Welcome to the 2021 EmblemHealth Special Needs Plan Model of Care training for providers.

We value your partnership in caring for our members.

This course will provide you with information to help you care for your patients with special needs.
TRAINING OVERVIEW

This training will provide you with an overview of the Special Needs Plan Model of Care (SNP MOC). By the end of this course, you will understand:

| The definition of a SNP and characteristics of the SNP population | The objectives and components of the MOC | Your responsibilities as a network provider for SNP members | The importance of your active participation in the MOC |
## DEFINITION OF SNP MOC

Let’s start by defining SNP model of care.

<table>
<thead>
<tr>
<th>SNP Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>C-SNP</td>
<td>beneficiary with a severe or chronic condition</td>
</tr>
<tr>
<td>I-SNP</td>
<td>beneficiary is institutionalized or eligible for nursing home care</td>
</tr>
<tr>
<td>D-SNP</td>
<td>beneficiary is dually eligible (Medicare and Medicaid)</td>
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Targeted care to individuals who are dual eligible for Medicare and Medicaid benefits.
DEFINITION OF SNP MOC

EmblemHealth offers four D-SNPs: the MOC applies to all four D-SNPs.

Comprehensive program through which care is efficiently delivered and well-coordinated by integrating all Medicare and Medicaid physical health, behavioral health, pharmacy, and community-based services through an interdisciplinary team.

The Centers for Medicare & Medicaid Services (CMS) regulate all SNPs. CMS reviews and approves each SNP’s model of care.
OBJECTIVES OF THE MOC

The Model of Care is the structure of the care management processes and systems to provide coordinated and appropriate care for our special needs members.

The key model of care objectives specific to the unique needs of the SNP population are to:

- Evaluate and improve members’ access to clinical and administrative services.
- Monitor continuity and coordination of health care.
- Review and evaluate the current status of care and service against regional and national requirements and benchmarks such as NCQA’s Quality Compass Accreditation/90th percentile, and CMS Medicare 5 Star Ratings.
- Ensure members’ access to safe medical and behavioral health care.
- Measure and address member satisfaction with care and services.
COMPONENTS OF THE MOC

There are four components of the model of care:

| MOC 1: Description of the SNP Population | MOC 2: SNP Provider Network | MOC 3: Care Coordination | MOC 4: Quality Measurements and Performance Improvement |

We will look closely at each of the four components of the model of care.
MOC 1: DESCRIPTION OF THE SNP POPULATION

This component describes some of the health and economic characteristics of the SNP population.

- Severe and multiple chronic conditions
- Violent crime neighborhoods
- Poor housing conditions
- Food insecurity
- Lower levels of education
- English language deficiency
- Low-level health literacy
- Social isolation
MOC 1: DESCRIPTION OF THE SNP POPULATION

• EmblemHealth currently has approximately 31,042 SNP members. They are a highly vulnerable population.
• SNP members have a high incidence of chronic conditions and behavioral health conditions including substance use disorders.
• Many SNP members have more than one chronic condition, which leads to higher risk of poor health. They need access to home and community-based services, intensive care coordination, and proactive monitoring of their health status.
MOC 1: DESCRIPTION OF THE SNP POPULATION

• The SNP population may live in neighborhoods with violent crime, have significant housing problems, and experience food scarcity.
• Limitations such as lower levels of education, English language deficiency, low-level health literacy, social isolation, and transportation issues lead to barriers in our members’ ability to effectively communicate with their health care professionals and receive the care they need at the right time.
MOC 2: SNP PROVIDER NETWORK

This component provides you with tools to help you care for your SNP patients, such as model of care training, medical policies, and practice guidelines.

EmblemHealth supports five SNPs with three provider networks.

- Members in EmblemHealth’s four SNPs have access to providers in the following networks:
  - VIP Bold Network
  - VIP Reserve Network

EmblemHealth also leases its **Network Access Network** to ArchCare for medical services.
MOC 2: SNP PROVIDER NETWORK

VIP Bold Network
- EmblemHealth VIP Dual (HMO D-SNP)
- EmblemHealth VIP Dual Select (HMO D-SNP)
- EmblemHealth VIP Solutions (HMO D-SNP)

VIP Reserve Network
- EmblemHealth VIP Dual Reserve (HMO D-SNP)

Network Access Network
- ArchCare Advantage (HMO SNP)
CMS requires all Medicare providers to complete model of care training for each of the SNPs with which they participate.

On an annual basis, providers are notified about the importance of completing SNP model of care training for EmblemHealth and ArchCare.

If you are a Network Access Network provider, you are required to take ArchCare’s SNP model of care training in addition to this one. Find ArchCare’s training on our website’s Learning Online page in the Provider Resources section [here].
EmblemHealth’s SNP model of care training module is available year-round on our Learning Online page.

| Individual and group practices are to download this training, and submit an attestation certifying the materials have been reviewed. | While one attestation may be returned for a group practice listing all providers, each provider is individually responsible for taking this training. | If you have a large group practice, consider reviewing the training module in a staff meeting. As you go through the material and review the requirements, discuss the procedures you have in place and create a plan of correction to address any gaps you identify. |
Medical Policies

- Providers are encouraged to review and implement EmblemHealth’s Medical Policies to determine the medical appropriateness of specific interventions.
- Medical Policies are posted [here](#). Our provider newsletter, “In the Know,” is sent via email about once a month. It will notify you of medical policy updates.
MOC 2: SNP PROVIDER NETWORK

Clinical Practice Guidelines

• EmblemHealth’s Clinical Practice Guidelines are available here.

• EmblemHealth uses preventive and condition-specific Clinical Practice Guidelines related to the treatment of acute, chronic, and behavioral health issues. These evidence-based guidelines are based on nationally recognized protocols for the assessment, care, and maintenance of health.

• Paper copies of Clinical Practice Guidelines are available upon request. Updates are included in the provider newsletter.
MOC 2: SNP PROVIDER NETWORK

• Keep your directory information up to date.
• Our members rely on our directory to find doctors quickly and easily.
• Check our provider directory to make sure we have the right information for you and your practice.
• For any demographic changes please visit here.
• For provider customer service please contact 866-447-9717.
MOC 3: CARE COORDINATION

Working together to care for the special health needs of your SNP patients is important, and your participation is essential for optimal coordination of care.

There are four elements in care coordination:

- Health Risk Assessment (HRAs)
- Interdisciplinary Care Team (ICT)
- Individualized Care Plan (ICP)
- Care Transitions Protocol
MOC 3: CARE COORDINATION

Health Risk Assessments (HRAs)

Used to identify a member’s baseline health status for medical, psychosocial, cognitive, functional, and mental health needs and risks. HRA responses are evaluated and stratified. Results are used to determine the types of services and support(s) a member needs for care coordination to meet health goals.

- Administered to all SNP members.
- Responses reviewed by EmblemHealth to determine outreach, evaluation, and development of an individualized care plan.
- Assessments identify members “at risk” and those needing condition-specific services.

Regulations 42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv)
MOC 3: CARE COORDINATION

Health Risk Assessments (HRAs)

CMS requires all SNPs to conduct an HRA for each individual enrolled in the SNP. The quality and content of the HRA should identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP beneficiary.

You can assist in this process by encouraging your EmblemHealth members to complete the HRA survey. The information provided in the HRA helps the EmblemHealth Care Management Department determine the types of services and supports they may need as part of their care plan. The Care Management Department refers HRA responses to other departments and/or programs for outreach as appropriate.
MOC 3: CARE COORDINATION

Here’s a case sample of the importance of an HRA.

A member’s daughter called Care Management and requested assistance for her mother – a 62-year-old female, alert, oriented to name, time and place, but forgetful, and lives with her daughter. The member was an HRA non-responder – our team was able to complete the HRA. Based on the responses, we learned the member had a recent post-hospital discharge due to tachycardia, bilateral leg swelling, diagnosed to have diabetes, and abnormal lab results.

The daughter reported the member’s blood pressure and fasting blood glucose level as always high. EmblemHealth’s care manager immediately contacted the member’s PCP office for care coordination. The PCP’s office scheduled a same-day appointment. The care manager followed up with the PCP, who indicated the member was seen and needed changes to her medication regime.
MOC 3: CARE COORDINATION

Interdisciplinary Care Team (ICT)

Regulations require all SNPs to use an Interdisciplinary Care Team in the management of care for each individual enrolled in the SNP.

Regulations 2 CFR §422.101(f)(iii); 42CFR §422.152(g)(2)(iv)
MOC 3: CARE COORDINATION

Interdisciplinary Care Team (ICT)

Multidisciplinary team structure which supports a member-centric approach to ensuring all areas of the member’s health spectrum are maintained.

In addition to the member or the designated family/caregivers, the ICT is comprised of clinicians representing various disciplines based on the member’s specific clinical needs.

The ICT meets biweekly for 90 minutes with selected SNP cases for presentation. Meetings are held telephonically/in-person with telephonic options for members, caregivers, and providers.
MOC 3: CARE COORDINATION

Interdisciplinary Care Team (ICT)

The ICT assists in the care plan development and implementation, and enables the member to have access to care coordination. The care management team proactively contacts the appropriate providers to identify the specific needs and services the member requires.

Providers are encouraged to participate in ICT meetings and collaborate with the ICT via the care manager. By providing relevant clinical information to the ICT, the member's care plan and coordination of care can be improved.
MOC 3: CARE COORDINATION

Here’s another success story with a member and daughter who participated in the ICT meeting.

A widowed, disabled, non-English-speaking, male member who lives with his 15-year-old daughter was experiencing a housing problem and wanted a two-bedroom apartment for both of them. He was saving money to be able to move, but had financial struggles. His daughter, translating for him during the ICT meeting, stated that she was also in need of school supplies and clothing.

EmblemHealth’s social worker informed and connected them to a church activity within their area. The daughter was able to get free school supplies and clothing. In addition, the social worker addressed the housing concern by linking the member to available housing resources, and he was able to get an apartment within his budget.
MOC 3: CARE COORDINATION

Individualized Care Plan (ICP)

Regulations stipulate all SNPs must develop and implement an Individualized Care Plan (ICP) for each individual enrolled in the SNP.

The ICP is the comprehensive care planning document customized to address the member’s needs. Development of the ICP begins when needs are identified during the administration of the HRA, interactions with the member, and/or the telephonic assessment of the member. The member is a vital component of the ICT and is involved in the development and review of their plan of care, whenever feasible.

Regulations 42 CFR §422.101(f)(ii); 42CFR §422.152(g)(2)(iv)
MOC 3: CARE COORDINATION

Individualized Care Plan (ICP)

Development of the care plan is a collaborative effort. The member’s health care needs, as recommended by providers and shared with the care manager, are incorporated into the member’s care plan. Information from providers helps in the management of the member’s health care needs, coordination of care, and supportive services.

The ICP focuses on actions to address existing problems, and incorporates the member’s health care preferences. Revisions are based on the member’s changing health needs, and feedback from providers.

Regulations 42 CFR §422.101(f)(ii); 42CFR §422.152(g)(2)(iv)
MOC 3: CARE COORDINATION

Care Transitions Protocol

Transitional care is essential for persons with complex care needs. Examples of transition between settings include: in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers, or home health. Based on a comprehensive plan of care, transitional care is the special effort to coordinate care, and as a result, reduce the risk of poor quality care, ensure patient safety, and maximize health outcomes.

Utilizing a multidisciplinary team approach to support SNP members’ medical, behavioral, pharmaceutical, social and financial needs, case managers work with the member, provider, and community delivery system to coordinate care and services.
Transitional care includes logistical arrangements, education of the member and family, and coordination among health professionals involved in both the sending and receiving aspects of the transfer. Care manager ensures the member’s assessment and care plan are updated with any applicable changes, and sets appropriate interventions in coordination with providers and the ICT.

Members are encouraged to complete and maintain their Personal Health Record, which contains member goals, a medication list, allergies, questions for providers, member conditions, and “red flags” to share with the member’s doctor or the treating facility.
### MOC 4: QUALITY MEASUREMENTS AND PERFORMANCE IMPROVEMENT

At EmblemHealth, our goals for SNP members are to improve and ensure receipt of:

| Essential medical, mental health, and social services. | Affordable care and preventive health services. | Coordinated care through the direct alignment of the HRA, ICT, and ICP. | Seamless transition of care across health care settings, providers, and health services. | Appropriate utilization of services. | Beneficial health outcomes. |
MOC 4: QUALITY MEASUREMENTS AND PERFORMANCE IMPROVEMENT

- Patient satisfaction is the cornerstone of patient engagement. Satisfied patients are more likely to comply with their care plan. Improving the patient experience can enhance your patients’ satisfaction, and potentially translate into improved clinical outcomes and patient safety.

- EmblemHealth uses the CAHPS and HOS tools to measure member satisfaction. CAHPS and HOS are fielded yearly per CMS requirements
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)®
  - Health Outcomes Survey (HOS)

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
You and your staff can encourage your patients to take these surveys, but do not influence their responses. The surveys ask them about their experience with you, their health plan, and the care they receive. Results of the surveys tell us how well we’re meeting their needs and where we may improve.

Based on these results, underperforming measures are identified, and interventions are planned accordingly as part of EmblemHealth’s performance improvement plan. Results of the surveys are used to establish future threshold goals to improve performance and member satisfaction.
IMPORTANT REMINDERS

Do not balance bill dual members with Medicaid and Qualified Medicare Beneficiaries.

- Providers must bill Medicaid or Medicaid plan for cost sharing in most cases.
- Medicare and Medicaid payment, if any, must generally be accepted as payment in full.
- Providers who inappropriately bill Medicare-Medicaid Qualified Medicare Beneficiaries are subject to sanctions.
CONGRATULATIONS

You should now have a better understanding of:

• The definition of a SNP and characteristics of the SNP population
• The objectives and components of the MOC
• Your responsibilities as a network provider for SNP members
• The importance of your active participation in the MOC
COMPLETE YOUR ATTESTATION

• Each year, the Centers for Medicare & Medicaid Services (CMS) requires you to complete the Special Needs Plan (SNP) Model of Care (MOC) provider training for each of the dual-eligible SNPs in which you participate.
  – Complete your attestation with this link.
Thank you