# LONGEVITY HEALTH MODEL OF CARE

2026 Model of Care Training

Provider Module

# Medicare/Medicare Advantage 101

## Medicare

- A federal system of health insurance for people over 65 years of age and for qualifying individuals younger than 65 years of age with disabilities
- **Part A (Hospital Insurance)**
  - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Part B (Medical Insurance)**
  - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Part D (Prescription Drugs)**

## Medicare Advantage

- **Part C (Medicare Advantage)**
  - "All in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- **Health Plan Options**
  - Approved by Medicare
  - Run by Private Companies
  - Available across the United States
- **Enrolled Members Receive Services Through the Plan**
  - All Part A and Part B Covered Services (A+B=C)
  - Some plans may provide additional benefits
- **Includes Prescription Drug Coverage (Part D)**
  - This is known as an MA-PD plan
- **Members are still in the Medicare Program**
  - Medicare pays the plan every month for the Member's care
  - Members have Medicare rights and protections

# Institutional Special Needs Plan (I-SNP)

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

An Institutional Special Needs Plan (-ISNP) manages care for individuals residing in nursing facilities.


# I-SNP Eligibility

## You may be eligible if:

You have lived (or plan to live) in a participating facility for 90+ days.

You have **Medicare Part A** (Hospital Insurance) and **Part B** (Medical Insurance).

# What is the Longevity Health I-SNP Model of Care?

The Model of Care (MOC) is considered a vital quality improvement tool for ensuring that the unique needs of each beneficiary enrolled in an I-SNP are identified and addressed. It is a set of member-driven, evidenced-based activities focused on positive health outcomes.

**Key Sections:**

- **MOC 1**: Description of the SNP Population
- **MOC 2**: Care Coordination
  - Clinical Staff Structure
  - Health Risk Assessment (HRA)
  - Face-to-Face Encounter
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT)
  - Care Transition Protocol
- **MOC 3:** Provider Network
- **MOC 4:** Quality Measurement and Performance Improvement


# What Creates Success?

**The Longevity Health Model of Care focuses on primary care visits, care coordination, and treatment in place**

**The Longevity Health Model of Care also helps Members to avoid unnecessary hospital stays and ER visits**

# MOC 1: General Description of the I-SNP Population

- Likely to be 65 years or older, female, widowed or single
- Often has multiple chronic conditions such as heart disease, diabetes, COPD, depression
- Likely prescribed one or more high-risk medications per month
- May be confined to bed or wheelchair and require assistance with activities of daily living
- Often has moderate to severe cognitive impairment, overall low health literacy, and potential socioeconomic issues creating barriers to care

# Most Vulnerable I-SNP Members

**A subset of the overall I-SNP population is particularly at risk for adverse outcomes based on the following indicators:**

**Longevity Health will work with Providers to identify the most vulnerable Members and support member-driven preventative care.**

1. **Current clinical status:** All Longevity Health I-SNP Members in a Medicare Part A skilled facility stay are considered high risk
2. **Utilization History:** High utilization of medical services results when chronic conditions are not stabilized and well-controlled
3. **Functional Status:** Risk for adverse outcomes increases when a chronic condition leads to the inability to care for oneself
4. **Medication Status:** Over-medication can pose health threats to Members. High-risk medications like anticholinergic and CNS drugs or new prescriptions for antipsychotics increase the risk of falls, behavior changes, and other dangerous side effects
5. **Chronic Conditions:** Members with multiple chronic conditions require additional monitoring, treatment titration, and stabilization efforts to minimize risk for adverse outcomes

# MOC 2: Care Coordination

- Clinical Staff Structure
- Health Risk Assessment (HRA)
- Face-to-Face Encounter
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocols

# Longevity Clinical Staff Structure

| Example of employed and contracted staff members | Roles and responsibilities |
|---|---|
| **APP – Advanced Practice Registered Nurse or Physician Assistant** | Provides primary care in collaboration with the primary care physician. Participates in/oversees care coordination activities such as completing HRAs, risk stratification, Member visits, ICPs, ICTs, and managing transitions of care. Identifies members of the ICT and leads the ICT meeting as needed. Oversees members of the clinical care team including RNs, social workers, behavioral health support specialists, and medical assistants. |
| **Plan Model of Care RN (RN Field Coordinator)** | Conducts care coordination activities in collaboration with the APP including completing HRAs, risk stratification, Member visits, ICPs, ICTs, and sharing health status information across settings and managing transitions of care. |
| **Plan Social Worker** | Collaborates with the clinical care team to address Members' social needs. In collaboration with the APP/RN participates in care coordination activities such as completing HRAs, ICPs, ICTs, and managing transitions of care. |
| **Licensed Practical Nurse** | Supports care management staff in completing care coordination activities based on guidelines outlined in State Nurse Practice Acts. LPNs work under the direction of a Nurse Practitioner or an RN and provide restorative and supportive care, health counseling, and teaching. |
| **RN Care Coordinator** | Provides telephonic care coordination and/or onsite care management for Members during transitions of care. Focus on sharing information across settings. |
| **PCP** | Oversees delivery of medical care and implementation of the model of care for Plan Members. Participates in ICT meetings. |

# How Health Risk Assessments Are Used to Improve Health Outcomes

The Health Risk Assessment is used to:

1. Initiate the development of the individualized care plan (ICP)
2. Collect information about the health status of Longevity Health Members
3. Identify potential gaps in existing care and immediate care needs
4. Monitor changes in health status on an annual basis and when the Member experiences a significant change in condition

# Health Risk Assessment (HRA) Requirements

All new Longevity Health members receive an HRA within 90 days of enrollment (some organizations may require a shorter timeframe)

Existing Longevity Health members receive an HRA annually and with a significant change in condition

The HRA identifies immediate or overlooked health needs and informs the care plan for each Longevity Health Member

# Health Risk Assessment (cont.)

**Results from the HRA directly contribute to a Member's care in the following ways:**

- Identification of urgent conditions requiring immediate intervention
- Stratification of HRA responses set the timing of the post-HRA visit
- Outcomes of the post-HRA visit, such as medication changes, therapy referrals, and/or diagnostic tests, will be incorporated into the Member's Individualized Care Plan (ICP)

# Face-to-Face Encounter

- The annual face-to-face encounter is required by CMS for all I-SNP Members
- Goal is to improve health outcomes, identify needs and risks, reduce gaps, and increase collaboration between the Member's ICT and the care management team
- May be completed in-person or through a real time, visual interactive telehealth visit
- Occurs within 12 months of enrollment

# Individualized Care Plan (ICP)

**Requirements:**

- Needs identified in the HRA are addressed in the Individualized Care Plan (ICP)
- The ICP is shared with the PCP to contribute relevant clinical information
- The ICP focuses on self-management goals and preferences
- All Longevity Health Members have an ICP that is updated with significant changes in health status and is available to the Member and the Care Team

# Interdisciplinary Care Team (ICT)

- The ICT revolves around the Longevity Health Member and is focused on the Member's goals and preferences
- The exact composition of the ICT varies and is dependent on each Member's unique needs
- Must include at a minimum the Member and/or Member representative, Member's care manager, and the Member's PCP
- ICT participants are selected based on their functional roles, knowledge, and/or established relationship with the Member
- The ICT reviews progress towards goals and updates the ICP as needed

# Care Transition Protocols

The Longevity Health Model of Care utilizes care transition protocols to safely transition Members between levels of care and across care settings using evidence-based clinical practices.

**Care transition protocols:**

Ensure that every Longevity Health Member has a centralized point of contact for care transitions

Minimize the need for transitions outside of the facility by treating in place if appropriate

Facilitate information-sharing with external providers/facilities to ensure coordinated care across settings

# Typical Transitions Specific to the I-SNP Population Include:

- Facility to Emergency Department
- Facility to Hospital
- Emergency Department to facility/SNF
- Hospital to facility/SNF
- Facility to Hospice Care
- Facility to Skilled Care (may be in same facility, but level of care change)
- Facility to community with home health
- Facility to a non-contracted facility
- Facility to home

# Transition Coordination & Communication

- Post-discharge, Longevity Health clinicians educate the Member and/or caregiver about their current health status

- Longevity Health clinicians coordinate follow-up orders for post-hospital specialist visits, diagnostic testing, and/or therapy

**Within 2 business days:**

Longevity Health clinicians assess the Member within 2 business days of notification of the Member's return to the nursing facility after an inpatient hospital stay

Longevity Health clinicians should be notified of all planned or unplanned care transitions ***before*** a facility sends a Member to the hospital

# Transition Coordination & Communication

## After the transition Longevity Health Clinicians perform the following activities:

- Educate the Member and/or caregiver on the reason(s) for hospitalization/transition
- Provide instruction on who to contact for concerns at any point in time
- Provide instruction on warning signs related to disease processes and new medications
- Educate on self-care to the degree possible
- Review the updated HRA and ICP
- Coordinate orders for post-transition follow-up including specialist visits, diagnostic testing, and/or therapy

# MOC 3: Provider Network

- Longevity Health Members have access to a comprehensive network of providers, facilities, ancillary services, specialist physicians, and acute care facilities with the specialized clinical expertise to care for I-SNP Members.
- Primary care services and supportive ancillary services such as therapy, diagnostic radiology, and labs are provided within the facility as appropriate.
- Longevity Health clinicians also coordinate services outside of the facility including specialist visits and diagnostic testing not available on campus.

# MOC 4: Quality Measurement and Performance Improvement

- The purpose of the Quality Improvement Program (QI Program) is to take a proactive approach to improve quality of care for Longevity Health Members
- The QI Program supports and promotes this vision through continuous improvement and monitoring of medical care, patient safety, and behavioral health services
- The QI Program is assessed annually to evaluate the overall effectiveness of the program
  - Enhancements are made to the QI Program based on the annual evaluation
- The QI Program provides the overall structure, framework, and governance to improve quality of care for Longevity Health Members

# MOC 4: Key I-SNP Quality Metrics

- Longevity Health tracks and reports data for the Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Advantage and Medicare Part D Star ratings, and NCQA accreditation standards as needed on an annual basis
- Key quality initiatives focus on:
  - Fall prevention
  - Medication adherence and deprescribing based on clinical guidelines
  - Hospitalization for potentially preventable complications and preventing unnecessary hospital readmissions
  - Improving Member satisfaction

# Suggestions for Improvement

**Please share your ideas with us!**

For recommendations on how to improve the Longevity Health Model of Care write to us at:

ISNPModelofCareUpdates@longevityhealthplan.com

# Thank you!