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January 18, 2008

Comments Submitted on Behalf of the National Senior Citizens Law Center on the Center for Medicare & Medicaid Services and the National Committee for Quality Assurance's Draft Special Needs Plan Requirements

The National Senior Citizens Law Center submitted the following comments on the draft requirements for Medicare Advantage Special Needs Plans (SNPs) proposed by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). CMS and NCQA's proposed quality measures would be used to evaluate SNPs. NSCLC's comments were written in cooperation with the Center for Medicare Advocacy, Inc., the Pennsylvania Health Law Project, California Health Advocates, the Medicare Rights Center, the Alzheimer's Association, and the National Council on Aging.

The draft proposed SNP evaluation requirements are available on the NCQA's website, www.ncqa.org.

SNP 1: Complex Case Management (CCM)

NSCLC is concerned that CMS and NCQA's proposed standards will do little to protect low-income Medicare beneficiaries, in particular dual eligibles. We strongly disagree with the plan to delay formulation of standards specific to dual eligible SNPs and/or treatment of dual eligibles enrolled in SNPs. As of March 2007, approximately 74% of SNP enrollment was in plans targeted at dual eligibles. Dual eligibles are likely heavily represented in plans serving institutionalized individuals and those with chronic or disabling conditions. Dual eligibles are the poorest Medicare beneficiaries and are disproportionately vulnerable. As such, many of our recommendations call for specific measures to enable evaluation of the appropriateness of SNPs for dual eligible enrollees.

NCQA should formulate its standards to allow for the comparison of SNP performance to non-SNP alternatives. For dual eligible SNPs, that control group would be enrollment in fee-for-service Medicare and local Medicaid plan(s).

The purpose of the complex case management standard is to help enrollees access "needed resources." NCQA should add an element that evaluates a SNP's ability to identify potentially "needed resources" accurately for the target population. This element should include consultations with beneficiary groups experienced with the special needs populations targeted by the SNP. The survey process contemplated by these standards relies almost exclusively on documentation of the existence of systems, with no audit of

actual use of the systems. This approach is insufficient to provide an accurate picture of the relative values of different plans. NCQA should build into its system an audit of each plan's responses to the survey.

Element A: Identifying members.

All members should receive complex case management in a Special Needs Plan. Having special needs was the threshold for admission into the plan. Once enrolled the questions from the plan should be, "What are your precise special needs?" and "How can we provide case management that will meet your special needs?" not "Are your special needs special enough to warrant our providing you with case management?"

Data sources should include those listed as well as: Medicaid information, information collected from an initial intake interview/needs assessment completed with the member, recurrent needs assessment completed with the member, and information from providers or caregivers.

The explanation section appropriately defines case management to include "determination of available benefits and resources." This must include elements beyond the SNP benefit package itself to encompass all benefits and resources potentially available to enrollees. This section must clarify that comprehensive assessment is not limited to the member's specific medical condition; it includes overall condition and characteristics including needs related to, e.g. physical health, mental health, language access, and dual eligibility. If case management is not offered to all plan members, it would be useful to know the percentage of members who are considered for it, found eligible for it, and who actually receive it.

Specific changes: First sentence: "The organization uses the following data sources to analyze the health *and mental health* status of members," with a similar change to the explanation section.

Element B. Access to case management

The data sources should also include: Medicaid program referral, State Pharmaceutical Assistance Program referral, and family member/caregiver referral.

Under the explanation, the organization must not be permitted to communicate information about self-referral solely through its website. This is not appropriate as the exclusive means of communicating to a special needs population, most of which does not use the internet for such information. It must communicate this information orally through its member intake interview/needs assessment processes and through its written materials.

Any intake interview and telephone hotlines must be available to members or potential members who are not proficient in English. Initial information about CCM should include the same language access evaluation that is included in later Elements.

To the extent that case management is limited, provider- or self-referral should result in automatic granting of case management. With respect to scoring, a system that does not include member self-referral and practitioner-referral should not score above 20%; meeting five factors should not result in a score of 100% if factors 5 and 6 are not both included.

Element C: Case management systems

CM systems must include staff dedicated exclusively to CM who are specially trained (in part through their professional/clinical training or education and in part through training specific to coordinating care and benefits for special needs populations). Evaluation should capture composition of the CM team—whether nurses, doctors, or social workers and in what proportions. Evaluation must also capture whether enrollees get assigned a designated member of the CM team upon whom they can rely and with whom they can build a useful, working relationship. Consistency is critical.

If SNPs are permitted to have eligibility criteria for their CM, the system must have a written protocol that includes the standard for eligibility, who determines eligibility and how, and the process through which a member can challenge the determination. Evaluation must measure the existence and accessibility of such a protocol.

CM systems should be transparent and available to consumers. Transparency should include appropriate access to the system so that a member can easily obtain a record of interactions with practitioners, providers, and the case manager.

The plan must publicize clinical evidence on which CM prompts or scripts are based. Evidence-based guidelines may not exist for certain commonly accepted interventions for specific diseases or for certain subpopulations. Even evidence-based guidelines appropriate for a particular member with respect to a particular disease may be inapt because of the member's complex co-morbidities. Some system is needed but not necessarily one that is exclusively evidence-based.

On scoring, since factors two and three are valuable and necessary but are not sufficient, a score that includes only those factors should not be acceptable.

Element D: Frequency of member identification

Case management cannot be solely premised on a one-time snapshot of a consumer's overall condition. There must be regular and routine assessments and reassessments of enrollees' needs.

SNPs must conduct an initial assessment of every new member. To the extent that SNPs are permitted to limit case management to a certain member, those that are provided with case management at the outset must be reassessed for potential changes in their case management needs every six months, after any hospital discharge, and after any outpatient surgical procedure. Those that are not provided with case management must

have their needs assessed at least every year, after any hospital discharge, after any outpatient surgical procedure, or after any referral from a source identified in Element B so that any developing need for which case management is appropriate can be captured and addressed. The evaluation must measure the extent to which case management needs are being reassessed or captured anew.

Element E: Providing members with information

All enrollees should be eligible for case management. Even if CM is limited to certain members, SNP should be evaluated for how it informs *all* members about the availability of, meaning of and benefits included in CM, referral processes and more. Information should be provided in person during an annual needs assessment as well as in written materials provided by SNP specifically on this topic. CMS should fully define “case management” so that SNP enrollees have a standard explanation of the service. Evaluation should measure the manner and frequency of informing members, whether SNP informs all enrollees of the process for requesting the benefit and how to challenge denial or termination of CM. NCQA should also evaluate whether SNP completely and accurately presents possible disadvantages or restrictions on care that could be associated with participation in CM program.

Explanation describes an “opt in” or an “opt out” system for accessing CM. Plans using opt out should be evaluated more strictly than plans using opt in. Provision of information must, for each member, take into account literacy, English language proficiency, and disabilities that would impair receipt of information, including cognitive impairments.

Factors not fungible, vis-a-vis scoring. Meeting two factors, if one of them isn't either 1 or 2, should not result in an 80% rating.

Specific changes: First sentence: The organization provides eligible members *or their representatives* with.... program information. Explanation should identify a representative as someone who helps an eligible member with health care decision-making and should include the term *or their representatives* after the word members in 1st sentence, 2d paragraph.

Element F: Case management process

Additional factors needed: assessment of enrollee's existing providers and allowance of transition process for continuity of care; assessment of enrollee's other insurance including Medicaid and assistance in getting benefits from same; assessment and promotion of enrollee's desired involvement of self and others in decision-making and care planning; assessment of appeal process for enrollees denied CM; periodic reassessment of appropriateness of SNP for enrollee.

Many factors that *have* been included are extremely important: assessment of mental health/cognitive function, evaluation of cultural and linguistic needs, evaluation of

available benefits (as modified by suggestions in this comment). Under explanation, discussion re: evaluating health status and clinical history must tie to the expectation that SNP assures continuity of care with a generous transition process. The text must clarify that informal-caregiver resources have no bearing on the CM determination. “Benefits” must include Medicaid and other benefits to which the member may be entitled, including Medicare Savings Programs & Part D low income subsidy. Included in the evaluation of “life planning” should be identification of risk factors for fraud and abuse. The factors in this Element are not equally important; scores should not reflect merely the number of factors included by the plan. E.g. life planning is not equal to clinical history, so having the latter but not the former is better than having the former but not the latter.

Specific comments: explanation of “Case management plan and goals” should include: ***Other programs, such as Medicaid, that can provide supplemental health and long term care services to members . Add referrals to Medicaid*** in explanation to Follow-up information.

Element G: Informing and educating practitioners

The evaluation should include how the SNPs inform providers of the existence and benefits of case management and how patients can obtain the service. The evaluation should include how the SNPs inform practitioners about Medicaid benefits and about balance billing.

Instructions to practitioners about how to use services and how the SNP works with patients in the program should be made available to the public as well as practitioners in a way that is easily accessible to members, potential members and advocates.

Element G should be expanded or a new element should be added to evaluate the SNP’s procedures for prompt payments of providers.

The examples should include the following additions:

In “Monitoring” – ***Member’s mental health status***

In “Managing” – ***Mental health condition
Communication with member’s representative***

Comments on SNP 2 – Improving Member Satisfaction

It appears that NCQA’s current standard for assessment of member satisfaction relies entirely on an evaluation of existing member complaints and appeals. This sets a very low bar, suggesting that members are satisfied if not overtly (to the point of public complaint) dissatisfied. Most people don’t complain unless their backs are up against the wall and there are no alternatives. Moreover, the poorest and most vulnerable enrollees, i.e. all SNP enrollees, are those who are least able to file complaints and pursue appeals on their own behalf. In NSCLC’s experience as advocates for dual eligible Medicare

beneficiaries, many individuals are unaware of their rights to file a complaint and/or are unable to navigate complaint filing procedures without the assistance of an experienced advocate.

Element A: Assessment of member satisfaction

What is the “appropriate population” discussed in Factor 1? What is the “affected population” discussed in Factor 2? Assessing member satisfaction has to start with education of members as to the methods available to them to file complaints or express satisfaction with services. It is unclear what is meant by “aggregating complaints by practitioner;” does this negate the previously stated requirement that complaints be coded by reason? Users of this data should be able to distinguish by type of complaint even with a single practitioner group. It is not clear from the Examples how to interpret the chart of rates. Such a chart should be publicly available and contain instructions for users of the data on how to read it. It is difficult to understand the meaning of the factors, so it is difficult to assess scoring. It seems, however, that any score that does not include Factor 3 should not be relevant.

NCQA should evaluate the accessibility to members of the SNP’s complaints and appeals processes. Plans should also use alternative methods of evaluation to improve the reliability of member satisfaction assessment for vulnerable populations. First, the plan should undertake proactive outreach to a selected sample of enrollees. This outreach should be in person and, where necessary, involve appropriate interpretation. It should involve open-ended questions to members about their experience with the SNP. Second, the plan should identify appropriate advocacy and consumer organizations that serve the target populations. The SNP should consult with staff whose members have had experiences with the SNP in order to assess general trends and identify any problems relating to member satisfaction.

Element B: Opportunities for improvement

The description under the Element says it is not applicable if the organization’s analysis does not result in opportunities for improvement. It is difficult to imagine a situation in which there is no opportunity for improvement. How would NCQA assess such an organization? How could it possibly determine that the conclusion was reasonable? Moreover, having a standard of two opportunities for improvement to achieve 100% suggests significant underachievement. Although as written, the element is not prescriptive of specific areas of improvement, it could be expanded to include examining whether the SNP has a self-assessment system that looks at the following questions: Does the SNP have a "system" for learning from the case management system it delivers? Does the SNP document the improved health status? Does it document the coordination of care and coordination of benefits? Does it document complaints received. Does it document feedback received? Does it meet with designated staff to review results? Does it craft additional training around results?

To identify opportunities for improvement, plans should identify the best practices of other organizations that serve the target population. Plans that serve primarily dual eligibles should use the experience of enrollees in original Medicare and the state Medicaid program as a basis for comparison.

We greatly appreciate inclusion of language access in the list of examples of opportunities for improvement.

Specific suggestion: In examples add a new bullet stating: ***Take action to develop a program to assist practitioners in communicating with persons with cognitive impairments and their representatives.***

SNP 3: Clinical Quality Improvements

It is difficult to understand exactly what this standard is measuring, in part because it talks only about “selecting” measures, not successfully implementing them, and in part because it offers no examples of the type of measures NCQA has in mind. While measures related to acute situations might consider improved outcomes (e.g. the uniform application of protocols demonstrated to be effective responses to particular situations), measures related to chronic situations should not necessarily focus on “improvements” in an individual’s functioning, but rather stabilizing their condition at the highest level of functioning possible or practicable. NCQA should add examples to Element A.

Element A: Relevance to Members

This Element measures only the *selection* of measures relevant to membership; it has nothing to do with *implementing* the measures or demonstrating that they improved quality. High risk or high volume aspects of care, as discussed in the explanation section, seem like important areas to measure quality. It is also valuable to preclude using decreased utilization as a measure of quality.

In the list of examples at the very end in parentheses after “chronic conditions,” add *dementia*.

Other

We strongly agree with NCQA’s recognition of the “need to focus on the ‘specialness’ of special needs plans as soon as possible.” This proposal does not meet that goal. According to the current timeline, it is not until “latter phases” of the project that CMS and NCQA will tailor evaluation measures to specific special needs populations. The timeline should be revised to prioritize the needs of dual eligibles.

Evaluation of plan marketing should also be added to the proposed standards. How a SNP offers itself to beneficiaries, in particular to dual eligible beneficiaries, and the accuracy of marketing information are highly relevant to the quality of the organization.

The scoring system gives equal weight to each factor within an element, even when, arguably the factors are not of equal importance. Even if the underlying score is available (i.e. it is easy to tell which factors were and were not met for each plan), it is likely that many users of the system will only look at comparative percentages for various plans. It would be helpful to know exactly how the information will, in fact, be presented for public use. What is the consequence to a plan of having all or most of its scores at 50% or below? Are sanctions applied? By NCQA? By CMS? Or is the expectation that the market will drive out those plans because people will not choose them? If the latter is the case, it is a dubious proposition, as the populations served by SNPs are not in a very good position to be shopping around for plans.

Thank you very much for your attention to our concerns. Please feel free to contact NSCLC if you have any questions or would like more information.

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