



**Special Needs Plans  
Models of Care**

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December 7, 2010



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**Presentation Overview**

- ◆ Background on Special Needs Plans (SNPs)
- ◆ Quality Improvement for SNPs
- ◆ Models of Care (MOC)
- ◆ Impact of the Affordable Care Act
- ◆ Closing Remarks



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**BACKGROUND**



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### Background

- Special Needs Plans (SNPs) were created by the Medicare Modernization Act of 2003 (the MMA)
- SNPs are Medicare Advantage (MA) plans authorized by the MMA to limit enrollment to 3 specific vulnerable populations:
  - Chronic Condition (C-SNP)
  - Dual Eligibles (D-SNP)
  - Institutional (I-SNP)



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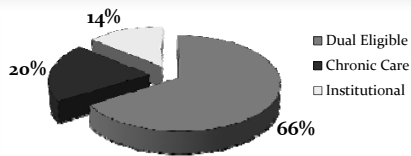
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### 2011 SNP Break Down



Percentage of SNP Types



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### Background (cont'd)

- SNPs were mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to have a Model of Care (MOC) that included:
  - Care management protocols
  - A specialized provider network
  - Evaluation methodology that ensures that the procedures developed are effective



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**Conditions for C-SNPs**

- ◆ Chronic alcohol and other drug dependence
- ◆ Autoimmune disorders
- ◆ Cancer
- ◆ Cardiovascular disorders
- ◆ Chronic heart failure

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**Conditions for C-SNPs (cont'd)**

- ◆ Dementia
- ◆ Diabetes mellitus
- ◆ End-stage liver disease
- ◆ End-stage renal disease requiring dialysis
- ◆ Severe hematologic disorders

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**Conditions for C-SNPs (cont'd)**

- ◆ HIV/AIDs
- ◆ Chronic lung disorders
- ◆ Chronic and disabling mental health conditions
- ◆ Neurological disorders
- ◆ Stroke

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# QUALITY IMPROVEMENT



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## SNP Quality

- ◆ Assessed through specific methods and/or tools
- ◆ Goal is to improve the health outcomes for the patient



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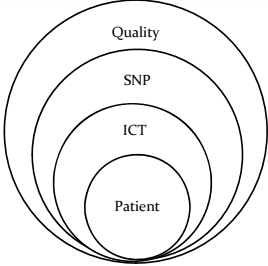
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## Quality is Multidimensional



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**Quality Improvement (QI) Program**

- QI Program Plan
  - Chronic Care Improvement Program (CCIP)
  - Quality Improvement Projects (QIPs)
  - Performance Measures
  - Health Information System
  - Program Review
  - Remedial Actions
- Care Coordination Plan
- Model of Care (MOC)

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**MODELS OF CARE**

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**Model of Care Elements**

- Description of SNP-specific Target Population
- Measureable Goals
- Staff Structure and Care Management Roles
- Interdisciplinary care team (ICT)
- Provider network having specialized expertise and use of clinical practice guidelines and protocols

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**MOC Elements (cont'd)**

- MOC training for personnel and provider network
- Health risk assessment
- Individualized care plan
- Communication network
- Care management for the most vulnerable subpopulations
- Performance and health outcome measurement

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**MOC ELEMENT  
COMPARISON**

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**Description of SNP-Specific Target Population**

**C-SNP**



- Provides special care to the SNP's beneficiaries having severe or disabling chronic conditions

**D-SNP**

- Provides specialized care to the Dual eligible population by combining the benefits available through Medicaid and Medicare

**I-SNP**

- Provides specialized care to the SNP's institutionalized beneficiaries living in the community but requiring an institutional level of care

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**Measurable goals specific to the target population of the SNP**

C-SNP



- For example: retina exam compliance for diabetes chronic SNP

D-SNP

- For example: improving access to preventive health services

I-SNP

- For example: reductions in falls, pressure ulcers, etc.

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**Adequate staff structure with care management roles, including employed and contracted personnel**

C-SNP



- SNP team's roles perform clinical and non-clinical functions required to support diabetic patients
  - For example: NP educates beneficiaries on disease process to manage uncontrolled blood sugars, wounds, high LDL levels

D-SNP

- SNP uses clinical and non-clinical staff to implement effective care management
  - For example: a benefit liaison who coordinates Medicare and Medicaid benefits and fields questions

I-SNP

- SNP team's roles focused to assure members receive necessary services in their own environment
  - For example: on-site visits by NP, frequent communication with member's family by social worker

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**Interdisciplinary Care Team (ICT)**

C-SNP



- A diabetic SNP team could include: Endocrinologist, NP, Ophthalmologist, Podiatrist, Dietician, Orthotic provider, wound care

D-SNP

- Core team could include: PCP, NP, Social Worker, Pharmacist, house call provider, Geriatrician

I-SNP

- Geriatrician, NP, Physical Therapist

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### Provider network has specialized expertise

**C-SNP**



- SNP ensures that all critical provider specialties are under contract to meet needs of target population

**D-SNP**

- SNP maintains network of providers who participate/ provide both Medicare and Medicaid services.

**I-SNP**

- SNP maintains network that specialize in institutional care to the elderly in nursing facilities

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### MOC Training for Personnel and Provider Network

**C-SNP**



- Training focused on SNP's specific disease condition (Diabetes, HIV/AIDS) and potential co-morbidities

**D-SNP**

- Training focused on how providers can better integrate Medicare and Medicaid services

**I-SNP**

- Training focused on preventing pressure ulcers or further disabilities

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### Health Risk Assessment

**C-SNP**



- Assesses the disease and identifies any co-morbidities

**D-SNP**

- Assesses how well the member's medical needs are being met and focuses on preventing further deterioration member's medical condition

**I-SNP**

- Assesses on-going need for long term care and prevention of pressure ulcers and falls for example

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### Individualized Care Plan

**C-SNP**



- Individualized care plans using Clinical Care Advance system
- Regular assessments ensure appropriate care plans

**D-SNP**

- Individualized, disease specific, functional and psychosocial
- Based on evidenced based guidelines

**I-SNP**

- Upon enrollment each member selects a PCP
- PCP and Care Coordinator develop a care plan

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### Communication Network

**C-SNP**



- Dedicated telephone network provides instant clinician communication
- Dedicated network for access to health information

**D-SNP**

- Network consists of Electronic tools (web-based access)
- Medical record

**I-SNP**

- Primary communication tool is electronic medical record
- Other traditional communication tools also utilized

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### Care Management for the Most Vulnerable Subpopulations

- SNPs must develop care management systems and tools to ensure the best care for their most vulnerable populations.
  - C-SNP
    - ▶ Requires care management systems to focus on chronic illnesses and co-morbidities
  - D-SNP
    - ▶ Requires integrated care management focusing on the most vulnerable duals including frail and/or disabled
  - I-SNP
    - ▶ Requires care management to improve quality of life and maintain highest possible functional status

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### Performance and Health Outcome Measurement

- C-SNP
  - HEDIS: Care for older adults for medication review
  - Structure and Process: SNP 1 Complex Case Management
- D-SNP
  - HEDIS: Care for older adults for functional status
  - Structure and Process: SNP 6 Coordination of Medicare and Medicaid
- I-SNP
  - HEDIS: Care for older adults for pain screening
  - Structure and Process Measure: SNP 5 Institutional SNP Relationship with Facility


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### SNP MOC Focused Review

- CMS is currently conducting a focused review of 13 SNPs and their models of care.
- Goals of the Review:
  - Determine SNP best practices
  - Benchmark SNPs against these standards
- Objectives of the Review:
  - Conduct an on-site review
  - Document the process and outcomes witnessed
  - Identify best practices
  - Identify challenges with the process


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### SNP MOC Focused Review

- The focused reviews of the 13 SNPs will be completed in early December 2010
- A final report on these reviews is due by the end of December 2010
- CMS will share the results of these reviews with the industry in early 2011


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**SNP MOC Focused Review Next Steps**

- In 2011 CMS intends to conduct additional focused reviews of SNP MOCs
- Review will include all type of SNPs and be conducted nation-wide



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**Impact of  
The Affordable Care Act  
and  
Proposed Regulatory Changes  
on  
Special Needs Plans**



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**The Affordable Care Act and SNPs**

- ◆ Overview of SNP Specific Provisions:
  - Extension of SNP Authority
  - State Medicaid Contract Requirements
  - Fully Integrated Dual Eligible SNPs
  - Frailty Adjustment Payments
  - C-SNP Risk Score Methodology
  - NCQA Approval



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**Extended SNP Authority**

- § 3205 of the Affordable Care Act
- Extends the authority for SNPs to restrict enrollment to special needs individuals
- Permits SNPs to continue to limit enrollment to special needs individuals through 2013
  - Exception: DE-SNPs without State Medicaid contracts

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**State Medicaid Contracts**

- § 3205 of the Affordable Care Act; 42 CFR § 422.107
- Extends the provision found in § 164 of MIPPA
- Allows existing DE-SNPs to operate in their existing service area without contracts with State Medicaid Agencies through Dec. 31, 2012
  - New DE-SNPs and DE-SNPs seeking a Service Area Expansion must have a contract with the State Medicaid Agencies in the States in which their plans operate

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**Proposed Definition of Fully Integrated Dual Eligible SNPs**

- § 3205 of the Affordable Care Act; 42 CFR § 422.2
- FIDE-SNP proposed definition:
  - Enrolls special needs individuals entitled to Medicaid
  - Provides dually-eligible beneficiaries Medicare and Medicaid benefits under a single MCO
  - Has a capitated contract with the State Medicaid Agency for primary, acute, and long term care
  - Coordinates care through a aligned care management and specialty networks
  - Coordinates & Integrates Member Materials

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### Proposed Frailty Payment for FIDE-SNPs

- § 3205 of the Affordable Care Act; 42 CFR § 422.308
- Allows for the PACE frailty payment to be applied to SNPs that:
  - Meet FIDE-SNP requirements
  - Have similar average levels of frailty to PACE organizations
    - ▶ This methodology will be specified in the Advance Notice & Rate Announcement

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### Improved Risk Scores to Reflect C-SNP Enrollees' Chronic Health Conditions

- § 3205 of the Affordable Care Act; 42 CFR § 422.308
- Effective 2011, revised risk adjustment methodology for C-SNPs to account for known underlying risk profile and chronic health status, including:
  - Higher medical and care coordination costs associated with frailty; multiple comorbid, chronic conditions; and individuals with diagnosed mental illness
  - Higher costs associated with high concentrations of these conditions
- This revised risk score is to be used instead of the default MA score.

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### National Committee for Quality Assurance (NCQA) Approval

- § 3205 of the Affordable Care Act; 42 CFR § 422.4; 42 CFR § 422.101; 42 CFR § 422.152
- Effective January 1, 2012 all SNPs must be approved by the NCQA
- All new and existing SNPs must submit their Quality Improvement (QI) Program description and Models of Care (MOC) as part of the application process to operate in 2012




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### NCQA Approval (Continued)

- CMS is considering a 1 – 5 year approval based on SNPs' scores:
  - Higher scores would equal a longer approval period
  - Guidance on scoring will be forthcoming in an HPMS memo
- NCQA Approval Timeline:
  - CY 2012 MA Application/SNP Proposal posted January 4, 2011
  - Industry Training for SNPs during the early part of January 2011
  - CY 2012 MA Application/SNP Proposal Due February 24, 2011



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### CLOSING REMARKS



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### CMS Contacts

- ◆ For questions about SNPs you may send an email to:
  - Email CMS SNP\_Mail@cms.hhs.gov



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