Effective March 14, 2008

Special Needs Plans
Structure & Process Measures

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 process, if applicable.**

Scoring

100%	80%	50%	20%	0%
The organization meets 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 *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

The organization implements case management for members. **Case management** is the coordination of care and services provided to members to facilitate appropriate delivery of care and services. 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. Operating within HIPAA regulations, the organization analyzes members' health status using available data systems.

The organization uses the clinical data sources to which it has access (directly or through a vendor) to analyze members' health status. If an organization provides case management to its entire member population, the organization receives a score of 100%.

Exception

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

Examples

Data captured through UM processes

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

Element B: Access to Case Management

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

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

Scoring

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

Data source Documented process, Reports, Materials

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 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. For factor 3, the organization is not required to have discharge planners on staff, as long as it works with the hospital discharge planners to ensure appropriate referrals are made.

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

If an organization provides case management to its entire member population, the organization receives a score of 100%.

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

Exceptions

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

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

Examples None.

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 date and time action on the case or interaction with the member occurred**
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 no factors

Data source Documented process

Scope of review SNP benefit package

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

Explanation

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 these prompts or scripts are evidence based, when available. Factor 1 requires the organization to provide documentation of the clinical evidence used to develop the systems. Organizations may exclude members who are frail or near the end of life given the smaller body of evidence for these populations.

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

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

Element D: Frequency of Member Identification

The organization systematically identifies members who qualify for case management.

Scoring

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

Data source Documented process, Reports

Scope of review SNP Benefit Package

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

Explanation 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.

If an organization provides case management to its entire member population, the organization receives a score of 100%.

Element E: Providing Members With Information

The organization provides eligible members with case management program information in writing and in-person or by telephone regarding:

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

Scoring

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

Data source Documented process, Materials

Scope of review SNP benefit package

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

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

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

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.

Exceptions

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

Element F: Case Management Process

The organization's case management procedures address the following.

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

Scoring

100%	80%	50%	20%	0%
The organization meets all 14 factors	The organization meets 11-13 factors	The organization meets 6-7 factors	The organization meets 3-5 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review SNP benefit package

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

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

Health status

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

Clinical history

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

Activities of daily living

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

Mental health status

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

Life planning

Assessment addresses life planning issues such as wills, living wills or advance directives and health care powers of attorney.

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.

Case management plan and goals

The case management plan identifies the following.

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

Barriers

Case management evaluation and plan address barriers to care, such as members' lack of understanding, motivation, financial need, insurance issues or transportation problems.

Follow-up schedule

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

Self-management plan

The self-management plan includes, but is not limited to, members' monitoring of their symptoms, activities, weight, blood pressure and glucose levels.

Assessing progress

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

Examples An assessment of cultural needs, preferences or limitations addresses:

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

Element G: Informing and Educating Practitioners

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

1. **Instructions on how to use services**
2. **How the organization works with a practitioner's patients in the program.**

Scoring

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

Data source Materials, Documented Process

Scope of review SNP benefit package

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

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

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

Monitoring

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

Managing

- Comorbidities
- Lifestyle issues
- Medication

SNP 2: Improving Member Satisfaction

The organization assesses and improves member satisfaction.

Intent

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

Element A: Assessment of Member Satisfaction

To assess member satisfaction, the organization evaluates member complaints and appeals by:

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

Scoring

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

Data source Reports

Scope of review SNPs benefit package

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

Explanation

Complaint categories

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

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

Data collection

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

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

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

Self-reported data

The organization may use self-reported data from members, such as member satisfaction with practitioner availability. Organizations may use existing surveys, such as CAHPS®, to meet the factors.

Examples

Conducting data collection to assess member satisfaction

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

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

Quality of Care, Access, Attitude and Service and Billing and Financial Issues.

The following rates were the results for the past year.

Category	2007
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

The complaint rates were also calculated by percentage of the total for each category.

Category	2007
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 one opportunity for improvement	No scoring option	The organization does not identify any opportunities for improvement

Data source Reports

Scope of review SNP benefit package

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

Explanation

Identifying opportunities for improvement

The organization must identify as many opportunities as possible and prioritize them based on its analysis and their significance for concerns to members and must indicate how it chose opportunities for improvement. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues. For each opportunity or barrier, the organization must describe its reasons for taking (or not taking) action.

Exception

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.

Examples

Identifying opportunities for improvement

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

SNP 3: Clinical Quality Improvements

The organization demonstrates improvements in the clinical care of members.

Intent

The organization measures quality of clinical care to improve the clinical quality of care that members receive.

Element A: Relevance to Members

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

Scoring

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

Data source Reports

Scope of review SNP benefit package

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

Explanation The organization must demonstrate that each of the three clinical issues is relevant to its membership. Meaningful clinical issues may involve a high volume of patients or may address conditions entailing a high degree of risk for patients. The organization should identify high-volume and high-risk aspects of care on an ongoing basis in order to set priorities for its Quality Improvement efforts.

Issues that involve only reducing utilization, such as decreasing the rate of hospitalizations, do not meet the element, but the data may be a starting point to identify quality issues. When justified by the organization's data, examples of appropriate clinical issues could be the management of asthma in primary care or appropriate therapy after heart attack. Organizations may use HEDIS® measures to meet the element.

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

SNP Structure & Process Measures

Glossary

Accessibility	The extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone and access and ease of scheduling an appointment, if applicable.
CAHPS®	A set of standardized surveys that measure patient satisfaction with the experience of care. CAHPS® is sponsored by the Agency for Health Care Research and Quality (AHRQ).
case management	The process for identifying covered persons with specific healthcare needs in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum enrollee 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, usually of slow progress and long continuance, requiring ongoing care. Examples include hypertension, asthma, and diabetes.
clinical practice guidelines	Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Such guidelines are usually evidence-based.
complex case management	The 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 assuring 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/enrollees, provide information on using an organization's services, respond to member/enrollee concerns and assist members/enrollees in accessing clinical services. Examples of customer service systems include, but are not limited to, enrollment, enrollee 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 can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed appropriately.
discharge planning	Comprehensive evaluation of an enrollee's health needs to arrange for appropriate care following discharge from an institutional clinical care setting.
disease management (DM)	A multidisciplinary, continuum-based approach to healthcare 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	An item within an element that is scored. 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 MCO to change a decision.
HEDIS® (Healthcare 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, utilization management, quality improvement, case management and complaint and resolution.
medical necessity	Determinations on decisions that are or which could be considered covered benefits. This includes determinations for covered medical benefits as defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits and care or service that could be considered either covered or noncovered, 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 whereby 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 whereby 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 which individuals are eligible for a particular 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 capabilities (systems, organization, processes) to measure and prevent medical errors and otherwise protect its members/enrollees.
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 the course of actions, including the methods in which the actions are carried out and the staff responsible for the various actions, 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: 1) The single site is the location of practice for at least the majority of their clinical time; 2) The nonphysician staff follow the same procedures and protocols; 3) Medical records, whether paper or electronic, for all patients treated at the practice site are available to and shared by all physicians as appropriate; 4) The same systems--electronic (computers) and paper-based--and procedures support both 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.
primary care practitioner (PCP)	An individual, such as a physician or other qualified practitioner, who provides primary care services and manages routine health care needs.

provider	An institution or organization that provides services for an organization's enrollees. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services. However, NCQA 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
quality assessment	Measurement and evaluation of the success of care and services offered to individuals, groups or populations.
quality assurance (QA)	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 improvement (QI)	The 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 utilization management 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.
special needs plan	Special Needs Plans (SNPs) were created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual eligibles and beneficiaries with severe or disabling chronic conditions. A SNP benefit package, referred to by the Centers for Medicare and Medicaid Services as the "plan," 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	The process of 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.
underutilization	Failure to provide appropriate or indicated services, or provision of an inadequate quantity or lower level of services than required.

utilization management (UM)	The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.
utilization review	A formal evaluation (prospective/preservice, concurrent or retrospective/postservice) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.