Nascentia Skilled Nursing Facility (I-SNP)

2025 ISNP Model Of Care

Nascentia Skilled Nursing Facility Plan

What does I-SNP Stands For:

I - Institutionalized

S - Special

N - Needs

P - Plan

What is I-SNP?

I-SNP is a Medicare Advantage **all-in-one plan** that usually covers Inpatient Services, Outpatient Services, and Part D prescription drugs Services.

I-SNP is designed to provide focused care coordination and improve quality of care to a specialized population.

I-SNP is surveyed and audited by Federal Department of Health and Human Services Centers for Medicare Services

2025 I-SNP Model Of Care

Key Components:

MOC 1: Description of SNP Population

- **Element A:** Description of Overall SNP Population
- **Element B:** Most Vulnerable Enrollees

MOC 2: Care Coordination

- **Element A:** SNP Staff Structure
- **Element B:** Health Risk Assessment Tool (HRAT)
- **Element C:** Face-to-Face Encounter
- **Element D:** The Individualized Care Plan (ICP)
- **Element E:** The Interdisciplinary Care Team (ICT)
- **Element F:** Care Transition Protocol

MOC 3: Provider Network

MOC 4: MOC Quality Measurement and Performance Improvement

MOC 1: Description of Special Needs Population

Element A: Description of Overall SNP Population

- Medicare-eligible beneficiaries who require Long-Term Institutional level of care and reside in Skilled Nursing Facilities for 90 days or longer.
- Live in covered geographic service area.
- The beneficiaries must be eligible for Medicare Parts A and B.
- The beneficiaries must live in Institution without plans to be discharged back to the community.

MOC 1: Description of Special Needs Population

Element B: Most Vulnerable Beneficiaries

I-SNP beneficiaries have complex medical and/or behavioral conditions:

- Beneficiaries with Cognitive deficits, Dementia, Diabetes, Hypertension (HTN), Stroke with residual disability, Coronary Artery Disease (CAD), Depression, Psychiatric disorder, Congestive Heart Failure (CHF), COPD, and Alzheimer's disease.
- Beneficiaries that are frail, elderly, disabled, or near end-of-life.
- Members with hospital readmissions within 30 days.

MOC 2: Care Coordination

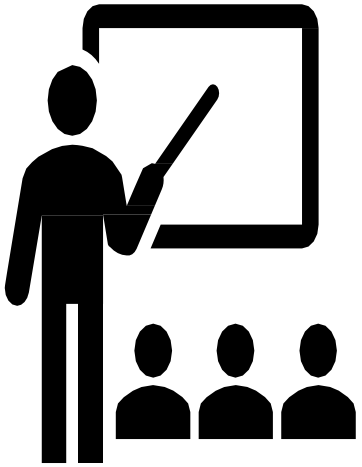
Element A: Staff Structure, Roles and Responsibilities

Experienced and well-qualified staff:

- Provides optimal services and ensures compliance with MOC and CMS guidelines.
- Enhances on-site support by providing Clinical Care Practitioner (NP/PA), who:
  - Responsible for providing direct care.
  - Collaborates with member's PCP and other nursing home staff.
  - Functions as a dedicated Care Manager.
  - Participates in the Interdisciplinary Care Team (ICT) in developing and implementing the Individualized Care Plan (ICP).
  - Attends to members needs by providing clinical assessments initially and ongoing based on risk stratification level.
  - Focuses on early signs of member's change in condition and addresses as appropriate.
  - Ongoing engagement with family members or health care agents.
  - Ongoing staff education as needs are identified.

MOC 2: Care Coordination

Element A: SNP Staff Structure, Roles and Responsibilities- Education and Training



- Nascentia will provide initial and MOC training in conjunction with the SNF through didactic and participatory learning.
- Training will be tracked through attendance sheets and web-based attendance confirmation.
- Training is mandatory per CMS and failure to complete in a timely manner can result in disciplinary action for the employee.

MOC 2: Care Coordination

Element B: Health Risk Assessment Tool (HRAT)

- Nascentia's NP/PA utilizes a customized HRAT as a starting point for the creation of the members' Individualized Care Plan which is used to coordinate members care on behalf of the plan.
- The HRA will be conducted within 30 days of enrollment date, annually based on the date of enrollment, and more often as needed, thereafter.
- NP/PA conducts direct assessments regularly and as needed, based on the beneficiary's health care status and assigned risk level.

MOC 2: Care Coordination

Element D: Individualized Care Plan (ICP)

- Includes individualized problems, goals, interventions and provides a guide for beneficiary's care.
- Includes demographics, historical medical, psychological, behavioral health needs, functional level, language, culture and support systems.
- Includes member self-management goals and preferences.
- Identifies services and interventions to maintain health status.
- Documented in the beneficiary's health record and updated as needed. NP/PA communicates the outcomes to the beneficiary and/or family and the ICT members.

MOC 2: Care Coordination

Element E: Interdisciplinary Care Team (ICT)

- Composition and frequency of meeting is determined by the beneficiary's health condition, risk level, and care needs.
- The team includes beneficiary and/or family/health care agent, NP/PA, PCP, and SNF staff.
- The NP/PA is responsible for communicating members information to the ICT regularly and more frequently based on health conditions and risk stratification level.

Role and Responsibility of Providers, Physicians & Clinicians

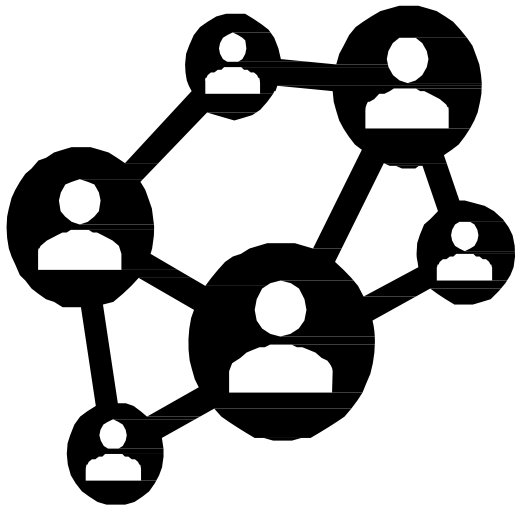
- **Communication:**
  - Communicate relevant information with plan regarding member's care
  - Respond to communication from Plan regarding member's care
  - This includes communicating with multiple people
    - Members
    - Care Givers
    - Care Management Teams
    - Other members of the Interdisciplinary Care Team
- **Participating in the development of the ICP**
- **Maintain ICP and transition of care notices from Plan**
- **Complete Model of Care Training Annually, and complete the Attestation form**

MOC 2: Care Coordination

Element F: Care Transitions Protocols

- The nursing home staff notifies PCP, Nascentia NP/PA, and family/health care agent when acute transfer occurs.
- The Nascentia NP/PA provides support to the beneficiary and/or health care agent during transitions from one care setting to another.
- The NP/PA closely follows the beneficiary's clinical status and continues to evaluate the beneficiary upon return to the nursing home to prevent hospital readmission.

MOC 3: Provider Network



- Nascentia's Provider Network includes PCPs, Specialists, other medical and clinical facilities required for beneficiary's care.
- Nascentia's Provider Network collaborates with the nursing home ICT to ensure the appropriate delivery of specialized services.
- Nascentia's NP/PA functions as a liaison to the providers and collaborates to ensure beneficiary's care needs are met.

MOC 4: Quality Measurement and Performance Improvement

➢ The Nascentia Quality Improvement Program (QIP)

- Is designed to effectively improve the quality of care and services, positively impact the health outcomes of beneficiaries, and specifically target the special needs of the I-SNP populations.

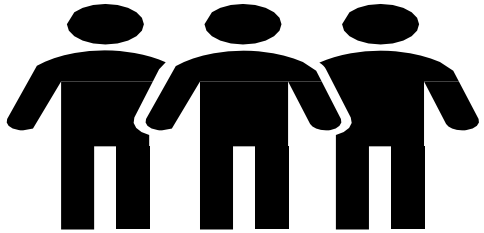
➢ Nascentia QIP Goals

- Conducting Health Risk Assessment and assigning risk stratification level timely.
- Compliance with preventive health guidelines and evidenced-based best-practice guidelines.
- Continuity and coordination of care between disciplines and across settings.
- Supporting the beneficiary through the transition process.
- Decreasing unnecessary hospital readmissions and ER visits.
- Timely provider timely accessibility and availability.
- Over/Under-Utilization of services.
- Beneficiary and provider satisfaction.
- Improving health outcomes or members through the care management by the NP/PA.

MOC Compliance

- Who is Responsible for compliance with the I-SNP MOC?

Everyone!



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Questions ?