SNP Alliance Issue Brief
Improving Performance Evaluation for Special Needs Beneficiaries

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Background

The Medicare Improvement and Patient Protection Act (MIPPA) required SNPs to establish evidence-based models of care (MOCs) to ensure that SNP care is uniquely tailored to special needs of Medicare's most vulnerable populations including those requiring an institutional level of care, dual eligibles and those with serious chronic conditions. These requirements differentiate SNPs from standard MA plans and establish clear expectations for care models and approaches based on 11 domains of care defined by CMS. CMS guidance issued between 2008 and 2010 further clarified expectations about SNP MOCs, indicating that care plans must include specialized add-on services and benefits to address the specialized needs identified in mandatory comprehensive annual risk assessments and must ensure that the most vulnerable and sickest beneficiaries receive care proportionate to their increased needs. CMS also contracted with NCQA to develop measures to promote quality improvement for SNPs. NCQA identified 6 structure and process (S&P) measures focused on the unique care and service delivery needs of SNP beneficiaries.

Misalignment of Specialty Care Performance Measures

While SNP MOC requirements and S&P measures were intended to provide SNP-specific metrics for special needs beneficiaries, effective performance measurement for specialty care plans is hindered by several factors:

1. Because the SNP Structure and Process measures were developed independent of the SNP MOC domains, the requirements governing MOCs are not well aligned with the S&P measures, even though both focus on effective performance for special needs beneficiaries. There is only one MOC domain that is directly aligned with SNP S&P measures. The "care management for the most vulnerable populations" domain has the same intent as the S&P measure for "complex case management."
2. Since SNPs also are required to report on all standard MA quality measures, and SNPs offering Medicaid services also report Medicaid measures, there is a tremendous amount of duplication across MA, SNP-specific and Medicaid reporting.
3. Because all standard MA measures are applied to SNPs without regard to the nature of the target populations served, some are irrelevant, inappropriate or potentially harmful to specific population groups.
4. Only one SNP-specific measure currently is included in the plan ratings used for consumer comparison shopping among plans or for determining bonus payments (Care of Older Adults). Another will be added for 2013 plan ratings (SNP care management). As a result, consumers do not have an accurate basis for comparing SNPs to standard MA plans and SNPs are encouraged to focus on quality improvements for the general population instead of the unique needs of the special populations they enroll based on the misaligned financial incentives in the current bonus structure.

To ensure SNPs are evaluated based on their performance, commensurate with their specialty care mandate, rather than measures designed for the general Medicare population, the SNP Alliance offers the following recommendations for improving performance evaluation for SNPs and dual demonstration plans to better align specialty care measurement with population needs.

Revise the SNP Model of Care and MOC Evaluation Process

1. Develop an integrated Model of Care that takes into account all primary, acute, long-term care and supplemental benefits covered by Medicare and Medicaid.
2. Re-evaluate and revise certain requirements such as routine face-to-face meetings of interdisciplinary care teams for every beneficiary, regardless of care plan or health status; and the requirement that all SNPs implement "care management for the most-vulnerable," including plans that specifically target a high-risk Medicare subset, such as nursing home certifiable beneficiaries, those with AIDS or ESRD.
3. Fully align SNP MOC domains and requirements with SNP evaluation measures. For example, there should be a single set of matched MOC domains and S&P measures (e.g. complex case management, individual plans of care, care transitions, etc.), some of which may not apply to certain SNP subsets (e.g., SNP relationship to facility only applies to ISNPs and Coordination of Medicare and Medicaid only should apply to SNPs that offer Medicaid services). Any HEDIS, HOS, CAHPS, QIP, CCIP, PIP or other measurement requirements should be linked directly

to the MOC domains – insofar as specific measures are relevant to the enrolled population.

4. Revise current MOC scoring criteria, which is a subjective set of volume driven criteria with a 5 point scale (0-4) related to "depth" of descriptions and number of examples or case studies given for each domain. MOCs should be evaluated based on the relevance of the proposed model and interventions for specific special needs subsets.
5. Permit all SNPs to offer expanded supplemental benefits that support models of care and to select the type of benefits most relevant to the target population, not be limited to a defined set of benefits. The goal of expanded supplemental benefits should not be limited to integration of Medicare and Medicaid benefits and services, but enhancement of care for all special needs beneficiaries.

Establish a Core Set of Performance Measures for Medicare/Medicaid Enrollees

1. Adopt a core set of uniform, population-based, case mix adjusted performance measures and methods for Medicare and Medicaid as a collaborative effort among CMS, NQF, and NCQA, with input from states, SNPs, dual demos and other relevant stakeholders.
2. Identify measures that are sensitive to the unique but diverse needs of major high-risk/high-need subsets, including persons who are poor; old and frail; those with physical, intellectual and developmental disabilities and/or behavioral problems; and/or persons with special medical needs, such as HIV-AIDS and severe and persistent mental illness -- rather than measures governing quality for relatively healthy Medicare beneficiaries; e.g.
    a. Eliminate standard MA measures that are irrelevant to the enrolled population such as osteoporosis management for older women with previous fractures and drugs to be avoided by the elderly for young adults with intellectual disabilities; or measures that are potentially harmful such as colorectal cancer screening for frail elderly and ESRD patients.
    b. Identify strategies for ensuring validity and reliability of self-reported data by beneficiaries with cognitive impairments, SPMI, intellectual disabilities, behavioral problems, etc.
    c. Address issues of unique importance to Medicaid, such as LTSS, behavioral health, and informal caregiver needs.
    d. Build upon NQF measurement recommendations for dually eligibles and those with multiple chronic conditions.
3. Streamline and eliminate duplication and conflicts among MA, SNP, and Medicaid measures, consistent with NQF's principle of parsimony, to use the smallest set of core measures needed to achieve program goals. Plans should submit a single set of HEDIS, HOS and CAHPS measures that are appropriate to the population served; one set of quality improvement projects instead of Medicare QIPs *and* CCIPs *and* NCQA CQIs *and* Medicaid PIPs; one set of functional measures instead of Medicare HOS and different state-based functional measures, etc.
4. Stratify and/or case-mix adjust performance metrics for high-risk/high-need populations such as frail elders, adults with disabilities and persons with complex medical conditions to account for health risk, geographic factors, demographics and other factors affecting quality independent of plan interventions.
5. Test, validate and implement a common set of outcome performance measures with special consideration for hospitalization/readmit rates, ER visits, long-term nursing home stays, adverse drug events, and consumer satisfaction.
6. Develop methods and metrics for evaluating the degree to which CMS, states and plans achieve full integration based on national integration standards.
7. Evaluate the degree to which reporting requirements add value and eliminate requirements for which there is no clear evidence that the added data burden enhances the value of specialty care.
8. Modify the existing bonus payment method which is based on standard STAR ratings for MA plans to incent, rather than penalize plans, for targeting persons with specialty care requirements by incorporating measures most relevant to targeted beneficiary groups. For example, SNPs report SNP-specific HEDIS and structure and process measures, only one of which has been incorporated into star ratings.
9. CMS should establish a core set of national integration program standards and metrics as the basis for a comparative analysis of integration demonstrations. Metrics should measure quality and cost outcomes as well as the degree to which states achieved care and program integration. Reporting requirements and methods should be clearly communicated to states and plans early in the process to ensure access to a common data set for a robust cross-state comparison.