I-SNP MODEL OF CARE

2025 Model of Care Training
Provider Module

Medicare/Medicare Advantage 101

LONGEVITY HEALTH PLAN

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

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

Institutional Special Needs Plan (I-SNP)

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Who can join an I-SNP?

- Enrolled in Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in Plan service area
- Must reside (OR is expected to reside) in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

What Creates Success?

- **The Longevity Health Plan (LHP) I-SNP Model of Care focuses on primary care visits, care coordination, and treatment in place**
- **The I-SNP Model of Care also helps LHP Members to avoid unnecessary hospital stays and ER visits**

What is the LHP 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

MOC 1: General Description of the I-SNP Population

LONGEVITY HEALTH PLAN

- 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:

1. **Current clinical status:** All LHP 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

LHP will work with providers to identify the most vulnerable Members and support member-driven preventative care.

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

LHP 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 is 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.

Health Risk Assessment

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 LHP Members
3. Identify potential gaps in existing care and immediate care needs
4. Monitor changes in health status on an annual basis and if the Member experiences a significant change in condition

LONGEVITY HEALTH PLAN

Health Risk Assessment (HRA)

Requirements

- All new LHP Members receive an HRA within 90 days of enrollment (some organizations may require a shorter timeframe)
- Existing LHP Members receive an HRA annually (between days 305 and 364) and with a significant change in condition
- The HRA identifies immediate or overlooked health needs and informs the care plan for each LHP 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 included in the facility's EMR and 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 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 focuses on self-management goals and preferences
- The ICP is shared with the PCP to contribute relevant clinical information
- All LHP 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 LHP 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 LHP I-SNP Model of Care utilizes care transition protocols to safely transition LHP Members between levels of care and across care settings using evidence-based clinical practices.

Care transition protocols:

- Ensure that every LHP Member has a centralized point of contact for care transitions
- 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

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, I-SNP clinicians educate the LHP Member and/or caregiver about their current health status
- I-SNP clinicians coordinate follow-up orders for post-hospital specialist visits, diagnostic testing, and/or therapy

Within 2 business days:

I-SNP clinicians assess the Member within **2 business days** of notification of the Member's **return** to the nursing facility after an inpatient hospital stay

I-SNP 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 I-SNP 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

- LHP 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.
- I-SNP 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 LHP 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 LHP Members

MOC 4: Key I-SNP Quality Metrics

- LHP 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 as applicable
- 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 of the I-SNP Model of Care

- 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

Thank you!