



National Health Policy Group

Improving Payment and Performance for High-Risk Beneficiaries

July 25, 2006

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development -A
7500 Security Boulevard
Room C4-26-05
Baltimore, MD 21244

RE: Agency Information Collection Activities: Proposed Collection; Comment Request CMS-10194: Comments on SNP Mail Survey and Moderator Guide for Beneficiary Focus Groups

ATTENTION: Melissa Musotto

Dear Ms. Sirs:

The National Alliance of Specialty Healthcare Programs (SNP Alliance) appreciates the opportunity to comment on survey instruments that will be used as part of the SNP evaluation for the Report to Congress required by the Medicare Modernization Act. We are attaching specific comments on the SNP Mail Survey that we understand will be distributed to all Special Needs Plans (Attachment A) and the Draft Moderator Guide for Beneficiary Focus Groups that will be conducted at a limited number of plans that are participating in SNP site visits (Attachment B). Below is a summary of key findings from the SNP Alliance Medical Director Work Group regarding both instruments. We look forward to discussing our comments further with CMS and MPR staff prior following the submission of comments

SNP MAIL SURVEY

We support the overall direction of the SNP Mail Survey and believe that it will produce important profiling information about SNPs. We have several suggestions regarding the data collection instruments that we believe will ensure that there is a uniform data collection period; a common understanding among plans regarding the questions and data requested; comparability in the type of information provided to CMS and a greater ability to differentiate among plans in areas such as care management, special services and clinical programs and approaches; risk sharing arrangements; provider contracting; and other areas where SNPs are likely to look or operate differently than a standard MA program. Toward this end, we recommend the following:

- Send the survey to the government relations/programs department and the plan compliance officer and advise them to identify which plan staff are best suited to respond to various parts of the survey.
- Direct plans to respond to the survey for the 2006 SNP contract year to produce the largest number of responses for a single contract year. Coordinate other plan data such as bidding and RAPS data with the 2006 contract year to ensure consistency in analyzing risk/benefit/cost analyses.

- Clarify intent of inquiry on patient distribution by size of group practice and modify to produce uniform responses across plans.
- Provide an opportunity for more open-ended responses regarding risk-sharing arrangements to allow SNPs to catalogue more fully the array of risk sharing strategies, better differentiate SNP risk sharing arrangements from standard MA plans and better understand the type of risk-sharing employed to produce specific outcomes.
- Section C on enrollment and target marketing has multiple response options with no structure for ranking or prioritization. Some type of ranking or metric should be included to allow CMS to scale methods within and across plans.
- Section D on special services offers an important opportunity to help CMS evaluate differences between standard MA plan and SNP clinical approaches to serving high risk beneficiaries. Several changes are critical to achieving this goal:
 - ✓ Care coordination (CC), case management (CM) and disease management (DM) functions are not differentiated. CMS should define these terms or ask plans to define.
 - ✓ Plans should respond to inquiries about lead health professionals responsibilities and specific care activities (managing transitions, health education, etc.) in relation to the three key functions identified (CC, CM, DM).
 - ✓ Plans should document FTEs by CC, CM and DM functions and CMS should add a question about percentage of special needs beneficiaries receiving these services.
 - ✓ CMS should consider including a basic list of services offered by SNPs to meet special needs in addition to CC, CM and DM (i.e., home care, medical transportation, specialty pharmacy management, AODA services, etc.).
- We recommend greater specificity for outcomes data; i.e., hospitalization rates for *ambulatory care sensitive conditions*. We also recommend adding additional categories that are unique to high-risk populations such as medication errors and nursing home admissions rates.
- Sections F and G relating to the dually eligible population should not be limited to dual SNPs. All SNPs serve dually eligible beneficiaries should respond to dual questions. Also, questions about special needs and services should be included for all 3 SNPs, not just duals.
- We recommend adding some questions in Section G on barriers to integrating Medicare and Medicaid benefits and on the impact of Part D cost-sharing rules for duals on access to needed drugs and access to other supplemental benefits.

MODERATOR GUIDE FOR BENEFICIARY FOCUS GROUPS

- We recommend giving a series of examples about what triggered enrollment in the SNP; i.e., attempting to meet a specific health need, physician recommendation, advice of a trusted advisor, better pharmacy benefits, etc.
- We recommend adding a question about whether the beneficiaries ever participated in a Medicare Advantage plan before as a benchmark for evaluating their SNP experience.
- We recommend adding more questions about the special needs of targeted populations to determine if plans are doing a better job with polypharmacy management, comorbidity management, care management and other needs unique to a SNP population.
- We recommend differentiating between direct services like dental or personal care and management functions like care management and disease management in Section D on awareness and use of plan benefits since beneficiaries may not perceive management functions to be a special service, nor are beneficiaries necessarily equipped to accurately rate this type of function.

We would be happy to answer any questions you may have about our suggestions and recommendations and to help further refine these survey instruments to ensure the most effective responses from Special Needs Plans. Please do not hesitate to contact us if we can help in any way.

Sincerely,



Richard J. Bringewatt
President, NHPG
Chair, SNP Alliance



Valerie S. Wilbur
Vice-President, NHPG
Co-Chair, SNP Alliance

Attachment A

Comments on SNP Mail Survey

SURVEY ADMINISTRATION

1. Please identify who the survey will be sent to at the health plan. We recommend sending it to the government relations/programs division and SNP compliance officer as they should be best equipped to identify which staff or departments are best suited to filling out various components of the survey related to provider arrangements, risk-sharing, enrollment, special services, etc.
2. Some MAOs are sponsoring dozens of SNPs in different parts of the country. For example, as of January, United Healthcare and Wellcare each sponsored upwards of 70 or more SNPs. We recommend that CMS identify a strategy for these organizations to respond on behalf of the many plans they sponsor instead of sending a survey to literally every plan. For example, it may be more appropriate for these organizations to fill out some type of grid that shows the range of benefits, provider contracting arrangements, risk-sharing arrangements and other information requested by CMS. This would ensure that CMS understands the overall direction of the company and the range of products they are offering without requiring them to duplicate the survey at the plan level for dozens of plans. We request the opportunity to work with CMS, MPR and Evercare to identify a strategy that provides CMS the information they need while minimizing undue data burden on MAOs like United.
3. The survey does not direct SNPs to provide responses for a particular year. We recommend that CMS request data for 2006 to ensure the largest number of responses for a single year. We also recommend that bid data, risk scores and other information used for the evaluation be collected for the 2006 contract year so that benefits, bid data, risk sharing arrangements and other related information is evaluated as part of the overall plan design for a given year.
4. The Instructions do not indicate when surveys need to be returned. A target date should be included.

SECTION A: ORGANIZATION

A2, A6 and A10: Type of SNP: Include two categories for each of the 3 SNP categories— plans *exclusively* serving institutional, dual or chronic condition beneficiaries and plans *disproportionately* serving these three categories. In addition, please add appropriate subsets of these key SNP categories consistent with CMS' impending decision to allow SNPs to serve subsets that are consistent with state dual policy.

A3: Enrollment Restrictions: Given the number of plans from dual demonstrations participating in this survey, we suggest that the following additional eligibility categories be added:

- seniors
- adults with disabilities
- nursing home certifiable beneficiaries
- dual subsets

SECTION B: PROVIDER ARRANGEMENTS

B1: Distribution of Beneficiaries by Practice Setting

- What is the intent of asking the question about percentage of members served by various sized practices? How does the size of the medical practices serving SNPs inform CMS' understanding of SNPs?
- What is meant by "independent practice"? Does this mean an individual physician or sole practitioner?
- Some plans will not be able to answer this question easily or it will take a lot of work to break down the data to give an accurate response. For example, some plans contract with IPAs that have small, medium and large group practices *affiliated with a single IPA*. For plans that contract with several IPAs, with multiple group sizes and types, it will be a complicated process to calculate the percentages of members affiliated with various sized groups across multiple IPAs and group practices. To the extent that plans have to interpret how to respond to this question, it will reduce the likelihood of a uniform response across plans. To help ensure a uniform response, it would be helpful to better understand the nature of the inquiry.

B3: Describe Risk Sharing Arrangements. SNP Alliance members indicated this is a complicated question that cannot simply be answered with a "full versus partial risk" response. Some plans are likely to have multiple risk sharing arrangements and would need to have a chart for each type of provider to fully catalogue the range of risk sharing relationships. There are different levels of risk between plans and IPAs, IPAs and physicians, plans and physicians, etc. that would not be captured by the response options.

We suggest the following options for enhancing responses to this question:

- Start out with key questions about financial incentives and outcomes:
 - ✓ Are your SNP provider relationships different from your current or historic relationships under "standard" managed care plans?
 - ✓ How did you structure your risk-sharing relationships to produce specific clinical and/or financial outcomes?
- In the box of definitions of risk levels, add another category called "other" and ask plans to describe on a separate sheet.
- Restructure the chart to allow plans to identify multiple risk-sharing relationships for each provider category and indicate they should provide additional detail needed on a separate sheet.
- Eliminate chart and include open ended question asking plans to describe the range of risk sharing relationships and ask them to rank in some way to indicate most and least prevalent contract types.

B8: Add a new question: What impact does Part D exclusions have on special needs plans beneficiaries? (e.g., over the counter drugs, benzodiazepines needed by disabled adults, etc.)

SECTION C: ENROLLMENT

C2: Target Marketing: This questions needs to be rank ordered to provide a meaningful response. We expect that many plans would check multiple boxes and CMS would not be able to determine which form of targeting is primary for each plan. We recommend:

- Directing plans to rank order identification methods from most to least prevalent or to use some other metric such as percentage of enrollment from various sources.
- Ranking the 4 different identification methods included in question C2(1)

- Dividing C2 (2) into 2 separate questions (passive enrollment vs. marketing to other MAO plans) so that CMS can specifically track the number of dual beneficiaries enrolled via passive enrollment. The Alliance believes it is very important to be able to compare “passive enrollment” plans with other plans on a number of levels and to track the experience and evolution of these plans over time.

SECTION D: SERVICES FOR MEMBERS WITH SPECIAL NEEDS

This section of the survey is most relevant to clinical programs and services and should tell CMS how SNPs are different from “standard” MA plans and what special approaches and interventions they will employ to address the special needs of their targeted high-risk population. The issues being addressed are extremely important and warrant greater clarification so that the data produced tells a meaningful story. Below are some specific suggestions for enhancing the data collected from this section of the survey and CMS’ ability to evaluate the output.

D1. Identifying Enrollees Needing Special Services. Most plans are likely to use multiple forms for identifying members who need special services. It would be helpful to further differentiate the responses to these options. For example, screening or assessment instruments may be administered at enrollment OR based on some other trigger identified by the plan. It would be more informative to ask plans to identify when screening surveys and clinical assessments are used; what type of instruments are used; who administers the surveys/assessments (nurse, social worker, therapist); whether the surveys are mail or telephone surveys, etc. Also, it is likely they would use different methods for different functions—they might use one type of screening for disease management and another type for medical case management or they might use screens to determine if the person needs disease management vs. complex care management.

D2. Member Management Functions. Care coordination, case management, care management, disease management are often used interchangeably. This line of questioning is much too important to leave open ended. We recommend that CMS either offer a generally accepted definition of each function or ask the plans to define these functions in their own terms so that the responses are aggregated on an apples-to-apples basis across plans. Then, eliminate question D4 which asks what the plan calls the service.

D3: Meeting Special Needs. We recommend including some options for plans to select relative to helping beneficiaries “get those needs met.” For example:

- a. Plan provides/arranges access to the following special services (check all that apply):
 - Specialty Pharmacy Management (ask plan to define)
 - Wound Care
 - Home and Community-Based Waiver Services
 - Medical Transportation
 - Fall Clinics
 - AODA programs
 - Other (ask plan to describe)

D5. Lead Health Professionals by Management Function. The type of health professional responsible for care coordination, case management and disease management is likely to vary according to the function. For example, social workers might do DM and advance practice nurses might do case management. We suggest a chart to better differentiate these functions:

D6: Staffing Ratios for Management Functions. FTEs should be identified for specific populations and functions; e.g., plans may need more FTEs per caseload for case management than disease

management. In addition, disproportionate SNPs should report the FTEs for the SNP target population, not across all plan enrollees. We also recommend that CMS ask plans to identify the percentage of beneficiaries that receive care coordination, case management and/or disease management. We recommend using a chart to collect these statistics.

Function	Components (Describe)	% Receiving	FTEs	Accountable Party					
				PCP	APN	RN	LPN	Social Work	Therapist
Care Coordination									
Case Management									
Disease Management									

D7: Primary Responsibilities: It would be helpful to better differentiate these functions by staff. Which staff are responsible for which tasks (e.g., managing transitions between care settings) and in relation to which functions (e.g., care coordination versus disease management). It also would be helpful to prioritize these tasks in relation to function. For example, health education is likely to be a principle function for disease management but may be less relevant to complex medical management. Also, monitoring, health education and other activities may be part of the three key “management functions” but the activities may vary by function as well as who carries out the activities.

We also recommend adding an additional item under D7 related to “serving as liaison to family members”

SECTION E: USE OF TECHNOLOGY:

General Points:

- SNP Alliance Medical Directors recommended clarifying the locus of use for the technology, e.g., physician office use vs. care management staff monitoring of community-based enrollees.
- **New:** Add a new question to identify whether multiple providers have access to the same medical record and, if so, which providers.

E9: Care Process Data. We recommend adding several process of care measures related to complex chronic care management such as asking plans to identify if they monitor continuity of care, safe and effective care transitions, adverse drug interactions, etc. and if so, what specific process measures they use. We recommend using the SNP Alliance Quality Domains for further guidance in this area (Attachment C).

E11: Outcomes Data: We recommend greater specificity on outcomes data:

- hospitalization *and* rehospitalization rates for ambulatory care sensitive conditions,
- ER visits for ambulatory care sensitive conditions
- Nursing home admission rates for nursing home certifiable beneficiaries
- Medication errors
- Proxies for frailty; e.g.
 - ✓ ADL/IADL impairments

- ✓ Weight loss
- ✓ Gait speed or other endurance measures

SECTION F: DUAL ELIGIBLES

General: This section should not be limited to Dual SNPs. All SNPs serve dual eligibles and all SNPs should fill out this section.

F1, 2, 3: Special Needs. These sections should not be limited to dual SNPs. CMS should collect similar data for all three SNP categories. Question F1 should be repeated for institutional SNPs and for SNPs serving those with severe or disabling chronic conditions. Follow up questions should be included on the most important special needs (F2) and how the plan intends to address the special needs (F3) for the institutionalized and chronically ill, not just for duals.

SECTION G: DUAL SNPS WITH MEDICARE AND MEDICAID MANAGED CARE CONTRACTS

General:

- This section should apply to all SNPs that have Medicare and Medicaid managed care contracts, not just dual SNPs.
- New questions should be added:
 - ✓ Is your plan be interested in pursuing an integrated approach to financing and oversight for Medicare and Medicaid services?
 - ✓ What do you see as the greatest barriers to financial integration?
 - ✓ What do you see as the greatest barriers to administrative integration?
 - ✓ Has Pt. D cost-sharing affected your beneficiaries' access to needed medications or compliance with prescribed drug regimens?
 - ✓ Did your pharmacies waive the cost-sharing at point of service for duals that could not pay the \$1 and \$3 copays?
 - ✓ Did your plan reduce supplemental benefits in order to allocate more rebate dollars to the Part D benefit?
 - ✓ Was your plan premium covered by the low-income drug subsidy?

Attachment B

Moderator Guide for Beneficiary Focus Groups

SECTION B: PARTICIPATION AND AWARENESS OF PLAN MEMBERSHIP

- Add a question about whether beneficiaries were previously enrolled in a Medicare Advantage plan as a benchmark against which to evaluate their expectations about differences in SNP services and their response to satisfaction with SNP special services.

SECTION C: DECISION TO PARTICIPATE

- **Question 4:** Why did you enroll? We think it would be helpful to identify some examples of why people may have enrolled to help evaluate the importance of specialized services to their decision; e.g.: enrollment was triggered by:
 - ✓ Special services offered
 - ✓ Recommendation of a trusted physician
 - ✓ Recommendation of a family member or trusted adviser
 - ✓ General affiliation with enrollee’s medical group or hospital
 - ✓ Geographic location
 - ✓ Superior drug benefit
 - ✓ Desire to meet specific special need – ESRD, CHF, general frailty or overall medical complexity

SECTION D: AWARENESS AND USE OF PLAN BENEFITS

Below are some comments on the questions in Section D. Please note that in some cases we are recommending edits to questions with specific language proposed. In these cases, we underline the words or phrases we recommend adding.

Question 3: Which of these special services have you used? Did a social worker, nurse practitioner or nurse help you access these services? Did a nurse, social worker or nurse practitioner provide you with extra help?

Question 4: Have you tried to use any of these services but were unable to do so? Has the plan provided extra help for you with your medical concerns? What happened?

Question 5: This question may offer insights into care coordination or care management functions performed by plan, but should not be not seen as an expectation, or indicator of quality.

Questions 3, 4 and 5 will offer insights into a plan’s “management functions” -- care coordination, care/case management, and disease management. We think it would be a good idea, however, to separate questions on “special services” like dental or personal care from questions on the management functions. We think it would be useful to add a few specific questions about care management, care coordination and disease management and perhaps ask beneficiaries if they are familiar with these terms and what they mean (see underlined questions below). The list of services under question 2 are “direct” or hands-on services that people can “see and feel.” The “management” services are about identifying need, evaluating options, arranging access to services, monitoring treatment plans and outcomes, etc. We think these services might not be as apparent to beneficiaries or considered “special services” to them. We have found in talking to a number of demos that it isn’t necessarily the care management functions that professionals value that attract a consumer to these demos – but rather it’s the services they can see and feel (e.g., personal care, generous pharmacy benefits, etc.). The value of “management” services can’t be

very well or completely assessed by the recipient, since the goal is not to “please” that person, but to provide better care. But we think it is important to understand what beneficiaries are aware of receiving from a plan and, ideally, whether they note a difference from prior experiences.

New Questions on Care Coordination/Management and Disease Management:

- Do you know who your care manager is and how to contact this individual if you have a problem?
- Did your plan evaluate your health care problems?
- Did they tell you what kind of services were available to help with your health conditions or concerns?
- Did they help arrange these services for you?
- Does your plan call you routinely to monitor a particular health care condition like diabetes or heart disease?

Question 6: What types of plan services do you use most? What services do you value most? Has the plan improved your health care? How?

SECTION E: SATISFACTION WITH PLAN BENEFITS

- **Question 2: Comparing SNP Care to Prior Experience:** We recommend defining “preventive care” and adding questions that are more targeted to the special needs of enrollees; e.g.:
 - ✓ Are the services more responsive to a specific condition or disease?
 - ✓ Do the plan and its providers do a better job coordinating care among all your different doctors and providers and helping you manage your prescription drugs?
 - ✓ Are the disease management or care management services different from those received from previous health plans?
 - ✓ Do you receive care from different types of professionals?
 - ✓ Does the plan promote greater involvement of your loved ones in meeting your care needs?
 - ✓ How does your overall experience with this plan differ from other Medicare plans or when you received original Medicare benefits?

Attachment C

Proposed Domains and Quality Indicators for Special Needs Plans

“The goal of medical care for the elderly has progressed beyond survival to maximizing quality of life, yet little attention has been paid to the overall quality of medical care that older people receive. In fact, existing measures of quality or health status are often inappropriate for the elderly.”

Rand Health

The Medicare Modernization Act of 2003 established Medicare Advantage Special Needs Plans (SNPs) to serve high-risk beneficiaries including those who are permanently institutionalized, dually eligible for Medicare and Medicaid and those with severe or disabling chronic conditions. The quality domains listed below were identified by the National Alliance of Specialty Healthcare Programs through a consensus process based on the experience of medical directors of plans specializing in programs for frail elders and adults with disabilities. Each domain includes a brief goal statement and recommended quality indicators related to the goals. These measures are intended as a framework for performance measurement that more appropriately reflects the health care needs of vulnerable, high-risk beneficiaries with multiple chronic conditions and complex medical problems.

1. **End of life care:** To enhance comfort and improve the quality of an individual’s life during the last phase of life.

Preliminary Quality Indicators:

- *Comprehensive advanced care planning is carried out, with evidence that:*
 - ✓ *advance directives have been reviewed and signed;*
 - ✓ *conditions, trajectory of diseases and treatment options have been discussed;*
 - ✓ *treatment and care plans are modified as conditions evolve or circumstances change.*
- *Palliative care is provided in setting of choice.*
- *A comprehensive palliative care plan is developed that includes, but is not limited to, pain management, symptom control and access to appropriate supportive services.*

2. **Continuity of care:** To ensure coherent, consistent and connected collective performance among patients and family caregivers and primary, acute and long-term care providers in addressing the needs and interests of individuals as their conditions evolve over time and across care settings.

Preliminary Quality Indicators:

- *An identified individual health professional or team member with primary responsibility for care management/care coordination across settings.*
- *Demonstrated evidence of interdisciplinary care teams and collaboration.*
- *Individual care plan shared by all care providers involved in the patient’s care.*
- *The ability of the beneficiary or his/her family caregiver to identify and name their primary care manager, or contact, and know how to access them.*

3. **Safe and effective care transitions:** To ensure that people move safely and easily from one place to another, from one level of care to another, and/or from one health care practitioner to another.

Preliminary Quality Indicators:

- *A member of the health care team sees or communicates with the patient or informal caregiver within 72 hours of discharge to a new care setting.*
- *A review of patient medications will be conducted within 24 hours of discharge.*
- *A member of the health care team facilitates communication between providers in a timely manner to ensure safe and effective care transitions.*
- *If a member is discharged from a hospital to home and has received a new prescription medication or a change in medication before discharge, then the outpatient medical record should acknowledge the medication change in a timely manner.*
- *If a member is transferred between emergency departments, acute care facilities, and/or long-term care facilities, or from one of these entities to another, then the medical record at the receiving facility should include medical records from the transferring facility or should acknowledge transfer of such medical records.*

4. **Functional independence:** To optimize the ability to perform self-care, self-maintenance and physical activity, including addressing issues of disability, impairment, and/or frailty.

Preliminary Quality Indicators:

- *Plans screen all members to identify risk of impairment in physical and cognitive functioning and have triggers in place regarding the need for comprehensive assessments.*
- *Health plans have policies for timing of assessments of physical and cognitive functioning which include appropriate triggers for reassessment.*
- *Health plans have capacity to conduct home safety evaluations in relation to physical functioning and triggers for when such assessments are appropriate.*
- *Health plans have a process for maximizing functional independence.*

5. **Member choice and quality:** to ensure consumer satisfaction as measured by consumer defined goals.

Preliminary Quality Indicators:

- *To ensure that individual care plans include consumer-defined goals, beneficiaries and/or their caregivers participate in the development of their treatment goals and care plans.*
- *An annual assessment of member and caregiver satisfaction is conducted.*

6. **Medication management;** to optimize compliance and drug performance and minimize adverse drug events, with particular regard for polypharmacy issues.

Preliminary Quality Indicators:

- *Health plans conduct an initial assessment of overuse, underuse, and inappropriate use of medications, reassess medication management at least annually and have triggers for conducting reassessments at other times, as appropriate.*
- *Health plans have a system in place to track and address medication errors.*
- *Health plans have a process for identifying and addressing non-compliance with medications.*
- *Principal care team, all physicians' outpatient records and hospital medical records should have current record of all patient medication.*
- *Health plans have a process for monitoring adverse drug events and the effects of polypharmacy.*

7. **Population Specific Medical Conditions:** to effectively manage falls, incontinence, dementia/delirium, incontinence, pain, pressure ulcers, osteoporosis, and other syndromes unique to special needs beneficiaries.

Preliminary Quality Indicators:

- *Health plans have a process for:*
 - ✓ *monitoring and identifying population-specific medical conditions for high-risk populations, with a focus on disease and disability prevention;*
 - ✓ *assessing and stratifying risk levels and developing appropriate interventions for disease and condition management relative to risk -- from patient education to aggressive treatment plans; and*
 - ✓ *evaluating outcomes of high-risk screening and assessment and treatment protocol and employing continuous quality improvement approaches to further enhance outcomes.*
- *All persons 75 or older and those at risk of falls should have documentation that they were asked at least annually about the occurrence of falls and treated for related risks, as appropriate (ACOVE).*
- *All females age 75 and older and those at risk of osteoporosis should be counseled about osteoporosis risk and pharmacologic prevention at least once.*
- *“Health plans should develop and/or implement population-specific preventive and treatment guidelines”*

8. **Management of multiple and/or co-morbid conditions:** to develop a multidimensional, integrated approach to medical and health care management, including special tools and the integration and adaptation of disease-specific guidelines, to address the interactive effects of multiple chronic conditions and associated health-related challenges of serving people with serious chronic conditions such as complex diabetes, hypertension, congestive heart failure, asthma, chronic lung disease, chronic depression, chronic renal failure, spinal cord injury, multiple sclerosis, fibromyalgia, and cerebral palsy.

Preliminary Quality Indicators:

- *Health plans account for the presence of comorbidities during the screening and assessment processes.*
- *Health plans adapt evidence-based guidelines and best practices for individual diseases in relation age, comorbid conditions, functional limitations, member goals and preferences and other variables affecting special needs beneficiaries’ ability and/or willingness to respond to traditional clinical protocols and approaches.*
- *Health plans develop individual care plans that account for comorbid conditions and other factors that affect traditional treatment approaches.*

9. **Mental illness/behavioral:** to optimize a person’s health and well being, with recognition of chronic depression, Alzheimer’s disease, schizophrenia, AODA and other mental illnesses as a primary and/or as a co-morbid condition in addressing other acute and/or chronic conditions.

Preliminary Quality Indicators:

- *Plans have a system in place to identify members at risk for behavioral health issues and have triggers in place regarding the need and timing for comprehensive assessments and re-assessments*
- *Appropriate members of the health care team conducts a comprehensive assessment of a member’s behavioral health issues and integrates findings into the individual’s plan of care.*
- *Health plans develop and implement appropriate protocols and programs for effective behavioral health management and integrate health and behavioral interventions into beneficiary care plans.*

10. **Family Caregiver Support:** *to recognize the critical role of family caregivers as part of the care team, integrate their support into member care planning and provide support and education that enhances their effectiveness as part of the care team. (Added to the prior list of indicators.)*

Preliminary Quality Indicators

- *Health plans have a process for:*
 - ✓ *HIPAA-compliant routine communication with family and informal caregivers;*
 - ✓ *including them in the care planning process, consistent with patient capabilities and preferences;*
 - ✓ *assessing the needs of the family/ informal caregiver; and*
 - ✓ *providing family/informal caregivers the type of education, training and support they need to be an effective part of the informal caregiving team.*
- *Members of the health care team spend adequate time with patients, treat them with respect and explain information to members and their informal caregivers in a manner that is understandable to them.*