

MOC.3.C.1 ISNP Model of Care Longevity Health 2027 Model of Care Training Provider Module

For internal use only- not for redistribution

Medicare and Medicare Advantage Overview



Original 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 certain disabilities.

A federal program providing:

- **Part A** (Hospital) Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care
- **Part B** (Outpatient/Medical coverage) Covers certain doctor's services, outpatient care, medical supplies, and preventative services
- **Part D** Prescription Drug Plan



Medicare Advantage (Part C)

An all-in-one alternative administered by private insurers. **Medicare Advantage Plan enrollees have:**

Part C (Medicare Advantage)

- Health plan options approved by Medicare and administered by private companies available across the United States
- **Enrolled members receive services through the plan:** All Part A and Part B covered services (Part A + Part B = Part C)
- **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 monthly for the member's care. Members have Medicare rights and protections

Special Needs Plans

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. There are D-SNPs for individuals who are dually eligible for Medicare and Medicaid, and C-SNPs for individuals living with chronic health conditions.

Longevity Health is an Institutional Special Needs Plan (I-SNP). I-SNPs manage care for individuals residing in nursing facilities.



Eligibility Criteria for I-SNP

- Enrolled in Medicare Part A (Hospital) & Part B (Medical)
- Resides in the plan service area
- Currently lives (or plans to live) in a participating facility for 90+ days.
  - ✓ Individual must meet requirements for institutionalized level of care

LONGEVITY HEALTH

4 Keys to Success

- **Proactive care** to identify and address needs early
- **Coordinated care management** across the interdisciplinary team
- **Treatment in place** whenever appropriate to reduce unnecessary transfers
- **Better outcomes** through fewer hospitalizations, fewer ER visits, and higher quality care

Model of Care Overview

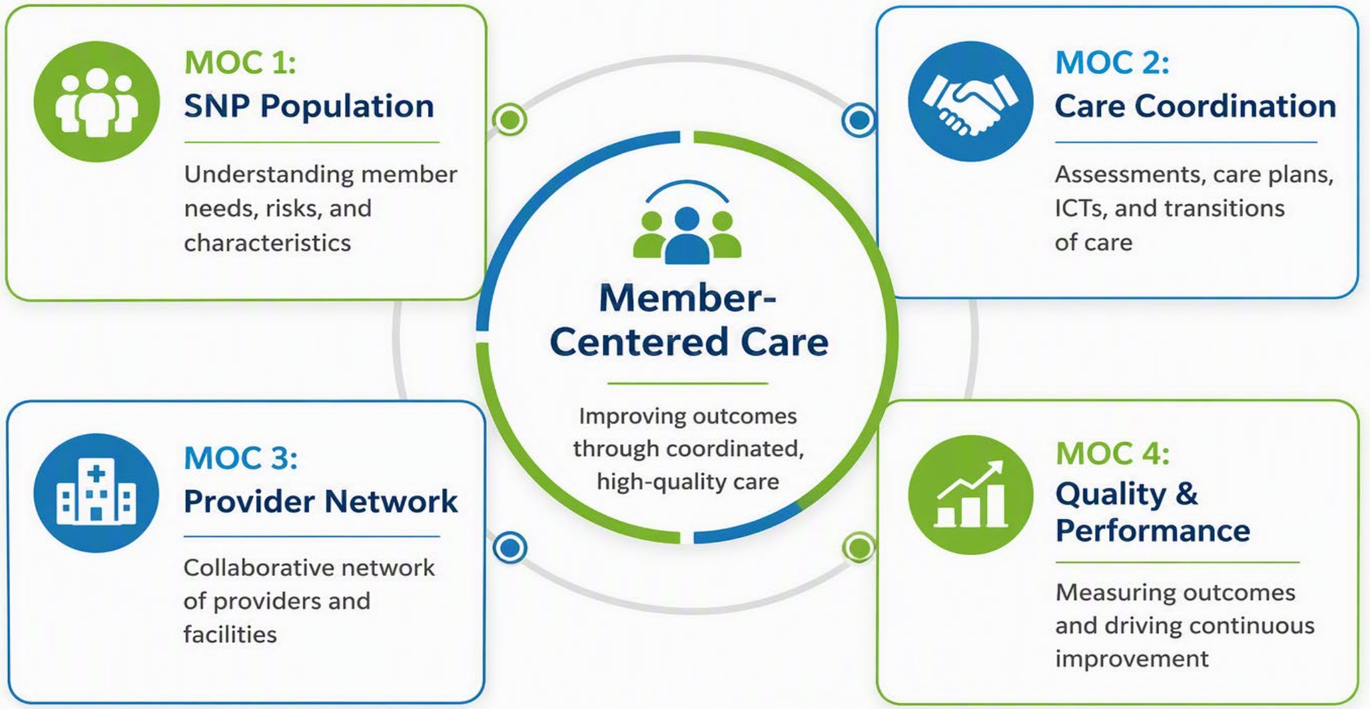
The Model of Care is a vital quality improvement tool for ensuring that the unique needs of each member are identified and addressed. It is a set of member-driven, evidenced-based activities focused on positive health outcomes.

Key Sections:

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



SNP Model of Care Components



For internal use only- not for redistribution



MOC 1.A Description of the SNP Population

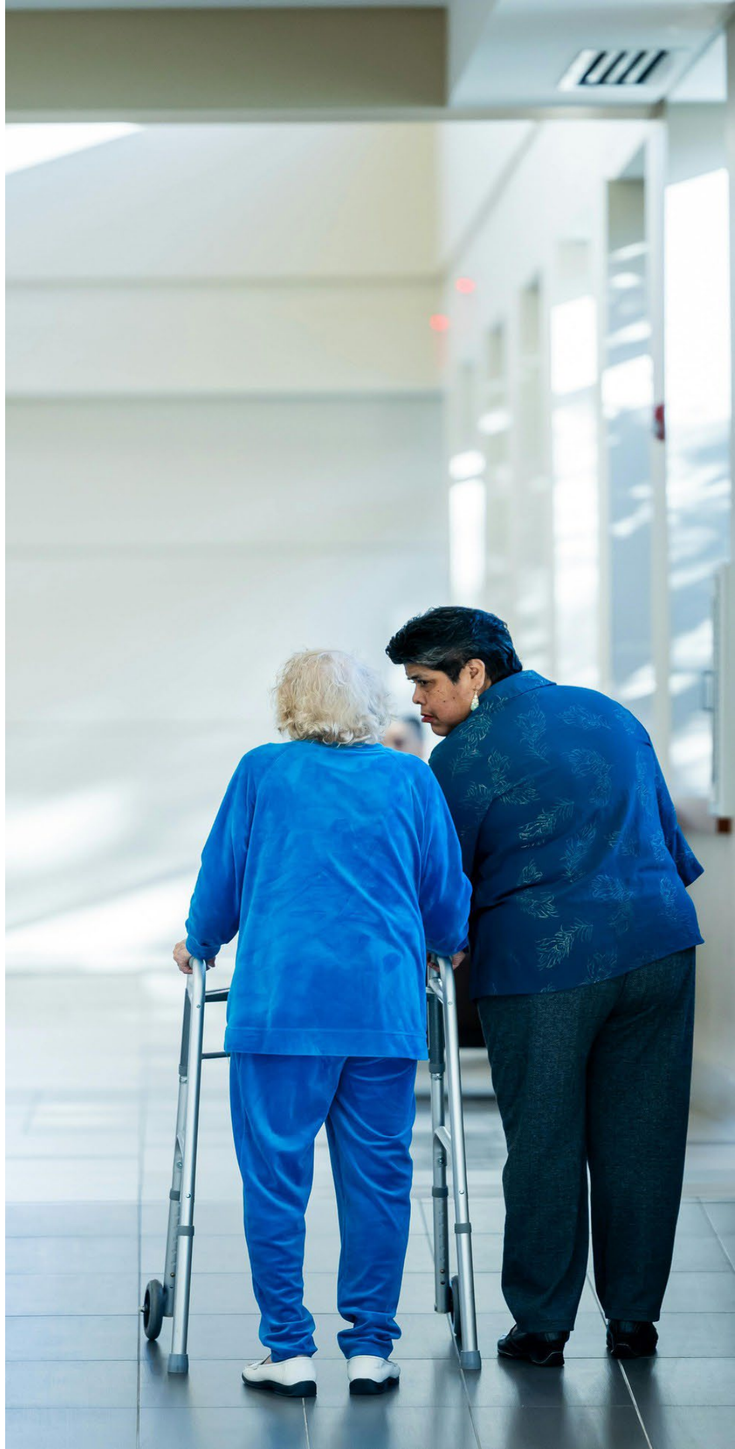
- High utilization of medical and pharmacy services
- Have complex medical conditions such as heart disease, diabetes, COPD, depression
- Likely to have cognitive impairment and a high risk for falls
- Likely to have functional impairments
- Concerns related to low health literacy

High-Risk Member Identification

A subset of the overall member population is particularly at risk for adverse outcomes based on the following indicators:

- **Current Clinical Status:** All members in a Medicare Part A skilled stay are considered high risk.
- **Utilization History:** High utilization of medical services results when chronic conditions are not stabilized and well controlled.
- **Medication Status:** Over-medication can pose health threats to members. High-risk medications like anticholinergics, CNS drugs, and antipsychotics increase risk for falls, behavior changes, and other dangerous side effects.
- **Chronic Conditions:** Members with multiple chronic conditions require additional monitoring, treatment titration, and stabilization efforts to minimize risk for adverse outcomes.

The Plan will work with providers to identify the most vulnerable members and support member-driven preventative care.





MOC 2 Care Coordination

MOC.2.A SNP Staff Structure

MOC.2.B Health Risk Assessment (HRA)

MOC.2.C Face-to-Face Encounter

MOC.2.D Individualized Care Plan (ICP)

MOC.2.E Interdisciplinary Care Team Meetings (ICT)

MOC.2.F Care Transition Protocols

MOC.2.A Clinical Staff Structure

Example of employed and/or contracted staff	Roles and responsibilities
APP – Advanced Practice Registered Nurse or Physician Assistant Care Manager	Provides primary care in collaboration with the primary care physician. Participates in/oversees care coordination activities such as completing HRAs, risk stratification, ICPs, ICTs, and transitions of care. Identifies members of the ICT. Oversees members of the clinical team including RNs, LPNs, and social workers.
Plan Model of Care RN Care Manager	Conducts care coordination activities in collaboration with the APP including completing HRAs, risk stratification, ICPs, ICTs, and transitions of care.
Plan Social Worker	Collaborates with the APPs and RNs to address members' social needs. Participates in care coordination activities such as ICPs, ICTs, and transitions of care.
Licensed Practical Nurse	Supports care management team in completing care coordination activities based on guidelines outlined in State Nurse Practice Acts. LPNs work under the direction of an Advanced Practice Registered Nurse or a Registered Nurse and provide restorative and supportive care, health counseling, and teaching.
RN Care Coordinator	Provides telephonic care coordination during transitions of care. Focuses on sharing information across settings.
Primary Care Physician	Oversees delivery of medical care.

For internal use only- not for redistribution

MOC.2.B The Health Risk Assessment (HRA)



Initiate the development of the individualized care plan (ICP)



Collect information about the health status of each member



Determine the member's risk stratification level and care coordination needs



Identify potential gaps in existing care and immediate care needs



Monitor changes in health status on an annual basis and when a member experiences a significant change in condition

Health Risk Assessment (HRA): Care Manager Responsibilities

- Document the results of the HRA and assess each member’s unique needs
- Communicate the results of the HRA to the member
- Review the member’s risk stratification level
- Update the member’s risk stratification level as needed based on the member’s needs



For internal use only- not for redistribution

How the Health Risk Assessment (HRA) Guides Member Care

- Identification of urgent conditions requiring immediate intervention
- Stratification of HRA responses sets the timing of care management visits
- Information collected in the HRA will be incorporated into the member’s individualized care plan (ICP)



For internal use only- not for redistribution

Health Risk Assessment (HRA) Requirements

The HRA identifies immediate or overlooked health needs and informs the care plan for each member

Requirements:

- All new members receive an HRA **within 90 days of enrollment** (time may vary depending on market)
- Existing members receive an HRA **annually** and with a **significant change in condition**, such as a discharge from the hospital

Risk Stratification and Visit Cadence

HRA results are used to determine a member's risk level (Low, medium, high), which drives visit frequency and care management interventions.

Risk level drives:

- Visit cadence
- Health education needs
- Advance care planning discussions

Examples of Risk Tiers:

LOW RISK	MEDIUM RISK	HIGH RISK
Chronic conditions controlled	Worsening symptoms	Recent hospitalization
Routine screenings	New cognitive changes	Recent fall
Participates in self-management	Daily pain	Increased care needs



MOC.2.C Face-to Face Encounter

- The annual face-to-face encounter is required by CMS for all 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 via telehealth visit
- Occurs within 12 months of enrollment



MOC.2.D Individualized Care Plan (ICP)

- Member preferences and needs identified in the HRA are addressed in the ICP.
- The ICP also includes needs identified through additional assessments, conversations with the member and/or member representative, review of the member record, and ICT input
- The ICP is person-centered, focuses on self-management goals and preferences, and is developed in collaboration with the member and/or member representative

Process for Developing the ICP

- The ICP is shared with the Primary Care Physician and members of the ICT to contribute relevant clinical information.
- All members have an ICP that is updated at a minimum every 90 days, with a transition of care, or significant change in health status. The ICP is available to the member and the care team.
- The ICP emphasizes member preferences for the delivery of services and benefits as prioritized by the member.
- ICP goals are specific and measurable and include specific services and benefits to be provided.



Basic Care Plan

If the member and/or member representative chooses not to participate in completion of the HRA, declines care management, or is unable to be reached:

- The care manager will use available administrative and clinical data sources to develop and maintain a basic care plan.
- The basic care plan will be shared with the member, primary care physician, and nursing facility.
- The member will be contacted at a minimum of once per year for HRA completion, or if the member experiences a transition of care.
- The member will be monitored and if they experience a transition of care, they will be asked again to participate in the HRA.



MOC.2.E Interdisciplinary Care Team (ICT)

- The ICT is facilitated by the care manager within 30 days of completion of the HRA
- The ICT revolves around the 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, the care manager, and the member's primary care physician
- 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

Referrals to Community Resources

- In collaboration with the Plan's contracted nursing facility partners, members of the ICT will identify community resources for members as needed. Community resources may include **transportation, financial, cultural, and spiritual support.**
- If a member transitions from a nursing facility to the community, the care manager will partner with nursing facility staff to ensure a smooth transition and promote continuity of care across health care settings.
- Community resources include local organizations and national organizations such as the American Heart Association and the Alzheimer's Association.

MOC.2.F Care Transition Protocols

The 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 the member has a centralized point of contact for every care transition
- Minimize the need for transitions outside the facility by treating in place if appropriate
- Facilitate information-sharing with external providers/facilities to ensure coordinated care across settings



Examples of Care Transitions

- Facility to Emergency Department
- Facility to Hospital
- Emergency Department to Facility
- Hospital to Facility
- Facility to Hospice Care
- Transitions between skilled and custodial care (may be in same facility, but level of care change)
- Facility to community

Coordination and Communication for Transitions of Care

- Nursing facility staff should notify the care manager about all planned or unplanned care transitions before the facility sends a member to the hospital.

- For planned transitions of care, the care manager or designee will fax the care plan to the receiving setting and inform applicable ICT members about the care transition.

- For unplanned transitions of care, the care manager or designee will fax the care plan to the receiving setting. The care manager or designee will also inform applicable ICT members about the transition within 2 business days of notification of the transition of care.

After the Transition of Care

The care manager will complete a health risk assessment within 2 business days of notification of return to the nursing facility after an inpatient hospital stay.

The care manager will update the ICP and ensure all applicable ICT members are informed of the member's needs after a care transition.

After the transition members of the ICT perform the following activities:

- Educate the member and/or member representative on the reason(s) for the transition
- Provide instruction on who to contact for concerns at any point in time
- Provide instruction on warning signs related to disease processes and any 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

- Members have access to a comprehensive contracted 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
- The care team also coordinates services outside of the facility including specialist visits and diagnostic testing not available on campus
- Both contracted providers and out-of-network providers seen by members on a routine basis receive initial and annual training on the I-SNP Model of Care

MOC 4 Quality Measurement & Performance Improvement

- The purpose of the Quality Improvement Program is to take a proactive approach to improve quality of care for members and provide the overall structure, framework, and governance to improve quality of care.
- The program supports and promotes this vision through continuous improvement and monitoring of medical care, patient safety, and behavioral health services and includes both process and outcomes measures.
- The program is assessed annually to evaluate the overall effectiveness. Enhancements are made to the program based on the annual evaluation.



Key Quality Metrics

The Plan 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 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 experience

Suggestions for Improvement

Please share your ideas with us!

For recommendations on how to improve the I-SNP Model of Care write to us at:

ISNPModelofCareUpdates@longevityhealthplan.com

LONGEVITY
HEALTH

Thank you!