SNP Quality Measurement for 2008

Introduction

SNPs were created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the dual eligible, the institutionalized and individuals with severe or disabling chronic conditions. A central goal of the SNP program is to promote using enhanced coordination and continuity of care models to improve care for Medicare beneficiaries with special needs.

There are three kinds of SNPs. *Dual-eligible SNPs* coordinate benefits and services by combining benefits and services available through Medicare and Medicaid. *Institutional* and C*hronic Condition* SNPs focus on the special needs of those populations.

SNPs may target enrollment, designing special clinical programs to accommodate groups with distinct health care needs. SNPs limit their enrollment to the particular population that they serve. SNPs are Medicare Advantage (MA) plans, and the organizations that offer SNPs must comply with all requirements of general market Medicare Advantage plans, except that general market MA plans must enroll all MA-eligible Medicare beneficiaries in their service area. Currently, there are approximately 1.2 million beneficiaries participating in SNPs, and more than 700 SNPs.

Measure Selection

Since January of 2007, the Geriatric Measurement Panel (GMAP) of the National Committee for Quality Assurance (NCQA) has been funded by the Centers for Medicare & Medicaid Services (CMS) to develop quality measures for evaluating SNPs. The GMAP includes representatives of managed care organizations, providers, consumers and policy makers and provides guidance on the development and maintenance of measures that are focused on care provided to older adults.

In March of 2007, CMS asked NCQA, utilizing the GMAP, to develop an assessment approach that would initially define and assess characteristics of SNPs, followed by an assessment of processes of care and eventually an assessment of SNP service outcomes. A phased approach was developed that builds successively, over three years, to create a system for understanding the quality of care provided to SNP members, taking into account the specific needs of the populations they serve. For the assessment of clinical process and outcomes for the first year, CMS selected the SNP performance measures from existing HEDIS measures; and for assessment of Structure & Process measures, CMS selected measures from current NCQA Accreditation standards. CMS used existing measures to allow rapid implementation of the approach and to deliver initial results on a timeline that would meet CMS requirements.

The process for Phase I used to develop the measures included translating evidence and guidelines into measures; field-testing; a public comment period; and approval by the

NCQA Standards Committee (Structure & Process measures) and the NCQA Committee on Performance Measurement (HEDIS measures). The GMAP, convened by NCQA at the direction of CMS, reviewed and approved all SNP requirements.

The GMAP, in November 2007, finalized the Phase I measure recommendations from existing measures. These recommendations included thirteen HEDIS measures, and a set of three Structure and Process measures.

SNP Data

From the initial set of thirteen HEDIS measures, four measures were chosen for initial public reporting based on their meaningfulness and understandability to consumers. These measures include:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Appropriate Monitoring of Patients Taking Long Term Medications
- Board Certified Physicians

The Board Certified Physicians Measure is an average of four other measures: family medicine board certification, internal medicine board certification, geriatricians' board certification, and other board specialists' certification.

In the data displayed on www.cms.hhs.gov/ SpecialNeedsPlans/CMS_gov-SNP Measures_2008_11_05(2).pdf, you will see that many of the plans were either too new or too small to collect this information this year; there is substantial variation in reported data between organizations. Plans that were required to report a measure but did not do so because their data were materially biased, received a "zero" and the footnote "Not reported. There were problems with the plan's data." Plans that decided not to report their data also received a "zero" for the particular measure.

The average across SNPs for each of the measures reported is as follows:

- 39 percent for colorectal cancer screening
- 39 percent for blood pressure
- 85 percent for appropriate monitoring of patient taking long-term medications
- 50 percent for board certified physicians

These averages incorporate "zeros" for plans that had biased data or decided not to report their data; as a result, the average is lower.

The data presented on this website reflect the first year results for SNPs. The scores reported in 2008 may reflect the inexperience of SNPs with HEDIS reporting requirements; for example, first year HEDIS scores are typically lower than subsequent scores. Thus, we expect improvements in these scores over time. The data are not risk

adjusted and we know SNPs tend to serve higher risk individuals than non-SNP Medicare Advantage plans. Consistent with past experience collecting new HEDIS measures, some organizations were not able to fully report during this first year and scores for individual organizations may be low due to data collection issues, as opposed to actual performance problems. We anticipate that future data will provide a more robust picture of the quality of care provided by SNPs as the set of measures mature.