II. SNP Guidance

A. Model of Care

42 CFR 422.101(f) - CMS 4138-IFC

Effective date: January 1, 2010

In the 2009 Call Letter, CMS discussed its requirement that Special Needs Plans (SNP) have a model of care (MOC), namely, a structure and process by which they delivered healthcare services and benefits to the special needs individuals they elected to target. We emphasized that, as MA plans, we expected all SNPs to offer coordinated care delivered by a network of providers who had the clinical expertise to meet the target population’s specialized needs, and who did not discriminate against its most vulnerable beneficiaries. The Call Letter guidance substantively fleshed out the SNP MOC architecture by describing eight components designed to support service delivery for special needs individuals. These components included:

1) Goals and objectives pertinent to the plan’s targeted special needs beneficiaries
2) Comprehensive risk assessment using a risk assessment tool
3) Specialized provider network
4) Care coordination
5) Service delivery system including protocols and out-of-network specialists
6) Communication and accountability system
7) SNP training for network providers
8) Performance measurement and improvement activities

The Call Letter also indicated that we would review the SNP MOC during regularly scheduled MA organization audits.

MIPPA added new specific statutory requirements pertaining to a SNP MOC. Beginning January 1, 2010, all SNPs must not only have an evidence-based care model with specialized providers, but must also have care management services that add the following components:

1. A comprehensive initial health risk assessment and annual reassessment of the physical, psychosocial, and functional needs of the special needs individual;
2. A care plan for each beneficiary that addresses goals and objectives, services and benefits provided, and measurable outcomes; and
3. An interdisciplinary team used in the care management of each beneficiary.
In the preamble of CMS 4138-IFC, we briefly discussed these new MIPPA requirements and are expanding our guidance in this compendium. First, SNPs are responsible for implementing an evidence-based MOC, a requirement which can be accomplished in several ways. Many existing SNPs have either a Medical Director or medical advisory committee who can monitor peer-reviewed medical journals and infuse research-supported systems and practices into its care management model. SNPs can contract with providers who use nationally-recognized clinical protocols developed by professional medical specialty societies or federally financed research scientists (see National Guideline Clearinghouse, Agency for Healthcare Research and Quality, at http://www.guideline.gov/). SNPs can also contract with providers who are accredited by nationally recognized quality and healthcare safety accreditation organizations whose standards assure evidence-based practice. Regardless of what approach is taken, SNP management must be able to articulate how this requirement is met and measure the extent to which evidence-based care management is ongoing.

Secondly, MIPPA is requiring that SNPs not only conduct an initial comprehensive health risk assessment, but also a comprehensive annual reassessment. The health risk assessment includes a medical, psychosocial, cognitive, and functional assessment that guides care management and accounts for health status changes. We expect the initial risk assessment to be conducted within ninety (90) days of enrollment and the annual risk assessment to be done within 12 months of the last risk assessment. Special needs individuals are likely to have labile health status and need more frequent assessments; consequently, annual reassessment should be adjusted to coincide with health status changes, not a fixed schedule tied to the initial assessment date.

Finally, MIPPA mandated an individualized care plan and an interdisciplinary care team for the care management of each beneficiary. The care plan must include essential care management elements such as goals and objectives, standard and specialized services and benefits that meet the specialized needs identified in the initial and subsequent risk assessments, and measurable outcomes that enable the SNP to determine the effectiveness of the care management plan. The care plan should reflect a stratification of needs matched to services and benefits in which the most vulnerable and sickest beneficiaries receive care proportionate to their increased needs. SNPs have latitude in determining the composition of the interdisciplinary care team for each beneficiary. They may adopt a standard team construct or consider each beneficiary’s risk assessment results to develop a unique team. For example, a chronic condition SNP may adopt a standard interdisciplinary care team modeled on a disease management paradigm and composed of a primary care provider, clinical pharmacist, nurse educator, and disease-specific medical specialists. An institutional SNP having institutional equivalent beneficiaries living in the community may have an interdisciplinary team comprised of a geriatrician, clinical pharmacist, discharge-planning nurse, restorative therapist, and geriatric psychiatrist. SNPs may also consider having other interdisciplinary team members be social workers, pastoral counselors, or caregiver/family members. Regardless of how the care team is developed, the SNP must design its teams to meet this MIPPA requirement, and must measure the effectiveness and extent to which each beneficiary’s care is managed by an interdisciplinary care team.