement using the following effect sizes. Effect sizes are based on a z-test for differences in rates, an alpha value of 0.05 and a one-sided test of improvement. Effect sizes may be increases or decreases in rates.

| Baseline Rate* | Minimum Effect Size |
|-----------------------|--------------------------------------|
| 0-59: | At least a 6 percentage point change |
| 60-74: | At least a 5 percentage point change |
| 75-84: | At least a 4 percentage point change |
| 85-92: | At least a 3 percentage point change |
| 93-96: | At least a 2 percentage point change |
| 97-99: | At least a 1 percentage point change |

* NCQA uses actual rates for this calculation, not rates with five points added for sampling variation as in HEDIS scoring for accreditation purposes.

If three measures demonstrate a significant increase, the organization receives a 100% score for this element. NCQA informs the organization of the number of improvements it achieves through HEDIS measures.

The organization demonstrates improvements in the clinical care of members.

The organization measures quality of clinical care and demonstrates improvements that positively affect the clinical quality of care that members receive.

Exceptions

This element is NA for SNPs undergoing an initial survey in 2012.

SNPs that do not have 30 members as of the CMS February 2011 SNP Comprehensive Report are exempt from reporting this measure and receive a score of not applicable.

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, notifying the patient's usual practitioner of the transition within a specified timeframe.

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|----------------------------------|----------------------------------|-------------------|---------------------------------|---|
| | The organization meets 3 factors | The organization meets 2 factors | No scoring option | The organization meets 1 factor | The organization does not meet any factor |

Data source Reports, Documented process, Materials

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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.

Unplanned transitions

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 and 3. For factor 3, the organization's documented processes must specify a timeframe for completion of the activities.

The organization actively manages the transition of a member from notification of admission throughout the transition process. An organization's documentation must specifically describe its procedures for managing members who have experienced an unplanned transition.

Planned transitions

Responsibility for planned transitions involves all activities in factors 1-3.

Factor 1 assesses an organization's ability to identify that a planned transition such as a scheduled procedure is going to happen, before it takes place. As a result, the following do not meet the intent of factor 1:

- A daily census showing admissions that have already occurred
- Reports for admissions that have already occurred denoting number of days authorized

In addition, an organization that submits a preauthorization policy for factor 1 that only focuses on payment or coverage and is designed to approve the requested service, will not meet the intent of this factor. For example, a preauthorization policy that describes the preauthorization process practitioners must follow and includes the list of procedures for which preauthorization is required, but does not trigger additional notification to the clinical care team, would not meet the intent of this factor. Alternatively, a preauthorization policy that details how the SNP uses preauthorization data to identify an impending transfer for a member and details the procedures it subsequently takes to provide transition support, could serve as a part of the documentation for factor 1.

For planned transitions, such as elective surgery or a decision to enter a long-term care facility, the organization must ensure that members have support prior to, during and after the transition.

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.

- **Planned Transitions** include elective surgery or a decision to enter a long-term care facility
- **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 when members experience transitions. 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. A hospitalist or an attending physician that only sees members in an acute care facility would not serve as the member's usual source of care.
- **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.

Transitions covered by this element

Factors 1 and 2, which are transition tasks, apply to at least two specific types of transitions: *to* an acute care hospital and *from* an acute care hospital.

Factor 3 applies to all types of transitions covered in this element, from any of the above care settings to another care setting.

In each case, communication between settings includes communication with and between practitioners responsible for the member's medical care. For planned transitions to the hospital, factor 2 requires the organization to have procedures for identifying the appropriate practitioner to receive the member's care plan (i.e., treating practitioner) and have evidence that it has shared the care plan with this practitioner within the specified timeframe.

A SNP must provide sufficient evidence to show it meets the intent of the activities specified in factors 1 through 3; a policy and a note from the organization's case management system for a discharge do not show that the SNP routinely performs the activities for each type of transition or that it performs the activities across the various care settings specified in each factor. SNPs must demonstrate that they perform the required functions across a variety of care settings, as noted in factors 1-3, on a consistent basis. At a minimum this includes:

1. A documented process and reports (such as case notes) or materials that address a planned transition to the hospital and a planned transition from the hospital to another care setting for factor 1
2. A documented process and reports or materials that address a planned and an unplanned transition to the hospital and a planned transition from the hospital to another care setting for factor 2
3. A documented process and reports or materials that address a planned and an unplanned transition to the hospital and a planned transition to another care setting for factor 3.

NCQA no longer accepts job descriptions as evidence of performance with the requirements of this element.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials showing it carries out the processes for each factor.

Examples

Planned or unplanned transition

An instance where a member experiences a change in condition and the caregiver calls his or her PCP and receives the instructions to take the member to the hospital immediately would be classified as an unplanned transition.

Documented process

- Policies and procedures for supporting members' moves between care settings, including items to be completed by each care setting

Reports

- Redacted reports used to identify planned transitions, changes in member health status and hospitalizations ordered by providers
- Reports used to identify unplanned transitions, changes in member health status

Materials

- Redacted care plans sent from sending setting to receiving setting
- Letters to usual source of care notifying them of a member's transition

Element B: Supporting Members Through Transitions

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

1. For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process within a specified timeframe
2. For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about changes to the member’s health status and plan of care within a specified timeframe
3. For planned and unplanned transitions from any setting to any other setting, providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system within a specified timeframe

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|----------------------------------|----------------------------------|-------------------|---------------------------------|--|
| | The organization meets 3 factors | The organization meets 2 factors | No scoring option | The organization meets 1 factor | The organization does not meet any factors |

Data source Reports, Documented process, Materials

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation Objectives of managing transitions

The organization must work actively to see that transitions are coordinated. A transition in care setting may be either planned or unplanned.

Planned transitions

For planned transitions, such as elective surgery or a decision to enter a long-term care facility, the organization must ensure that members have support prior to, during and after the transition. As a result, for planned transitions, factors 1 and 2 require communications with the member or responsible to occur before, during and after the transition and these communications may continue beyond discharge. Post-transition follow-up alone does not meet the intent of factors 1 and 2.

Responsibility for planned transitions involves all activities in factors 1-3.

Unplanned transitions

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 1-3; 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 1-3, the organization's documented processes must specify a timeframe for completion of the activities.

The organization actively manages the transition of a member from notification of admission throughout the transition process. An organization's documentation must specifically describe its procedures for managing members who have experienced an unplanned transition.

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.

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.

Supporting members through transitions

In addition to describing the process and showing implementation of it, factor 3 requires an organization's documentation to show when it notifies members of the person who is responsible for supporting them through transitions between any two care settings.

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.
 - **Planned Transitions** include elective surgery or a decision to enter a long-term care facility
- **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 when members experience transitions. 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).

- **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.

Transitions covered by this element

All factors apply to all types of transitions covered in this element, from any of the above care settings to another care setting. A SNP must provide sufficient evidence to show it meets the intent of the activities specified in factors 1 through 3; a policy and a note from the organization’s case management system for a discharge do not show that the SNP routinely performs the activities for each type of transition or that it performs the activities across the various care settings specified in each factor. SNPs must demonstrate that they perform the required functions across a variety of care settings, as noted in factors 1-3, on a consistent basis. At a minimum this includes:

- A documented process and reports or materials that address a planned and an unplanned transition to the hospital and a planned transition to another care setting for factors 1, 2 and 3.

NCQA no longer accepts job descriptions as evidence of performance with the requirements of this element.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials showing it carries out the processes for each factor.

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

- Redacted reports used to identify planned transitions, changes in member health status and hospitalizations ordered by providers
- Reports used to identify unplanned transitions, changes in member health status

Materials

- Information prepared for members experiencing transitions
- Checklists or scripts used when communicating with the member about transitions

Element C: Analyzing Performance

The organization analyzes its performance on managing care transitions:

1. For all transitions, conducting an analysis annually of its aggregate performance: identifying that a planned transition is going to occur; sharing the sending setting’s care plan with the receiving setting within one business day of notification of planned and unplanned transitions; and notifying the member’s usual practitioner of planned and unplanned transitions within a specified timeframe.
2. Drawing appropriate samples from the affected population for the transitions specified in factor 1, if a sample is used
3. For all transitions, conducting an analysis annually of its aggregate performance: communicating with the member or responsible party about the care transition process within a specified timeframe; communicating with the member or responsible party about changes to the member’s health status and plan of care within a specified timeframe; and providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system within a specified timeframe.
4. Drawing appropriate samples from the affected population for the transitions specified in factor 3, if a sample is used

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|--------------------------------------|----------------------------------|---------------------------------|---------------------------------|----------------------------------|
| | The organization meets all 4 factors | The organization meets 3 factors | The organization meets 2 factor | The organization meets 1 factor | The organization meets 0 factors |

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation **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.
 - **Planned Transitions** include elective surgery or a decision to enter a long-term care facility
- **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 when members experience transitions. 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 must annually collect performance data for Elements A and B, Factors 1 through 3 and the measures it uses for these factors must allow direct assessments of performance. This may be part of a quality improvement process.

Transitions covered by this element

Factors 1 and 3, apply to the types of transitions covered in Elements A and B, as indicated.

An organization's analysis for factors 1 and 3 must be specific to the SNP benefit package; an organization that has multiple SNPs can present an aggregated analysis of performance across all of its plan benefit packages, as long as the organization breaks out the data and results for each individual plan benefit package in the report.

These analyses, whether the organization performs one separately for factor 1 and another for factor 3 or combined for both factors, must at a minimum, cover the activities specified in factors 1 through 3 of Element A and factors 1 through 3 of Element B respectively.

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

Data collection

Factors 1 and 3 require a plan to conduct an analysis of aggregate performance. The term “aggregate” refers to all SNP members that experienced transitions over a period of time. The term “sample” in factors 2 and 4 refers to the data an organization chooses to pull from the entire universe of transitions to assess its performance. An organization can use its entire universe of transitions or it may choose to select a sample from the universe. Factors 2 and 4 require an organization that uses a sample to accurately describe the universe and the sampling methodology in its documentation. NCQA evaluates the appropriateness of the sampling methodology, if applicable.

If an organization uses a sample of its aggregate transitions, it must draw a minimum of three months’ worth of data (one quarter) between March 2011 and the submission date of October 15, 2012. Plans that use their entire universe of transitions for a year or the period from March 2011—June 2012, and accurately document this in their analysis, will receive credit for factors 2 and 4.

Analysis

A SNP’s documentation for factors 1 and 3 must show; 1) data collected; 2) a quantitative and qualitative analysis and 3) the identification of opportunities for improvement.

The following do not meet the intent of factors 1 and 3:

- An analysis of HEDIS/CAHPS survey results

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports showing it carries out the processes for each factor.

Exception

Element C is not applicable for a SNP that does not have any members as of the April 2012 CMS SNP Comprehensive Report.

Examples

Reports

- Report showing aggregate analysis of transition task performance

Documented Processes

- policies for data collection and analysis
- procedures on methodology

Element D: 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 NCQA looks for evidence of completion of the required activities during the 6 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. 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.

Long-term care facilities

NCQA's definition for long-term care facilities aligns with CMS' definition of nursing facilities; it includes facilities that primarily provide skilled nursing care to residents and relates to services for the rehabilitation of injured, disabled, or sick members. These facilities cover health care and related services for more than 90 days and the services are above the level of custodial care. It does not include facilities that provide custodial care or nonskilled, personal care such as help with activities of daily living and care most individuals perform themselves.

Reporting method

Reports must be specific to the plan benefit package and contain admission and notification dates. They 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. At a minimum, an organization's documentation must include:

- a documented process and reports showing notification of three unplanned admissions to hospitals within the specified timeframe
- a documented process and reports showing notification of three unplanned admissions to long-term care facilities within the specified timeframe

Unplanned admissions within an organization's reports may not be dated before October 15, 2011.

Documentation

To demonstrate performance on this element, the organization must provide both (1) documented processes and (2) reports showing it carries out the processes for each factor.

Exception

NCQA scores SNPs that do not have any members at the start of the look-back period based on their policies. The organization must provide information on its enrollment and NCQA will verify this information using enrollment data from the April 2012 CMS Comprehensive Report.

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

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

Element E: Analyzing 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. Analyzing rates of all member admissions to hospitals and ED visits at least annually to identify areas for improvement.

| 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 0 factors |

Data source Reports, Documented process

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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.

Identifying members at risk

To minimize avoidable and unplanned transitions, for factor 1, 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 the organization uses to identify members at risk of a transition may overlap with the information that the organization collects for case management (SNP 1: Complex Case Management, Elements A, B and D). The information collected for case management meets factor 1 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.

Analyzing patient-based data

Factor 1 requires an organization's documentation to show; 1) data collected; 2) members targeted; and 3) the identification of areas in which it can act to minimize the risk of unplanned transitions and keep members in the least restrictive setting, (i.e., once at-risk members are identified, what actions or interventions does the SNP take to help prevent or mitigate unplanned transitions and keep members in the least restrictive setting). Enrolling members in case management after two unplanned admissions to the Emergency Department, or enrolling a member in a Medication Therapy Management (MTM) program if their medication regimen puts them at risk for falls or other adverse reactions are examples of appropriate documentation for this factor.

In addition, the organization's documentation for Element F details the specific care coordination and educational activities it performs to proactively address the health issues or risk status it identifies in the monthly analysis of patient based data.

Analyzing population-based data

In addition to identifying potential problems, for factor 1, 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 all hospitals.

Factor 2 requires an organization's documentation to show; 1) data collected; 2) a quantitative and qualitative analysis and 3) the identification of opportunities for improvement. Although factor 2 requires an annual analysis of admission and ER visit data, a SNP must provide evidence of one analysis it performed within the look-back period, when it submits its survey tool on or before October 15, 2012.

An organization's analysis for factors 1 and 2 must be specific to the SNP benefit package; an organization that has multiple SNPs can present an aggregated analysis of performance across all of its plan benefit packages, as long as the organization breaks out the data and results for each individual plan benefit package in the report.

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 showing it carries out the processes for each factor.

Exception

Factors 1 and 2 are NA if the organization has no members as of the start of the look-back period. The organization must provide information on its enrollment and NCQA

will verify this data by using the enrollment data from the April 2012 CMS Comprehensive Report to determine applicability for this element.

Examples

Documented process

- Procedures that describe the data an organization collects and analyzes at specified intervals to identify members who are at-risk for a health status change and potential transition
- Procedures detailing the collection and analysis of data regarding admissions, readmissions, and ER visit patterns and trends for all of the organization's members.

Reports

- Redacted reports that identify high-risk patients using claims data or other data
- Redacted 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

Element F: Reducing Transitions

Based on the findings from its monthly analysis of data to identify individual members at risk of a transition, the organization minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by:

1. Coordinating services for members at high risk of having a transition
2. Educating members or responsible parties about transitions and how to prevent unplanned transitions

| 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 0 factors |

Data source Reports, Documented process, Materials

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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 it identifies as high risk. It requires the organization to submit evidence showing how it: 1) acts proactively to coordinate care for high-risk members and 2) educates members on how they can prevent unplanned transitions, in response to findings from the monthly patient-based analysis specified in Element E.

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 the functions addressed by factors 1 and 2 to providers and practitioners.

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 contact the at-risk members or their providers and practitioners with information about potential problems and how to avoid them. Additionally, the organization’s staff may re-assess member needs and address current issues.

Some examples of educating members include:

- Enrolling a member with congestive heart failure who has several recent visits to the ER in diagnosis-related education classes to reinforce self-management e.g., weight/fluid management.
- Enrolling a member with medication issues into an MTM program to help them better understand the importance of medication adherence and also how and when to take medications safely (proper time of day, with/without food, etc.).
- Working with the member or their responsible party to conduct an in-house risk assessment for falls such as taping down loose rugs, eliminating long electrical cords and installing grab bars in the bathroom, to help the member reduce the risk of falling.
- Distributing educational materials to members which are aimed at reducing future transitions a member may experience for specific chronic conditions,

Educational materials that are unrelated to the results of the patient-specific analysis required by factor 1 of SNP 4 Element E will not meet the intent of factor 2.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials showing it carries out the processes for each factor.

Examples

Documented processes for factor 1 may include:

- 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

Documented processes for factor 2 may include:

- Procedures for case managers to educate members on how to reduce their risk for subsequent ER visits or hospitalizations for congestive heart failure that include an emphasis for maintaining their weight and being familiar with symptoms indicating that their condition is declining
- Procedures for the organization’s staff to enroll members in nutrition classes to help them reduce risk and maintain better control over their diabetes and hypertension

Reports for factor 1 may include:

- Reports of enrollment into case management or other programs to help at-risk

members prevent or mitigate unplanned transitions.

- Monthly report of calls made to at-risk members to coordinate care

Materials for factor 2 may include:

- Brochures specific to reducing care transitions distributed to members
- Brochures on prescription adherence to reduce avoidable hospital readmissions
- Training materials for in-class educational sessions provided to members
- Educational materials on how to manage chronic conditions such as diabetes which specifically indicate how to reduce transitions and help the member maintain in the least restrictive setting.

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 monthly, 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 monthly | No scoring option | The organization monitors information at least quarterly | 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 NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation **SNP 5 is applicable for Institutional SNPs with members that reside in contracted nursing facilities and institutional equivalent members residing in assisted living facilities.**

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. Such communications include information that may indicate a change in health status, or no health change and occur at least monthly. The organization might monitor high risk members more often than monthly.

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 this information and is collected at least monthly, it can be used to meet this element.

Monitoring methods

The organization identifies the approach it uses to monitor its members, including, but not limited to 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 showing it carries out the processes.

Exceptions

Element A is not applicable (NA) for an Institutional SNP that does not have any contracts with nursing facilities or assisted living facilities. The organization must provide documentation demonstrating this.

This element is not applicable 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

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

Materials

- Facility briefing materials

Element B: Monitoring Changes in Members' Health Status

The organization monitors and responds to triggering events and changes in members' health status by:

1. **Setting parameters for the types of changes and triggering events contracted facilities must report within 48 hours, 3 calendar days and 4 to 7 calendar days**
2. **Identifying who will act on that information and should therefore be contacted**
3. **Identifying how the member's care will be coordinated with appropriate clinicians or the clinical care plan**
4. **Identifying one monitoring or data collection method it uses to assess changes in all members' health status.**

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|--------------------------------------|-------------------|--|-------------------|---|
| | The organization meets all 4 factors | No scoring option | The organization meets 3 factors including factors 1 through 3 | No scoring option | The organization meets 0-2 factors or does not meet factors 1, 2 or 3 |

Data source Documented process, Reports, Materials

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation Objectives of monitoring triggering events and major health status changes

To enable the organization or treating practitioners to intervene with members in a timely fashion, this element requires the organization to set 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)
3. How the member's care will be coordinated with appropriate practitioners or integrated in the member's care plan
4. The time frame for reporting. The requirement is that reports for certain changes or triggering events must at a minimum be within 48 hours of the event.

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

SNP 5: Institutional SNP Relationship With Facility

and/or the organization, as applicable, to respond.

Monitoring methods

The organization must take at least one 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 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 showing it carries out the processes.

Exceptions

Element B is not applicable (NA) for an Institutional SNP that does not have any contracts with nursing facilities or assisted living facilities. The organization must provide documentation demonstrating this.

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

Examples

When facility staff notes a significant 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

- Redacted reports of member health change reports from staff visits to members
- Redacted 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, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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) reports showing it carries out the processes.

Exceptions

Element C is not applicable (NA) for an Institutional SNP that does not have any contracts with nursing facilities or assisted living facilities. The organization must provide documentation demonstrating this.

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

Examples Documented process

SNP 5: Institutional SNP Relationship With Facility

- Policies describing increases in the frequency of visits to members by the organization's nurse managers to assess, revise the care plan and monitor his or her condition after a health status decline and resulting inpatient stay.

Reports

- Screenshots from the organization's care management system documenting monitoring visits, assessments and care plan changes the nurse managers discussed with the member's treating practitioner and notes confirming the practitioner's agreement.

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 in order to provide better integrated care to members.

Element A: Coordination of Benefits for Dual-Eligible Members

The organization coordinates Medicare and Medicaid benefits by:

1. Giving members access to staff who can advise them on using both Medicare and Medicaid
2. Giving members clear explanations of benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers
3. 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 3 factors | The organization meets 2 factors | No scoring option | The organization meets 1 factor | The organization meets 0 factors |

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

SNP 6: Coordination of Medicare and Medicaid Coverage

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, grievances and appeals).

Objectives of coordinating administration

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.

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 a documented process that enables it to give a member 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 must submit a documented process that shows it has staff who can respond to questions about Medicare benefits, including questions regarding state payment of Medicare cost sharing at any level of Medicaid eligibility and cost sharing for Medicaid services for which the member may be liable. 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 explanation of benefits and grievance and appeal procedures

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. 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.

Documentation

To demonstrate performance on this element, the organization must provide (1) reports showing it coordinates Medicare and Medicaid benefits for dual-eligible members and may also provide (2) documented processes or materials describing the processes it uses to do so.

Exceptions

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

SNP 6: Coordination of Medicare and Medicaid Coverage

Examples

- Evidence of Coverage documentation

Materials

- 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

Element B: Administrative Coordination of D-SNPs

The organization coordinates Medicare and Medicaid benefits by:

1. Using a process to identify changes in members' Medicaid eligibility
2. Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible

| 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 Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

Explanation 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 instances where dual-eligible members are losing and regaining Medicaid eligibility, and the organization monitors both kinds of change.

Coordinating adjudication of claims

The organization adjudicates all Medicare claims and Medicaid claims for services it administers under a contract with the state Medicaid agency. An organization that does not have a contract with the state to adjudicate Medicaid claims, can meet the intent of factor 2 by providing a documented process and reports or materials that show it helps members understand the state's adjudication of claims submitted by providers.

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 for each factor.

Exception

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

SNP 6: Coordination of Medicare and Medicaid Coverage

Examples

Documented process

- Procedures for an organization's staff that show it helps members to understand the Medicaid portion of claims submitted by providers
- Procedures used to determine changes in members' Medicaid eligibility
- Procedures used to coordinate adjudication of Medicare and Medicaid claims

Materials

- 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

- Redacted reports on Medicaid eligibility used by the organization

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 0 factors |

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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. 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 for Chronic SNP members involve gaining and losing Medicaid eligibility, and the organization monitors both kinds of change. On the other hand, an Institutional SNP's documentation only needs to address changes that

SNP 6: Coordination of Medicare and Medicaid Coverage

pertain to the member gaining Medicaid eligibility, since those who reside in a facility and have Medicaid eligibility are unlikely to lose it.

Informing members about maintaining Medicaid eligibility

The organization's documented process shows that it helps members or refers 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 a documented process that enables it to give a member 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 must submit a documented process that shows it 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.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials showing it carries out the processes for each factor.

Exception

This element is NA for Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. For organizations selecting the NA scoring option, NCQA will verify this data by using enrollment data from CMS to determine applicability for this element.

Examples

Documented process

- Procedures that show how case managers or other staff provide certain information to members and direct them to the appropriate Medicaid agency staff for additional information
- 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

SNP 6: Coordination of Medicare and Medicaid Coverage

- Scripts or guidelines for staff who help members with eligibility and benefits information for both Medicare and Medicaid

Reports

- Redacted 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. Helping members obtain services funded by either program when assistance is needed

| Scoring | 100% | 80% | 50% | 20% | 0% |
|---------|----------------------------------|----------------------------------|-------------------|---------------------------------|----------------------------------|
| | The organization meets 3 factors | The organization meets 2 factors | No scoring option | The organization meets 1 factor | The organization meets 0 factors |

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 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 arrange for a member's 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 includes providers in its network and publishes a directory for members, so that:

- All members have access to providers that accept Medicare for services paid only by Medicare

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- Dual-eligible members can obtain services from providers who accept Medicaid payments
- For services that are reimbursed by both Medicare and Medicaid for dual-eligible members, such as physicians' services for which the state pays the Medicare copayment, the organization stipulates that physicians in the network:
 - do not bill dual-eligible members for more than the copayment amount that the state pays for individuals in that category of Medicaid eligibility.
- For institutional benefit packages, the provider directory may be designed for use by the member's responsible party or by institution staff.

Educating providers

When members need services, the organization alerts 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 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.

The organization's documentation for factor 3 must include: a process that describes how it helps members to obtain services covered by Medicare or Medicaid when they need assistance and a report or materials that illustrate what it does when these instances occur. Depending on the member's benefits, this instance may involve providing a policy and an authorization form that describe how a case manager obtains home health services for a member primarily under his or her Medicare coverage and a policy and an authorization form for DME consisting of tub stools and grab bars under his or her Medicaid benefits.

Alternatively an organization may submit a policy and materials it gives to members that details how they can obtain non-emergency transportation services for appointments and medical procedures.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials showing it carries out the processes for each factor.

Exception

This element is NA for Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. For organizations selecting the NA scoring option, NCQA will verify this using enrollment data from CMS to determine applicability for this element.

Examples

Documented process

- Policies and procedures for arranging services for members

SNP 6: Coordination of Medicare and Medicaid Coverage

- 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
- Relevant sections or chapters of the provider manual

Reports

- Reports detailing how members were assisted in obtaining services from Medicaid when needed.

Element E: Network Adequacy Assessment

The organization coordinates delivery of services covered by Medicare and Medicaid by assessing the adequacy of the network for member access to practitioners and providers; to do so it:

1. Establishes quantifiable and measurable standards for the number of each type of practitioner and provider
2. Establishes quantifiable and measurable standards for the geographic distribution of each type of practitioner and provider
3. Annually analyzes performance against the standards for the number of each type of practitioner and provider
4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner and provider.

| 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 0 factors |

Data source Documented process, Reports

Scope of review SNP benefit package

Look-back period NCQA looks for evidence of completion of the required activities during the 6 months prior to the survey date.

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 meet the intent of this element, an organization must perform an analysis of its network. This network adequacy analysis includes practitioners and providers that accept members' Medicare and Medicaid coverage for care and services within defined geographic areas. It shows the extent to which the organization provides the appropriate types and numbers of practitioners and providers necessary to meet the needs of its members for services covered by Medicare and

SNP 6: Coordination of Medicare and Medicaid Coverage

Medicaid.

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.

NCQA reviews the organization's documented process for factors 1 and 2 and reviews reports for factors 3 and 4. The organization's documented process must contain the geographical and numeric standards for practitioners and providers and a description of the methodology it uses to perform the analysis.

The organization must determine whether its delivery system allows adequate access for members for the following types of practitioners.

- Primary care practitioners (e.g., general practitioners, internal medicine specialists)
- High volume specialists (e.g., cardiologists, neurologists, gynecologists, psychiatrists)
- Providers (e.g., hospitals, skilled nursing facilities)

Availability standards

The organization must have quantifiable, measurable standards for:

- The number of each type of: 1) practitioner providing care or 2) practitioner practicing under an unrestricted access health care delivery model that accepts members' Medicare and Medicaid coverage
- The number of providers
- Practitioner and provider distribution in a given geographic region

A SNP's analysis must include a network access indicator (e.g., ratio of member to practitioner availability in an area based on an acceptable number of miles or minutes). It may supplement its assessment of network access data with other: 1) access data (i.e., appointment availability); 2) data on members' cultural, linguistic or ethnic needs; or 3) satisfaction data (surveys or complaint, appeal).

This analysis must be specific to the SNP benefit package; an organization that has multiple SNPs can present an aggregated analysis of performance across all of its plan benefit packages, as long as the organization breaks out the data and results for each individual plan benefit package in the report.

Data analysis

The assessment methodology selected must allow direct measurement of performance against standards.

NCQA reviews the rigor of the methodology, including the data source, the sampling (if used) and the analysis. Analysis of findings must include comparison of results against the standard and an analysis of the causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.

If an organization does not identify any network gaps or deficiencies based on its analysis, NCQA evaluates reports containing a summary for each type of practitioner and provider and whether this conclusion is reasonable.

SNP 6: Coordination of Medicare and Medicaid Coverage

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports showing it carries out the processes for this element.

Exception

This element is NA for Dual-eligible benefit packages with no enrollment as of the start of the look-back period and Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. For organizations selecting the NA scoring option, NCQA will verify this using enrollment data from CMS to determine applicability for this element.

Examples

Expressing the number and geographic distribution of practitioners

- *Number of practitioners*
 - The ratio of member-to-practitioner availability in each area
 - The ratio of the number of sites accepting new members for primary care to the number of members in each geographic area
 - The ratio of the number of open practices to the number of members within each geographic area
- *Geographic distribution of practitioners*
 - The percentage of members with a practitioner of each type available within a certain number of miles
 - Acceptable driving times to primary care sites that are accepting new members

Documented process

- Policies and procedures that detail the organization's process for performing an analysis of its network that include information on the data its collects, the frequency of data collection and its availability standards for practitioners and providers.

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

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| 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). |
| 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: <ol style="list-style-type: none"> 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. |
| 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 |

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| | 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 |

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| | 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: <ul style="list-style-type: none"> • 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 |

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| | <p>appropriate</p> <ul style="list-style-type: none"> • 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. |

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| 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. |
| 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. |
| 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. |