2008 Special Needs Plan Chronic Condition Panel
Final Report

Background

In July 2008, Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (P.L. 110-275) which restricted enrollment in chronic condition Special Needs Plans (CC-SNPs) to special needs individuals that "have one or more co-morbid and medically complex chronic conditions that are substantially disabling or life-threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care." MIPPA further mandated Center for Medicare and Medicaid Services to convene a Panel of clinical advisors to determine the SNP-specific chronic conditions that met the statutory definition of severe or disabling. Congress stipulated that the Director of the Agency for Healthcare Research and Quality (AHRQ) be a member of the Panel.

Time Line

Center for Medicare and Medicaid Services had a restrictive time frame in which to convene and conclude the work of the Panel in order to disseminate implementation guidance by November 18, 2008, to Medicare Advantage organizations (MAOs) interested in offering MIPPA-defined CC-SNPs in 2010. Center for Medicare and Medicaid Services was committed to engaging the public – industry, advocates, beneficiaries, and medical professional societies – in the discussion about appropriate SNP-specific chronic conditions. However, the tight time line precluded the invocation of the statutory process for convening a Panel that would seat non-Federally employed clinical advisors. In the interest of achieving an expeditious determination of SNP-specific chronic conditions, Center for Medicare and Medicaid Services scheduled an Open Door Forum on September 10, 2008, to solicit oral public comments, and maintained a dedicated electronic mailbox for written public comments from September 10 through October 10, 2008. Center for Medicare and Medicaid Services concurrently recruited chronic condition experts from the Agency for Healthcare Research and Quality, the Center for Disease Control and Prevention, and Center for Medicare and Medicaid Services to serve as Panelists and act on behalf of the public commenters (see Attachment A – SNP Chronic Condition Panel Members). The ultimate goal was to conduct the Panel, publish the SNP-specific chronic conditions adopted by the Secretary, and disseminate industry guidance by November 18, 2008, in time to inform applicant decisions when submitting Notices of Intent to Apply for the 2010 contract year.

Convening the SNP Chronic Condition Panel

The 2008 SNP Chronic Condition Panel met on October 1, 2008, for the first of its two sessions. The Panelists reviewed and discussed the written public comments from 87 stakeholders representing the industry, advocacy groups, medical societies, and beneficiaries. They also examined the chronic conditions already covered by existing CC-SNPs. Additionally, they employed their collective national and international experience with chronic condition research and clinical practice to weigh other pertinent chronic conditions. To guide their discussion, they employed the following criteria:

- The Panelists assured that each SNP-specific chronic condition met the MIPPA mandated definition of severe or disabling, i.e., medically complex, substantially disabling or life-threatening, high risk of hospitalization or other adverse outcomes, and needing a specialized delivery system across care domains. They purposefully scrutinized whether each chronic condition could be comparably served in a general market Medicare Advantage plan, or

whether the condition was sufficiently severe or disabling to warrant the specialized care management afforded in a CC-SNP. Specifically, they weighed conditions in which beneficiaries were likely to have chronic exacerbations requiring specialized medical care and coordination of services across ambulatory, long-term care, and home care domains as well as among primary, specialty, and ancillary providers.

- The Panelists also considered the condition's prevalence in the Medicare community, a factor that potentially would affect the capacity of an MAO to attract eligible enrollees and be viable in a given service area. The Panelists were sensitive to the reality that CC-SNPs require sufficient disease prevalence and access to a specialized provider network within the marketable service area to manage risk under a capitated payment system (albeit risk-adjusted), and effectively and efficiently serve the targeted special needs beneficiaries.

- The Panelists reflected on the need for beneficiaries, healthcare practitioners, and the healthcare industry to recognize the SNP-specific chronic conditions and consider them appropriate for a specialized service delivery system in order to stimulate participation.

- Finally, the Panelists were cognizant of the MIPPA mandate that SNPs develop and implement models of care that are evidence-based. Center for Medicare and Medicaid Services additionally required SNPs to assure that their providers use nationally-recognized clinical practice guidelines and protocols whenever feasible. The Panelists attempted to recommend SNP-specific chronic conditions that are highly likely to have nationally recognized protocols and guidelines to support evidence-based care management.

The Panel was not charged with and did not make judgments based on business considerations (i.e., the potential profitability of the selected chronic conditions) as Center for Medicare and Medicaid Services expects interested Medicare Advantage organizations to reach their own conclusions about the products and markets in which they wish to operate, and to file applications accordingly.

Recommendations to Center for Medicare and Medicaid Services

On October 16th, the Panel conducted its second and concluding session. The Panelists reviewed and discussed additional public comments received subsequent to their initial session. They reexamined the applicability of the inclusion criteria to the universe of proposed chronic conditions, and unanimously recommended fifteen SNP-specific chronic conditions to the Administrator for consideration by the Secretary (see Attachment B, SNP-specific Chronic Conditions; and Attachment C, 2010 SNP Chronic Condition Inclusion Criteria Table).

Although the breadth of public comments indicated there was great interest in the Panel's deliberations and a far-reaching impact on Medicare-eligible beneficiaries, the Panelists emphasized that their recommendations were **SNP-specific chronic conditions**, and not meant to be generalized beyond the intent of this Congressional mandate to clarify eligibility for a particular coordinated care plan benefit package. They also acknowledged that the present recommendations should be re-evaluated at the Secretary's discretion as Center for Medicare and Medicaid Services gathers evidence of the effectiveness of care coordination through the SNP product, and healthcare research demonstrates advancements in chronic condition management.

Attachment A - SNP Chronic Condition Panel Members

Jeffrey Kelman, M.D., Chairperson **Center for Medicare & Medicaid Services**

JEFFREY A. KELMAN, M.D., is the Chief Medical Officer for the Center for Drug and Health Plan Choice at the Centers for Medicare & Medicaid Services. Dr. Kelman received his A.B. in 1969 and M.M.Sc. in 1971 from Brown University and his Doctorate of Medicine in 1973 from Harvard Medical School. He is board certified in Internal Medicine, Pulmonary Medicine, Geriatrics, and Medical Direction LTC. Dr. Kelman trained at The Peter Bent Brigham Hospital and the National Heart, Lung, and Blood Institute of the National Institutes of Health. He served as Medical Director for Collington Episcopal Life Care Center, and as Senior Medical Consultant, Congressional Budget Office, before joining Center for Medicare and Medicaid Services.

Mary Barton, M.D. * **Agency for Healthcare Research and Quality**

MARY BARTON, M.D., MPP, is Scientific Director of the United States Preventive Services Task Force (USPSTF) at the Agency for Healthcare Research and Quality (AHRQ). Her responsibilities include supporting and providing oversight for the methodologic, evidence review, and recommendation-making work of the USPSTF and Evidence-based Practice Centers upon whose work the Task Force relies and overseeing the team of medical officers whose work supports the USPSTF. In addition, she leads the Clinical Services team within AHRQ's Prevention and Care Management Portfolio. Dr. Barton is an internist who received an M.D. from Harvard University as well as a Masters in Public Policy from the Kennedy School of Government at Harvard. She trained in primary care internal medicine at Brigham and Women's Hospital in Boston and completed a general medicine research fellowship at Harvard. Prior to joining AHRQ she was Assistant Professor at Harvard Medical School where she performed clinical epidemiology and health services research related to cancer screening and prevention in terms of access, test performance, and outcomes. Dr. Barton has a clinical interest in and has presented widely about the performance of the clinical breast examination. She is a member of the American College of Physicians and the Society of General Internal Medicine.

George Mensah, M.D. **Center for Disease Control and Prevention**

GEORGE A. MENSAH, M.D., FACC, FACP, currently serves as the Distinguished Scientist, Heart Disease and Stroke Prevention, and Chief Medical Officer and Associate Director of Medical Affairs at the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), in Atlanta, Georgia. Dr. Mensah graduated with honors in biology from Harvard University and has a doctorate in medicine from Washington University. He completed postgraduate training in internal medicine and cardiology at Cornell. Since that time, he has held many academic leadership positions and served on the cardiology faculties at Vanderbilt University and the Medical College of Georgia (MCG). Prior to joining CDC in 2000, he was professor with tenure at MCG, chief of cardiology at the VA Medical Center in Augusta, Georgia, and the Practice Site Director for the medical specialties practices at the MCG Hospital and Clinics. Dr. Mensah has received several awards including the 2006 Savage Memorial Science Award, the highest scientific honor awarded by the Association of Black Cardiologists and the "Mentor/Champion of Excellence" Award for Health Equity at the 2006 Annual CDC Honor Awards Celebration. He currently serves on the American College of Cardiology Board of Governors as Governor for Public Health.

***Designee of Carolyn Clancy, M.D., Director, AHRQ**

Paul McGann, M.D. **Center for Medicare & Medicaid Services**

PAUL E. MCGANN, SM, M.D., is Deputy Chief Medical Officer for the Centers for Medicare & Medicaid Services in Baltimore, MD. Dr. McGann received his S.M. in biology at the Massachusetts Institute of Technology and his M.D. at McGill University in Montreal, Quebec. He is board-certified in internal medicine and geriatric medicine. He has served as Assistant Professor at Queen's University School of Medicine, Associate Professor and Director of the Residency Training Program in Geriatric Medicine at the University of Alberta, and Associate Professor of Internal Medicine and founding Clinical Director of the J. Paul Sticht Center on Aging at Wake Forest University School of Medicine. Dr. McGann began his Center for Medicare and Medicaid Services service as Senior Geriatric Advisor for the Office of Clinical Standards and Quality, Quality Improvement Group. He is currently a member of the Editorial Board for the Journal of the American Geriatrics Society and has authored several book chapters and countless journal articles on chemistry and geriatric topics. Dr. McGann is an annual speaker at the American Geriatrics Society professional conference. He was the recipient of the Center for Medicare and Medicaid Services Administrator's Achievement Award in 2007 and 2004.

James R. Farris, M.D. **Center for Medicare & Medicaid Services**

JAMES R. FARRIS, M.D., graduated from the University of Texas at Austin and Howard University College of Medicine in Washington, D.C. He completed his internship and residency training in Internal Medicine at Martin Luther King General Hospital in Los Angeles, California and served as Chief Medical Resident. Dr. Farris served as Clinical Director, and ultimately Health Department Director, of the Dallas County Health Department. He has lectured extensively and published numerous articles on public health topics, and has held the positions of Assistant Attending Physician in Internal Medicine at St. Paul Medical Center and Clinical Assistant Professor of Internal Medicine at the University of Texas, Southwestern Medical Center. In 1996, Dr. Farris began his Federal career serving as Regional Health Administrator for the U.S. Department of Health and Human Services. From 2000 until 2007, Dr. Farris served as the lead Center for Medicare and Medicaid Services Regional Administrator for rural health issues, and served on the Secretary's National Vaccine Advisory Committee. In 2007, Dr. Farris was named Center for Medicare and Medicaid Services Consortium Administrator for Quality Improvement and Survey and Certification Operations. Dr. Farris was the recipient of the Presidential Rank Award at the Meritorious level in 2002 and the Roger W. Jones Award for Executive Leadership from American University in 2003.

Craig Miner, RPh, JD **Center for Medicare & Medicaid Services**

CRAIG MINER, RPh, JD, is a senior technical advisor in the Medicare Drug Benefit Group, Center for Drug and Health Plan Choice, Centers for Medicare & Medicaid Services (Center for Medicare and Medicaid Services). Mr. Miner received his Bachelor of Science in Pharmacy from Northeastern University in Boston and his Juris Doctor from Suffolk University Law School. Prior to joining Center for Medicare and Medicaid Services, Mr. Miner practiced pharmacy in both retail and mail service settings including the coordination of a drug utilization review department and implementation of a drug utilization review program targeting inappropriate drug use in the elderly. He joined Center for Medicare and Medicaid Services in 2004 to work on drafting the proposed and final rules for the Medicare Prescription Drug Benefit. Craig currently works on various Medicare Part D policy and operational issues involving areas such as Medication Therapy Management, Part D formularies, and e-prescribing. He has nearly 20 years of pharmacy experience in hospital, retail, mail service, and consulting practice.

Attachment B – Special Needs Plan-specific Chronic Conditions

The fifteen conditions that the 2008 Special Needs Plan Chronic Condition Panel determined met the definition of severe or disabling and needed specialized care management are:

1. Chronic alcohol and other drug dependence

2. Autoimmune disorders limited to:
   - Polyarteritis nodosa
   - Polymyalgia rheumatica
   - Polymyositis
   - Rheumatoid arthritis
   - Systemic lupus erythematosus

3. Cancer excluding pre-cancer conditions or in-situ status

4. Cardiovascular disorders limited to:
   - Cardiac arrhythmias
   - Coronary artery disease
   - Peripheral vascular disease
   - Chronic venous thromboembolic disorder

5. Chronic heart failure

6. Dementia

7. Diabetes mellitus

8. End-stage liver disease

9. End-stage renal disease requiring dialysis (any mode of dialysis)

10. Severe hematologic disorders:
    - Aplastic anemia
    - Hemophilia
    - Immune thrombocytopenic purpura
    - Myelodysplatic syndrome
    - Sickle-cell disease (excluding sickle-cell trait)
    - Chronic venous thromboembolic disorder

11. HIV/AIDS

12. Chronic lung disorders:
    - Asthma
    - Chronic bronchitis
    - Emphysema
    - Pulmonary fibrosis
    - Pulmonary hypertension

13. Chronic and disabling mental health conditions:
    - Bipolar disorders
    - Major depressive disorders
    - Paranoid disorder
    - Schizophrenia
    - Schizoaffective disorder

14. Neurologic disorders:
    - Amyotrophic lateral sclerosis (ALS)
    - Epilepsy
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
    - Huntington's disease
    - Multiple sclerosis
    - Parkinson's disease
    - Polyneuropathy
    - Spinal stenosis
    - Stroke-related neurologic deficit

15. Stroke

Attachment C - 2010 SNP Chronic Condition Inclusion Criteria

	A	B	C
	Chronic Condition	**Prevalence in Medicare Population (2008 FFS %)**	**Inclusion Factors:** • **Medically complex** • **Substantially disabling or life-threatening** • **High risk of hospitalization or other adverse outcome** • **Needs specialized delivery system across care domains** • **Has nationally recognized protocols or guidelines**
1	Alcohol and other drug dependence, chronic	>1.3%	• Has high potential for physiological and/or psychological dependence • Has high potential for psychosocial, cognitive, functional, or physiological disability • Has high potential for repetitive relapse or hospitalizations • Has high potential for need of coordination of care across inpatient and outpatient care domains using primary, specialty, and group therapy modalities • Has nationally recognized protocols or guidelines
2	Autoimmune disorders • Polyarteritis nodosa • Polymyalgia rheumatica • Polymyositis • **Rheumatoid arthritis** • Systemic lupus erythematosus	>4.5%	• Has high potential for complex medical and medication management • Has high potential for functional disability • Has high potential for multiple organ system dysfunction • High potential for repeated emergency service visits or hospitalizations • Has high potential need for significant assistance with ADLs • Moderate potential for need of coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists
3	Cancer [Excluding pre-cancer or in-situ status]	>12%	• Has high potential need for multimodal therapies including surgical, radiotherapy, and chemotherapy as well as multi-drug management of symptoms and pain • Is second leading cause of mortality; high potential for major organ dysfunction, metastasis to multiple major organs, and poor survival rates • Has high potential for repeated hospitalizations and recurring need for complex therapies • Has high potential need for coordination of care across inpatient, outpatient, rehabilitation, long-term care, and home domains • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Is likely to have nationally recognized protocols or guidelines
4	Cardiovascular disease • Cardiac arrhythmias • Coronary artery disease • Peripheral vascular disease • Chronic venous thromboembolic disorder	>21%	• Has high potential for complex medical, surgical, and medication management • Is leading cause of mortality (with congestive heart failure) • Has high potential for major organ failure, multiple organ dysfunction, functional decline, or organ transplantation • Has high potential for repeated hospitalizations or surgeries, implantation of cardiac or vascular devices, or limb amputation • Has high potential need for coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied

	A	B	C
	Chronic Condition	**Prevalence in Medicare Population (2008 FFS %)**	**Inclusion Factors:** • **Medically complex** • **Substantially disabling or life-threatening** • **High risk of hospitalization or other adverse outcome** • **Needs specialized delivery system across care domains** • **Has nationally recognized protocols or guidelines**
			health, rehabilitative, and palliative care specialists • Is likely to have nationally recognized protocols or guidelines
5	Chronic heart failure	14.22%	• Requires complex medical and medication management • Is among the leading causes of mortality (with CVD) • Has high potential for multiple organ dysfunction, functional decline, or organ transplantation • Has high potential for repeated hospitalizations • Has high potential need for coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Has nationally recognized protocols or guidelines
6	Dementia		• Has high potential for complex medical and medication management • Has high potential for functional, cognitive, and psychosocial disability as well as multiple organ dysfunction • Has high risk for emergency service visits and long-term care placement • Has high potential need for 24-hour supervision and significant assistance with ADLs • Has high potential need for coordination of care across outpatient, rehabilitative, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, rehabilitative, and palliative care specialists • Has nationally recognized protocols or guidelines
7	Diabetes mellitus	>25.50%	• Has high potential for complex medical and medication management • Is sixth leading cause of mortality • Has high potential for major organ failure, multiple organ dysfunction, dialysis status, or organ transplantation • Has high potential for repeated emergency service visits for diabetic emergencies, hospitalizations, or surgeries including limb amputation • Has high potential for micro-vascular, retinopathic, nephropathic, or neuropathic complications • Has high potential need for coordination of care across inpatient, outpatient, rehabilitative, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Has nationally recognized protocols or guidelines
8	End-stage liver disease	0.34%	• Has high potential for complex medical and medication management • Has high potential for multiple organ dysfunction, inhibited systemic detoxification, functional decline, or organ transplantation

	A	B	C
	Chronic Condition	**Prevalence in Medicare Population (2008 FFS %)**	**Inclusion Factors:** • **Medically complex** • **Substantially disabling or life-threatening** • **High risk of hospitalization or other adverse outcome** • **Needs specialized delivery system across care domains** • **Has nationally recognized protocols or guidelines**
			• Has high potential for repeated emergency service visits or hospitalizations • Has high potential need for coordination of care across inpatient, outpatient, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, and palliative care specialists • Has nationally recognized protocols or guidelines
9	End-stage renal disease requiring dialysis (all modes of dialysis)		• Requires complex medical and medication management • Has high potential for multiple organ dysfunction, functional decline, or organ transplantation • Has high potential for repeated emergency service visits or hospitalizations • Requires frequent visits to dialysis facilities • Has high need for coordination of care across inpatient, outpatient, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, dialysis, and palliative care specialists • Has nationally recognized protocols or guidelines
10	Severe hematologic disorders • Aplastic anemia • Hemophilia • Immune thrombocytopenic purpura • Myelodysplastic syndrome • Sickle cell disease (excluding sickle cell trait) • Chronic venous thromboembolic disorder	1.06%	• Has high potential for complex medical and medication management • Has high potential for multiple organ dysfunction, functional decline, or frequent infections • Has high potential for repeated hospitalizations or blood transfusions • Has high potential need for coordination of care across inpatient, outpatient, rehabilitative, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, rehabilitative, and palliative care specialists
11	HIV/AIDS	0.31%	• Has high potential for complex medical and medication management • Has high potential for functional, cognitive, and psychosocial disability; high potential for multiple organ dysfunction • Has high potential for opportunistic infections and other chronic co-morbidities • Has high potential for repeated emergency service visits or hospitalizations • Has high potential for need of coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Has nationally recognized protocols or guidelines
12	Lung disease, chronic • Asthma	>14.33%	• Has high potential for complex medication management • Has high potential for supplemental oxygen dependency, life-threatening exacerbations, and

	A	B	C
	Chronic Condition	**Prevalence in Medicare Population (2008 FFS %)**	**Inclusion Factors:** • **Medically complex** • **Substantially disabling or life-threatening** • **High risk of hospitalization or other adverse outcome** • **Needs specialized delivery system across care domains** • **Has nationally recognized protocols or guidelines**
	• Chronic bronchitis • Emphysema • Pulmonary fibrosis • Pulmonary hypertension		functional disability • Has high potential for repeated emergency service visits or hospitalizations • Has high potential for need of coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Is likely to have nationally recognized protocols or guidelines
13	Mental health conditions, chronic disabling • Bipolar disorder • Major depressive disorder • Paranoid disorder • Schizophrenia • Schizoaffective disorder	>7.0%	• Has high potential for complex psychiatric and medication management • Has high potential for functional, cognitive, and psychosocial disability • Has high potential for self-harm or harm to others • Has high potential for repeated residential treatment or hospitalizations • Has high potential for need of coordination of care across inpatient, outpatient, rehabilitative, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, and psychological rehabilitative care specialists • Has nationally recognized protocols or guidelines
14	Neurologic conditions, chronic disabling • Amyotrophic lateral sclerosis (ALS) • Epilepsy • Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) • Huntington's disease • Multiple sclerosis • Parkinson's disease • Polyneuropathy • Spinal stenosis • Stroke-related neurologic deficit	>7.5%	• Has high potential for complex medical, surgical, and medication management • Has high potential for functional, cognitive, and psychosocial disability • Has high potential for multiple organ system dysfunction • Has potential for respirator and/or tracheostomy dependence as well as assistive devices or equipment to do major life activities • Has high potential for repeated emergency service visits, hospitalizations, or long-term care placements • Has high potential of need for 24-hour supervision and significant assistance with ADLs • Has high potential for need of coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Is likely to have nationally recognized protocols or guidelines
15	Stroke	>4.5%	• Has high potential for complex medical and medication management • Has high potential for functional, cognitive, and psychosocial disability; high potential for multiple organ system dysfunction • Has potential for respirator and/or tracheostomy dependence as well as assistive devices or equipment major life activities

	A	B	C
	Chronic Condition	**Prevalence in Medicare Population (2008 FFS %)**	**Inclusion Factors:** • **Medically complex** • **Substantially disabling or life-threatening** • **High risk of hospitalization or other adverse outcome** • **Needs specialized delivery system across care domains** • **Has nationally recognized protocols or guidelines**
			• Has high potential for repeated emergency service visits, hospitalizations, or long-term care placements • Has high potential of need for 24-hour supervision and significant assistance with ADLs • Has high potential for need of coordination of care across inpatient, outpatient, rehabilitative, allied health, long-term care, and home care • Is likely to require coordination among a wide range of providers including primary, specialty, allied health, rehabilitative, and palliative care specialists • Has nationally recognized protocols or guidelines

KEY:

- Prevalence in Medicare population = June 2008 statistics on % of Medicare beneficiaries in fee-for-service plans having the listed chronic condition
- Medically complex = MIPPA definition
- Substantially disabling or life-threatening = MIPPA definition (significant acuity)
- High risk of hospitalization or other adverse outcome = MIPPA definition (specialized and skilled care)
- Needs specialized delivery system across care domains = MIPPA definition (coordinated care across healthcare settings and providers)
- Nationally recognized protocols or guidelines = operationally limited to guidelines or protocols developed by a medical specialty society or federal agency in the United States