Texas Independence Health Plan

TIHP Model of Care (MOC) Provider Training

2024

Goals of Training

Texas Independence Health Plan

- Describe the purpose of the MOC and what is an Institutional Special Needs Plan (I-SNP)
- Show how TIHP's MOC can help facility staff and patients
- Help you understand your role in the I-SNP MOC

Overview

- The Medicare Modernization Act of 2003 (MMA) established an MA Coordinated Care Plans (CCP) specifically designed to provide targeted care to individuals with special needs.
- In the MMA, Congress identified “special needs individuals” as:
    1) Institutionalized Individuals (I-SNP)
    2) Dual eligibles (D-SNP)
    3)Individuals with severe or disabling chronic conditions (C-SNP)
        - *As specified by CMS.*
- MA CCPs established to provide services to these special needs individuals are called “Specialized MA plans for Special Needs Individuals,” or SNPs.
- SNPs were first offered in 2006.
- The MMA gave the SNP program the authority to operate until December 31, 2008.

Regulatory Requirements

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees **§ 422.101 (f)**

- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff **§ 422.101 (f)**

Background and Purpose of MOC

- The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.
- TIHP MOC ISNP Plan was initiated in January 2020 in 35 Regency facilities for the institutionalized residents with long term advanced illness or disabilities.
- In January of 2022, a Service Area Expansion added 18 additional Regency facilities.
- The TIHP MOC was created to provide NP and RNCC services in Regency managed facilities.
- The ISNP MOC is managed by Nurse Practitioner Services of Texas (NPST).

What is the MOC Plan?

The MOC Plan is TIHP's detailed, written commitment to CMS on how we will provide specialized care to enrolled I-SNP members.

The MOC contains the following required components:

- Description of the Plan Population
- Care Coordination Process
  - Health Risk Assessment with Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice
  Guidelines and Protocols
  - MOC Training for Staff, Providers and Facilities
- Quality Improvement and Performance Monitoring

Institutional Special Needs Plan (I-SNP)

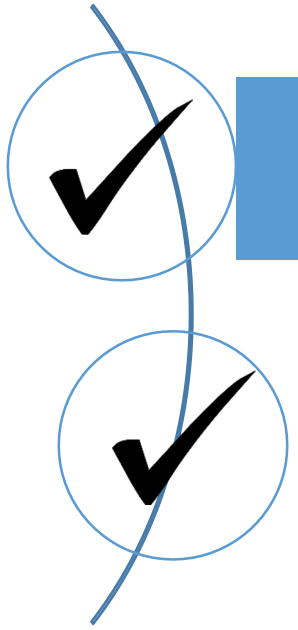
Texas Independence Health Plan

I-SNP : A Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care to special needs individuals who reside in a long-term facility.

Enrollment is restricted to:

- Individuals with Medicare Part A and Part B
- Live in LTC for 90 days or longer or can still enroll if the patient was admitted for LTC and there is no plan for discharge
- Have had or are expected to need the level of services provided in a LTC Nursing Facility

To be eligible for TIHP enrollment, LTC facility residents must:



- Reside in a TIHP contracted long term care facility for at least 90 days or if admitted for LTC and there is no plan for discharge
- Be enrolled in Medicare Part A and Part B

What is the MOC?

The MOC is TIHP's detailed, written commitment to CMS on how we will provide specialized care to enrolled I-SNP members.

**CMS will audit TIHP against the processes and commitments described in the MOC*

The MOC contains the following required components:

- Description of the Plan Population
- Care Coordination
  - Health Risk Assessment, Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice Guidelines and Protocols
  - MOC Training for Providers and Facilities
- Quality Improvement and Performance Monitoring

Goals of TIHP's I-SNP Plan

Texas Independence Health Plan

The I-SNP Plan is designed to:

- Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
- Maintain the residents at an optimal level of function
- Increase compliance with appropriate screenings/testing
- Increase compliance with clinical practice guidelines
- Enhance identification and address problems earlier to optimize member function
- Improve communication related to member's care

Advantages for Nursing Facilities

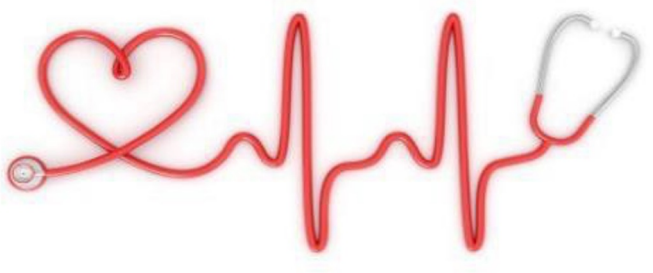
TIHP's MOC offers many advantages for nursing facilities, including:

- A local and dedicated provider clinical team that provides additional on-site primary care, case management and care coordination
- Better quality of care and health outcomes for patients as measured by HEDIS® scores and hospital use rates

In the following slides, look for the "star" symbol for quick tips and summaries of what facilities can expect from the Plan

Key I-SNP Staff – NP

Nurse Practitioner



- Assigned to each nursing facility and all TIHP members in residence
- Communicates and collaborates with Health Care team
- Enhance family/caregivers' communication
- Promotes continuity of care,
- Coordinates care plan communications and implementation and clarification of goals
- Provides on-site primary urgent/acute care
- Support treatment in place to avoid unnecessary hospital transfers
- Visits/assesses each member at least monthly - and as often as daily, based on member's condition

The NP will work closely with facility staff to manage members' care and will keep everyone informed on their progress

Key I-SNP Staff- RNCC

RN Care Coordinator

- Assigned to each nursing facility and dedicated to all TIHP members in residence
- Liaison between the NP and facility staff
- Rounds on each TIHP member and alerts NP to changes in member condition or transitions
- Partners with the NP to coordinate care and follow up for the TIHP member.

The RNCC will be in the facility on weekdays as scheduled . Contact the RNCC or the NP if you have any concerns with a TIHP member.

CMS Care Coordination Requirements and TIHP's Approach

CMS MOC Regulatory Requirement		TIHP MOC Process
HealthRisk Assessmen t (HRA) §42 CFR (f)(1)(i)	1) All SNP members must have an initial HRA within 90 days of enrollment and at least annually thereafter within 364 days of the previous HRA	• ISNP NP conducts a comprehensive HRA within 30 days of enrollment and at least annually thereafter. • NP conducts interim assessments at least monthly. • Member risk level assigned with each assessment and determines NP or RNCC visit frequency.
Individualized Care Plan (ICP) §42 CFR (f)(1)(ii)	2) All SNP members must have an ICP based on the needs identified within the HRA	• NP develops member's ICP whilst completing the HRA and in the same member visit. • ICPs completed annually and are reviewed/revised as needed.
Interdisciplinary Care Team (ICT) §42 CFR (f)(1)(iii)	3) All SNP members must have an ICT that collaborates in care plan development and implementation	• NP is the "hub" of each member's ICT and coordinates communications with other participants. • The NP will talk to you about the member's HRA results and care plan along with any revisions or updates.

All these activities are documented centrally in the member's chart at the facility as well as in TIHP's electronic medical record.

Health Risk Assessment (HRA)

- Conducted at least annually by the NP, the HRA identifies the medical, psychosocial, cognitive, functional and mental health needs and risk level of each member
- Risk level dictates the member's visit schedule by the NP or RNCC
  - High risk: members are seen at least bimonthly
  - Moderate risk: members are seen at least monthly
- The member is reassessed if there is a change in health condition or care transition
- HRA findings are used to develop/update the member's care plan

NP may contact you for assistance with the interventions especially if the member is cognitively impaired

How the I-SNP program works in your SNF

Interdisciplinary Care Team (ICT) is designed to help everyone involved in TIHP Member's Health to Know:

- What is important to the member/responsible party
- The member's goal for the next 12 months
- About the member's health conditions
- The healthcare and support the member needs
- NP coordinates communications among ICT members and may request a formal meeting.
- At a minimum, the Interdisciplinary Care Team (ICT) includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.

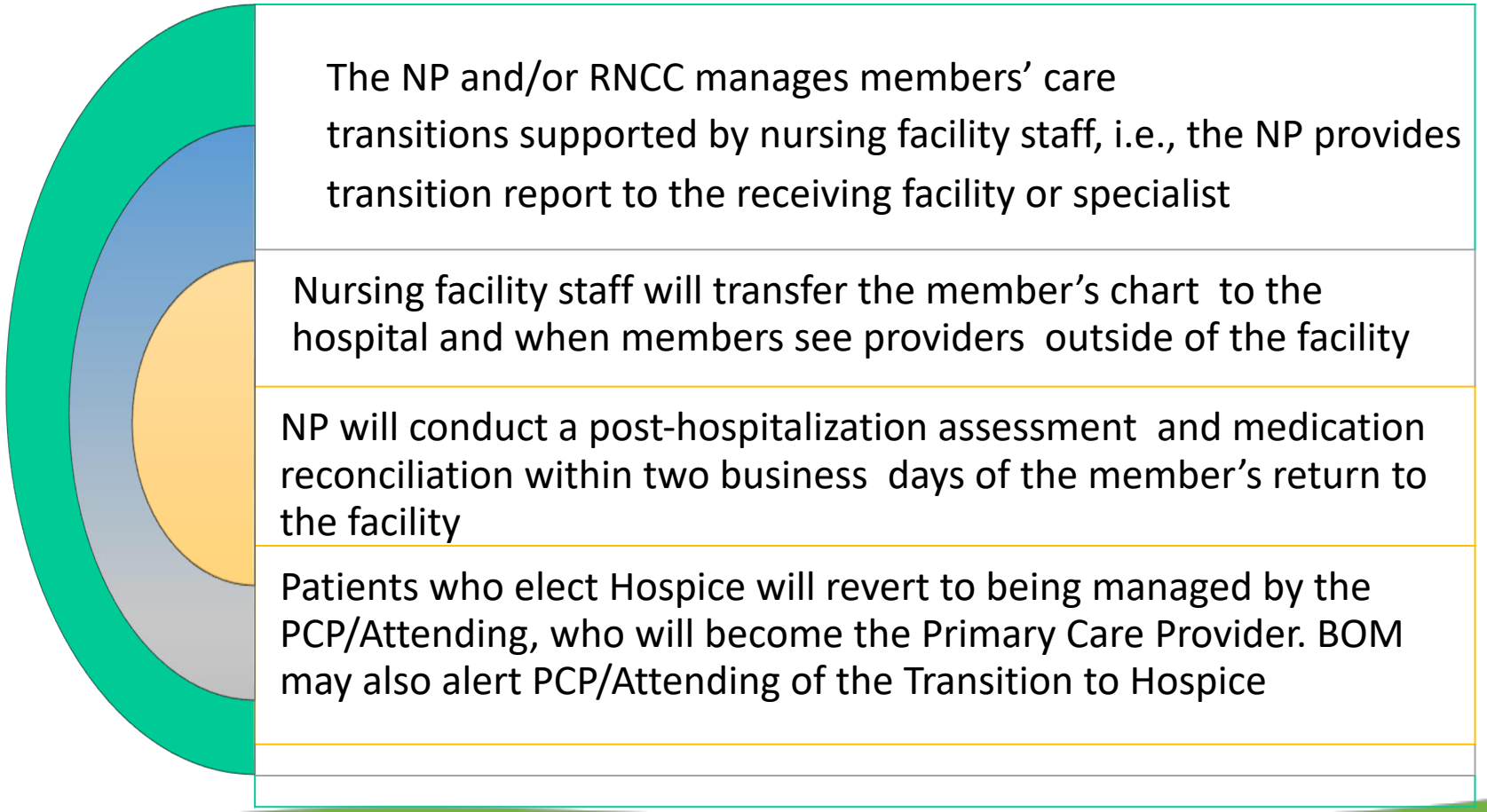
Please participate in ICT with the NP
to discuss changes to the member's care plan.

Interdisciplinary Care Team (ICT)

- Every member has an ICT tailored to the needs identified on the HRA and ICP
- The ICT oversees and coordinates the member's care plan
- Composition varies but, at a minimum, the ICT includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.
- NP coordinates communications among ICT members and may request a formal meeting.

Please participate in ICT planning meetings if requested and contact the NP to discuss changes to the member's care plan.

Care Transitions Protocols



The NP and/or RNCC manages members' care transitions supported by nursing facility staff, i.e., the NP provides transition report to the receiving facility or specialist

Nursing facility staff will transfer the member's chart to the hospital and when members see providers outside of the facility

NP will conduct a post-hospitalization assessment and medication reconciliation within two business days of the member's return to the facility

Patients who elect Hospice will revert to being managed by the PCP/Attending, who will become the Primary Care Provider. BOM may also alert PCP/Attending of the Transition to Hospice

If you see that a TIHP member is at risk for a hospitalization, please contact the NP or RNCC immediately!

A Partnership For Care

TEXAS INDEPENDENCE HEALTH PLAN

Specialized Provider Network

- TIHP maintains a comprehensive network of primary care providers and specialists
    - Includes providers with specialized expertise in the long-term care population and who routinely care for members in network nursing facilities
- All contracted providers are credentialed
- A network adequacy report is completed annually to ensure that members have access to services

Use of Clinical Practice Guidelines

- TIHP has approved and promotes the use of the American Medical Directors Association (AMDA) clinical practice guidelines among internal clinical staff and providers which are tailored to the long-term care population.
- They can be found here: https://paltc.org/product-store/full-set-clinical-practice-guidelines

The Plan also measures internal and external provider adherence to evidence-based guidelines via CMS-required HEDIS® reporting

Expectations for Nursing Facilities

- Get to know the NP and RNCC teams assigned to TIHP members. We are here to help you!
- Communicate ALL changes in condition no matter how small!!
- Early identification of changes in condition and report directly to the ISNP NP/RNCC.
- Report any changes, no matter how small, they may be clues to patients impending change in condition which needs to be addressed before becoming decompensated and unmanageable.
- Discuss the member's care plan and participate in ICT conferences and activities
- Call the NP or RNCC if a TIHP member is at risk for a transition/transfer to ER.
- Notify the NP or RNCC as soon as the member returns from a hospital stay
- Deliver care in accordance with appropriate evidence- based guidelines

When in doubt call ISNP NP
No Call TOO Small!!

Model of Care Quality Measures

Measurable Goals and Health Outcomes	HEDIS®
	Chronic condition management
	Medication adherence
	Utilization
Compliance with CMS-required MOC processes	HRA and Care Plan completion rates
	Timely member visits
	Care transitions management
	Staff and Provider MOC Training
Member Satisfaction	TIHP-designed survey conducted once per year

Evaluation of the Model of Care

- Data is collected, analyzed and evaluated on a monthly, quarterly and annual basis from each domain of care to monitor performance and identify areas for improvement and to ensure program goals have been met

- Annual Evaluation of the MOC
  - Formal evaluation of MOC effectiveness led by TIHP's Quality Improvement (QI) department.

You can request info on TIHP's quality measures and MOC performance data.

Provider Attestation

I attest that I have received the 2024 Model of Care Training for TIHP:

_____ _____

Printed Name Organization Name (if applicable)

_____ _____

Signature Title

_____

Date