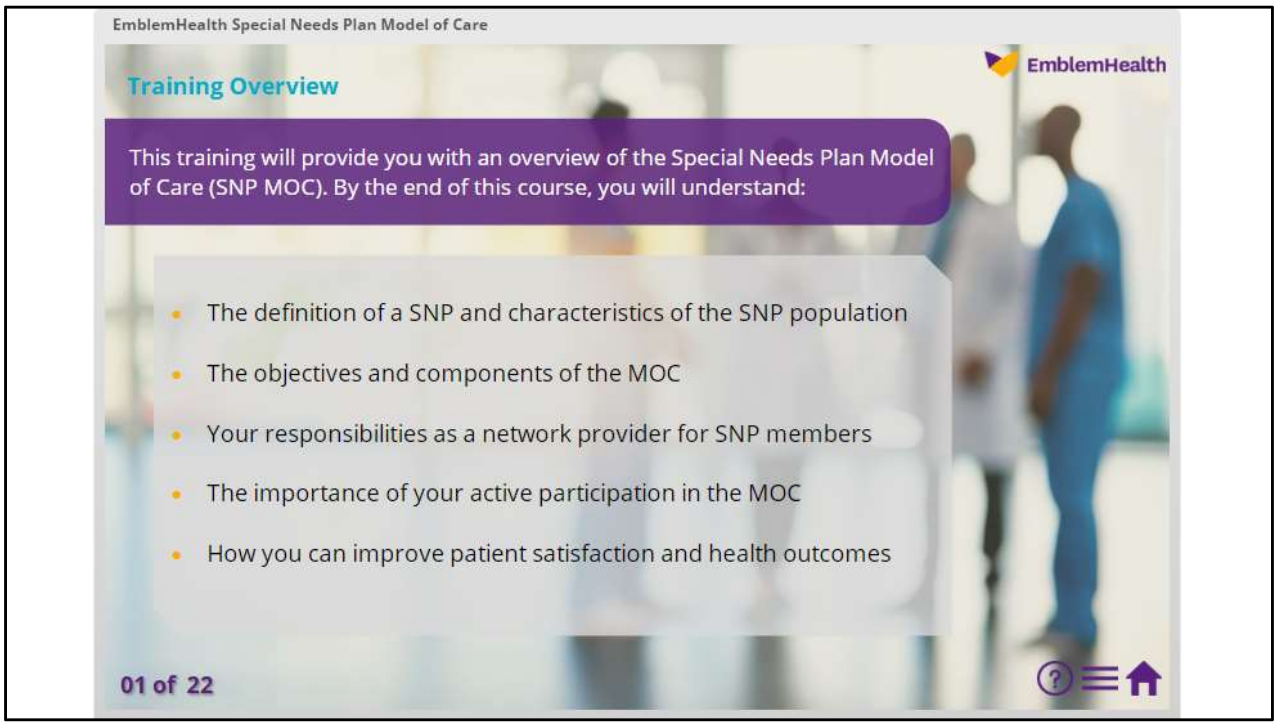
Welcome to the 2020 EmblemHealth Special Needs Plan Model of Care training for providers.

We value your partnership in caring for our members.

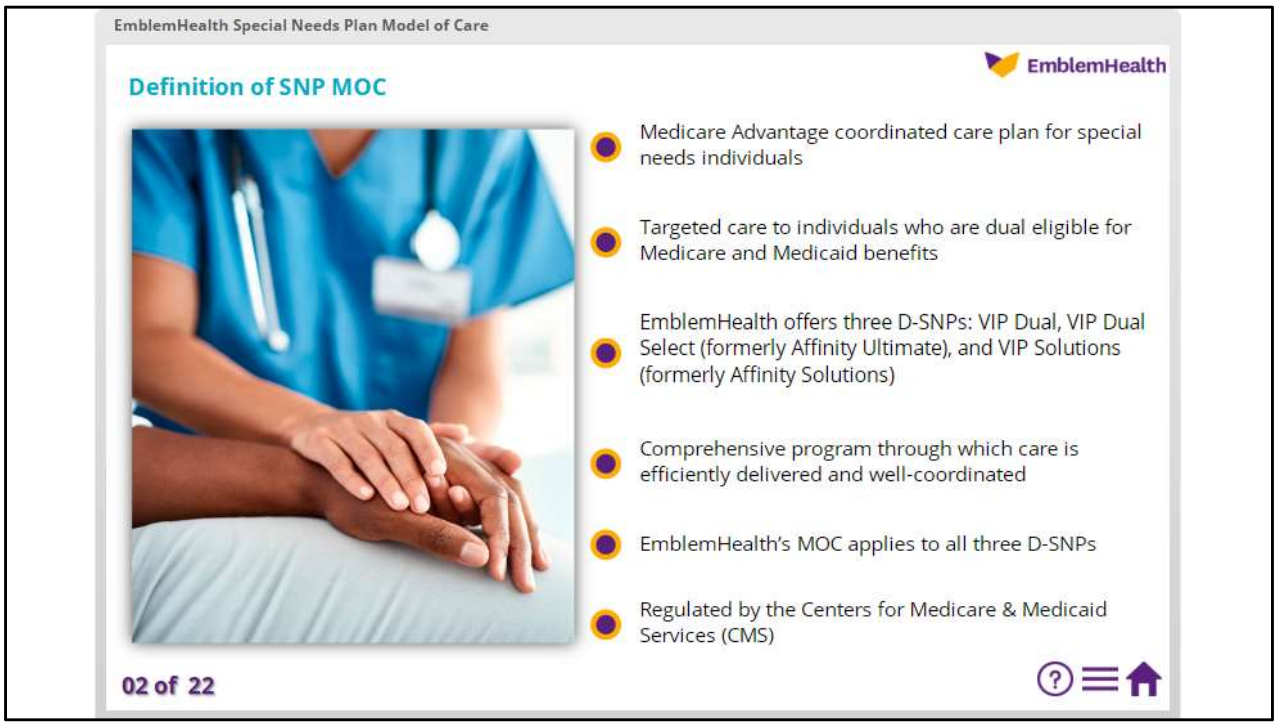
This course will provide you with information to help you care for your patients with special needs.

Click the Start button to launch the course.



This training will provide you with an overview of the Special Needs Plan Model of Care. 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 model of care.
- Your responsibilities as a network provider for SNP members.
- The importance of your active participation in the model of care.
- How you can improve patient satisfaction and health outcomes.



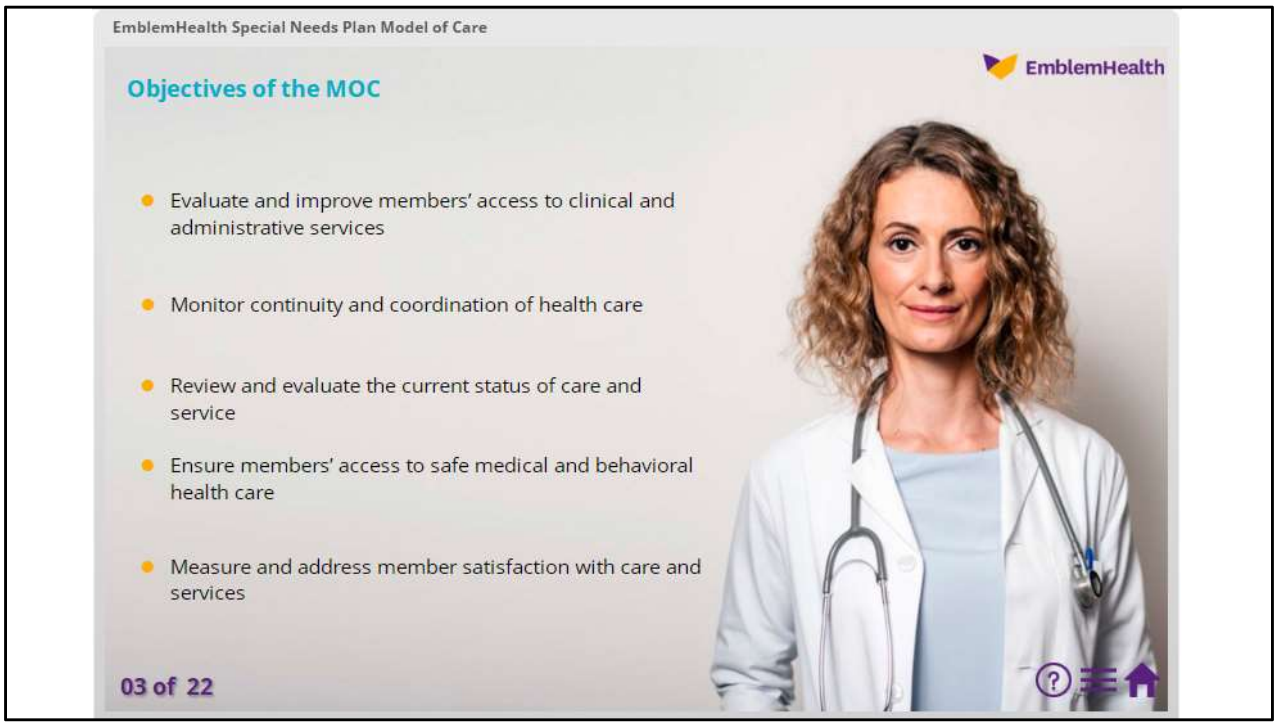
Let's start by defining SNP model of care.

SNP is a Medicare Advantage coordinated care plan that limits enrollment to Medicare beneficiaries with special needs (i.e., live in an institution, have Medicare and Medicaid benefits, or have a chronic condition).

SNPs designed to provide targeted care to individuals who have both Medicare and Medicaid benefits (also known as "dual eligibles") are Dual Eligible SNPs (D-SNPs). EmblemHealth offers three D-SNPs with varying benefits: VIP Dual, VIP Dual Select (formerly Affinity Ultimate), and VIP Solutions (formerly Affinity Solutions). We'll discuss these plans in more detail later in this training.

SNP model of care is a 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. EmblemHealth's model of care applies to all three of our D-SNPs.

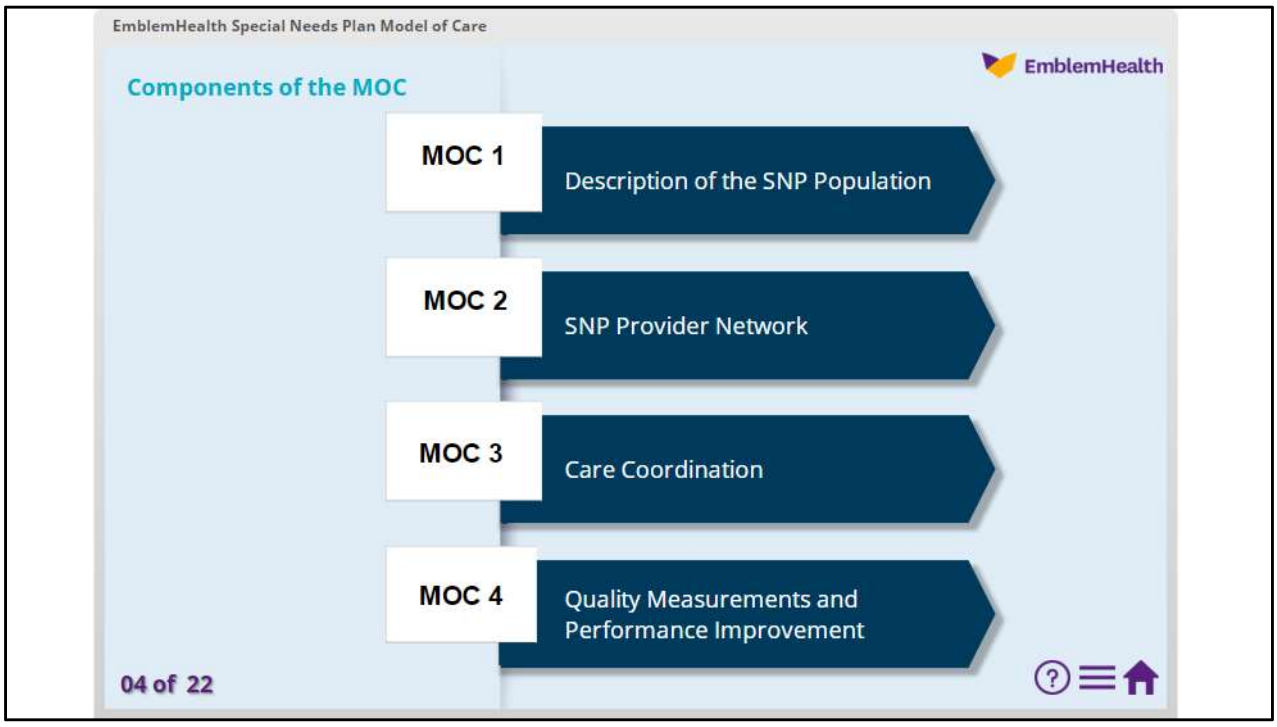
The Centers for Medicare & Medicaid Services (CMS) regulate all SNPs. CMS reviews and approves each SNP's model of care.



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:

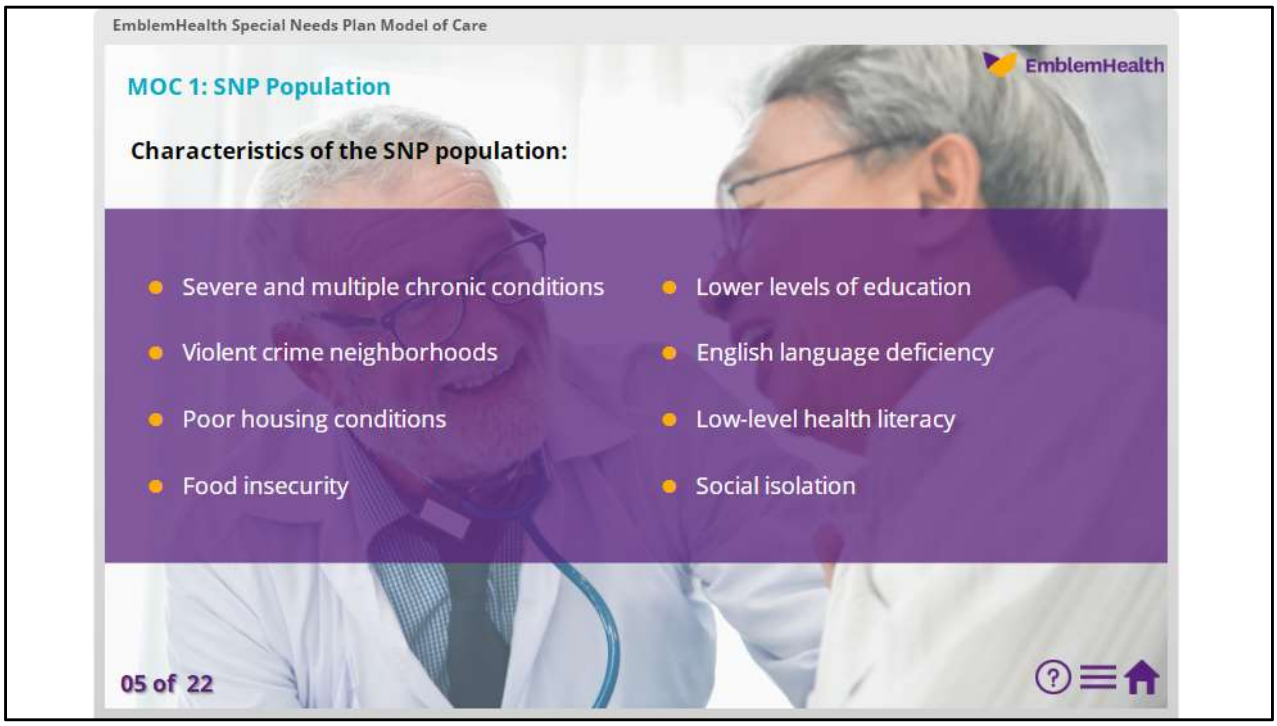
- Evaluate and improve members' access to clinical and administrative services.
- Monitor continuity and coordination of health care.
- Review and evaluate the current status of care and service against regional and national requirements and benchmarks such as NCQA's Quality Compass Accreditation/90th 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.



There are four components of the model of care:

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

Now, let's look more closely at each of the four components of the model of care.



Model of Care 1 is the SNP Population. This component describes some of the health and economic characteristics of the SNP population, and the EmblemHealth resources you can make available to them.

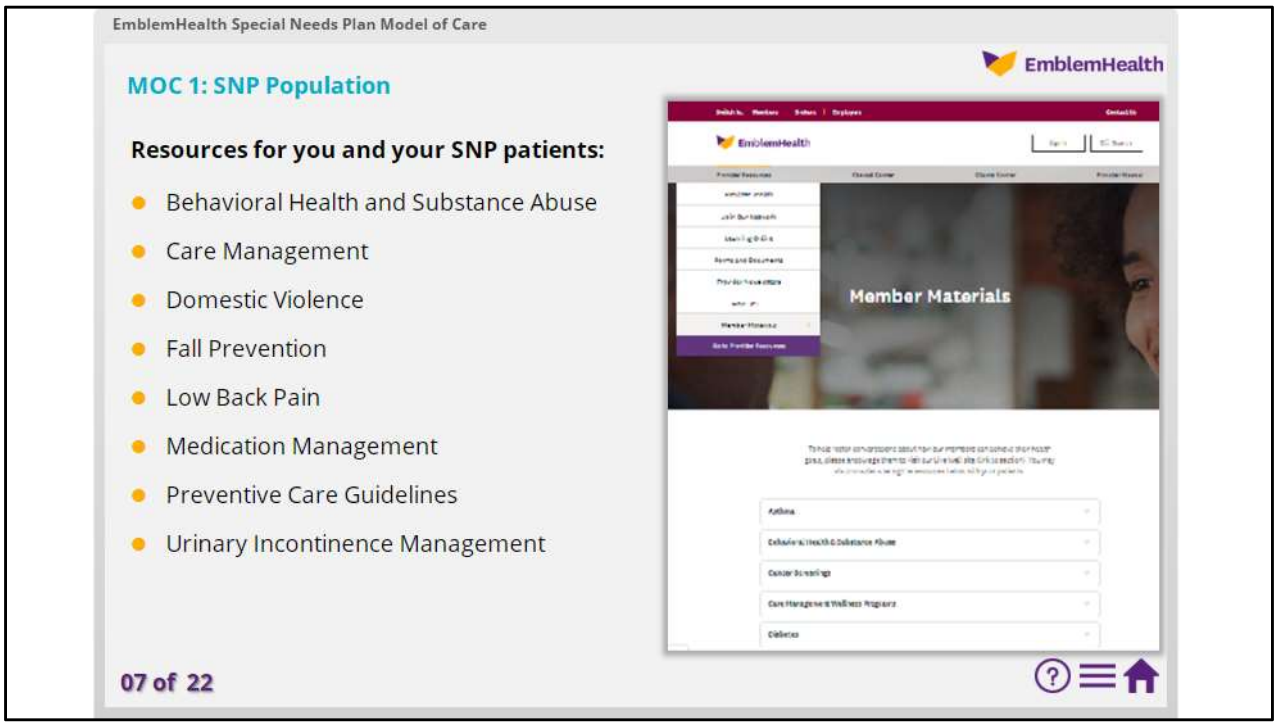
EmblemHealth currently has approximately 23,893 SNP members. They are a highly vulnerable population. SNP members have a high incidence of chronic conditions and behavioral health conditions including substance use disorders. Many SNP members have more than one chronic condition, which leads to higher risk of poor health. They need access to home and community-based services, intensive care coordination, and proactive monitoring of their health status.

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.

EmblemHealth offers three SNPs with varying benefits: VIP Dual, VIP Dual Select (formerly Affinity Ultimate), and VIP Solutions (formerly Affinity Solutions).

Our plans include all the coverage included with Medicare, plus extra benefits designed to meet our members' needs in a personal way, like preventive and/or comprehensive dental, hearing aids, vision, and Medicare Connect Concierge.

EmblemHealth Medicare Connect Concierge can help members make a doctor's appointment, get referrals if needed, coordinate preauthorizations, answer benefit questions, verify mailing address, arrange transportation, and confirm over-the-counter drug card balance. Please make sure your patients know about these benefits and take advantage of them.



EmblemHealth shares information with members in simple and clear communication. Many of these materials are available for you to give to your patients as well – visit Member Materials in the Provider Resources section of **emblemhealth.com/providers**.

For assistance with interpreter services for multi-language, and speech and hearing impaired, providers can call our Provider Call Center at **866-447-9717**.

For assistance with services for the visually impaired, providers may contact Lighthouse Guild at **800-284-4422**.

For Continuing Education and Resources in Cultural Competency, visit our Learning Online page under Provider Resources at **emblemhealth.com/providers**.

For assistance with care coordination services, providers can contact Care Management at **800-447-0768**, Monday thru Friday from 9 am to 5 pm.

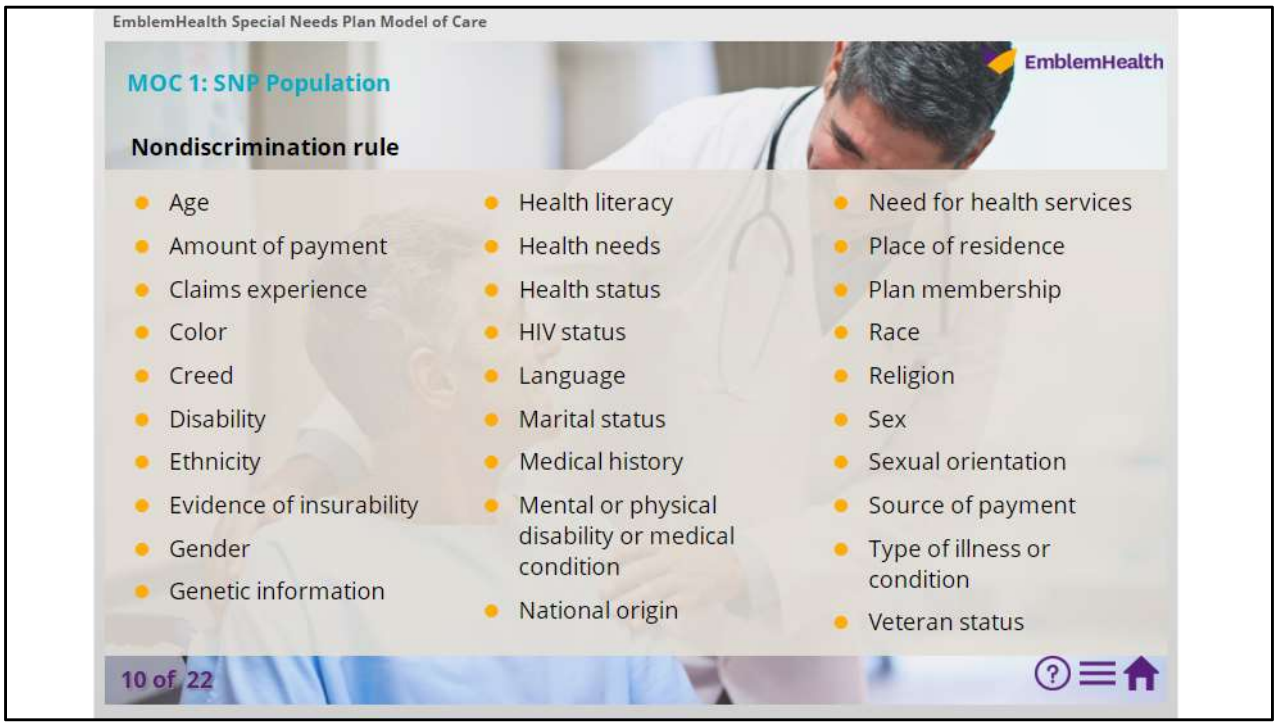
EmblemHealth Neighborhood Care helps practitioners manage patient care by supporting the practitioner-patient relationship. Neighborhood Care provides in-person customer support, access to community resources, and programming to help the community learn healthy behaviors. Members and non-members alike can visit Neighborhood Care and take advantage of our classes, tools, and face-to-face support. Our health and wellness classes support the different dimensions of wellness, including physical, financial, social, and emotional.

These are some examples of the classes and community referrals offered. To recommend a member visit a local Neighborhood Care site for services, you can use the EmblemHealth Neighborhood Care Physician Referral form located in the Provider Toolkit under the Provider Resources tab at **emblemhealth.com/providers**. For more information, visit **emblemhealth.com/neighborhood**.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from Medicare-Medicaid dual-eligible individuals.

Providers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, New York state can limit Medicare cost-sharing payments, under certain circumstances.

Medicare and Medicaid payments, if any, must generally be accepted as payment in full. Medicare-Medicaid dual-eligible individuals are exempt from Medicare cost-sharing liability.



Providers must comply with all applicable laws prohibiting discrimination against any member and in accordance with the same standards and priority as the provider treats their other patients regardless of any of these factors.

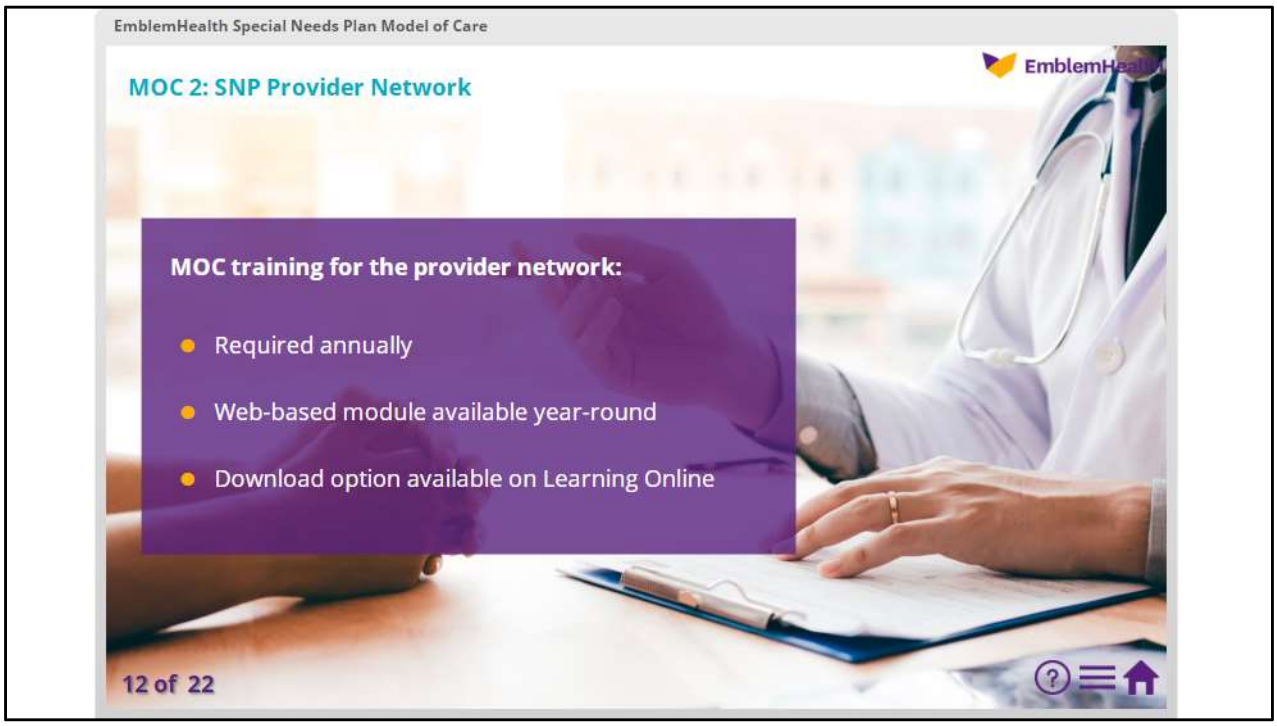
In addition, our providers must comply with:
• Terms of EmblemHealth's and ArchCare's contracts with the New York State DOH and/or CMS
• Laws that apply to recipients of federal funds, and all other applicable laws or regulations
• Age Discrimination Act of 1975
• Americans with Disabilities Act
• Title VI of the Civil Rights Act of 1964
• Health Insurance Portability and Accountability Act
• HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law
• Section 1557 of the Affordable Care Act of 2010

Model of Care 2 is the SNP Provider Network. This component provides you with tools to help you care for your SNP patients, like model of care training, access standards, medical policies, and practice guidelines.

EmblemHealth supports four SNPs with two provider networks.

Members in EmblemHealth's three SNPs have access to providers in the VIP Prime Network: VIP Dual, VIP Dual Select (formerly Affinity Ultimate), and VIP Solutions (formerly Affinity Solutions).

EmblemHealth also leases its Network Access Network to ArchCare for medical and hospital services.

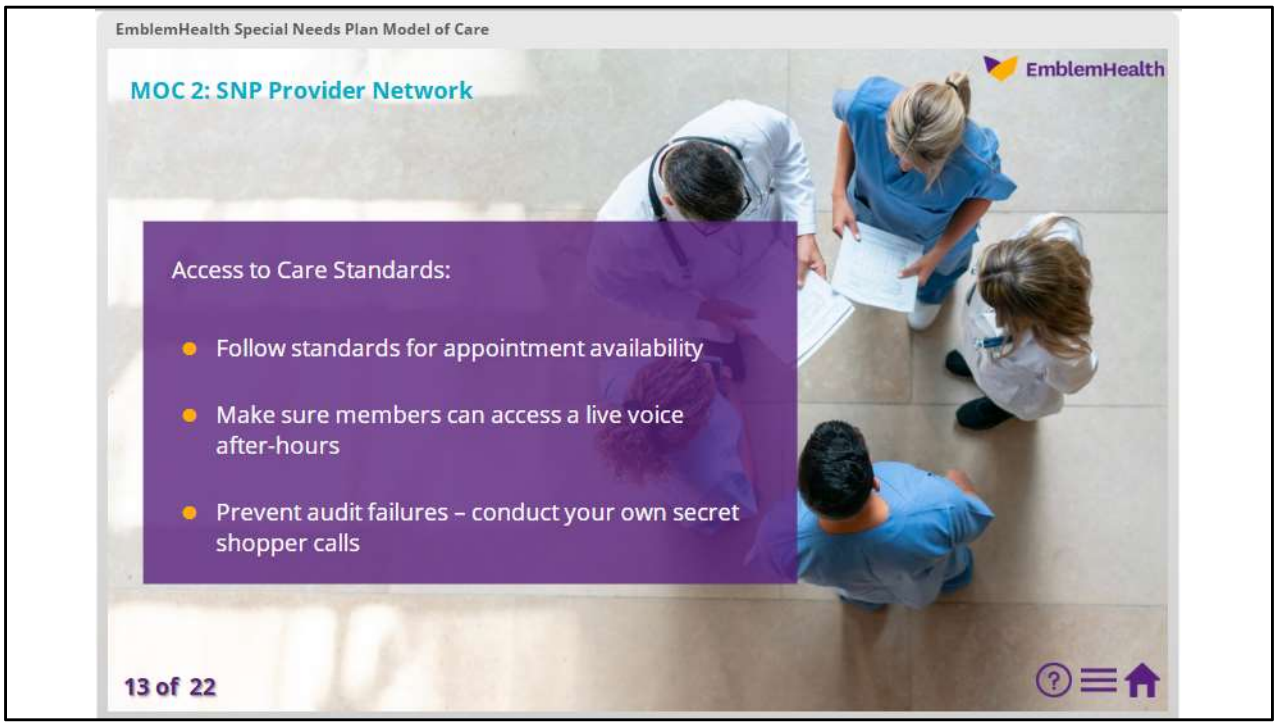


CMS requires all Medicare providers to complete model of care training for each of the SNPs with which they participate. On an annual basis, providers are notified about the importance of completing SNP model of care training for EmblemHealth and ArchCare.

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 of **emblemhealth.com/providers**.

EmblemHealth's web-based SNP model of care training module is available year-round on our Learning Online page. As an alternative to completing this training online, the Learning Online page offers an option for individual and group practices to download this training, and return 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.

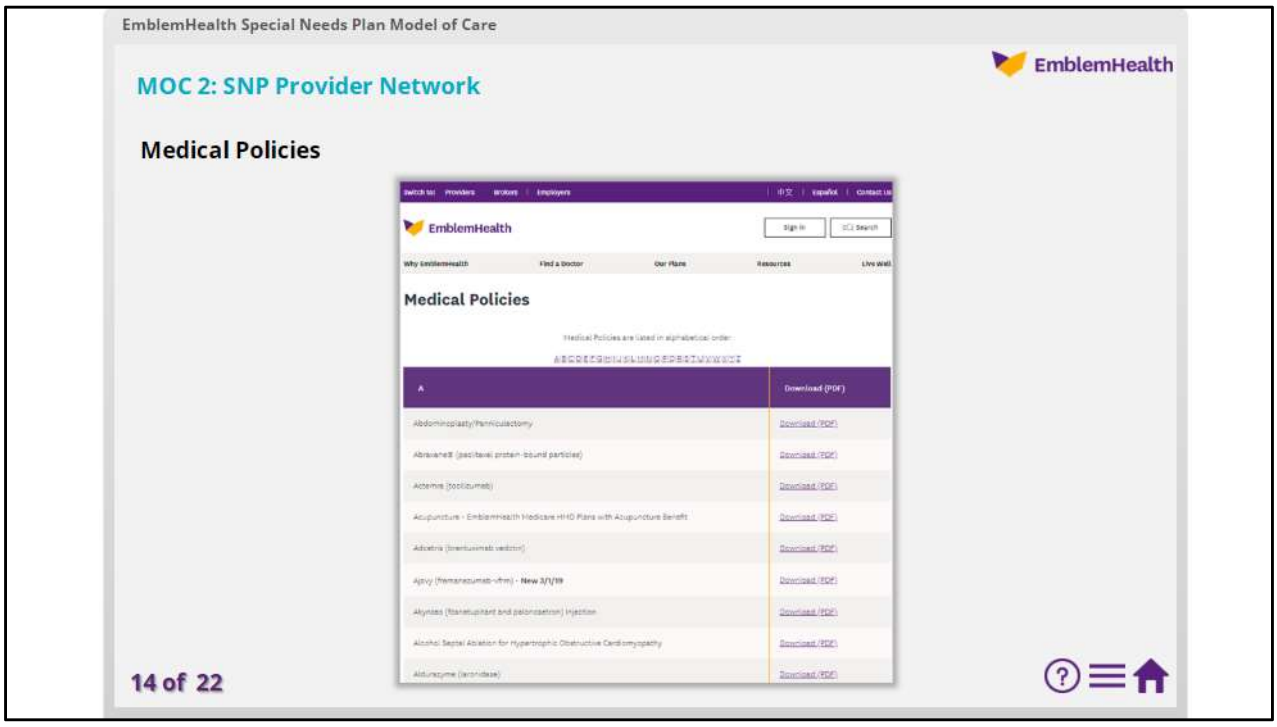
If you have a large group practice, consider reviewing the training module in a staff meeting. As you go through the material and review the requirements, discuss the procedures you have in place and create a plan of correction to address any gaps you identify.



It's important for our members to get the right care at the right time. It's a part of our joint commitment to quality patient care.

Providers are expected to adhere to EmblemHealth's appointment availability and 24-hour access standards such as: non-urgent sick visit within 48 to 72 hours, routine care visit within 4 weeks, and oncology specialist visit within 3 business days. For after-hours coverage, make sure members can access a live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner.

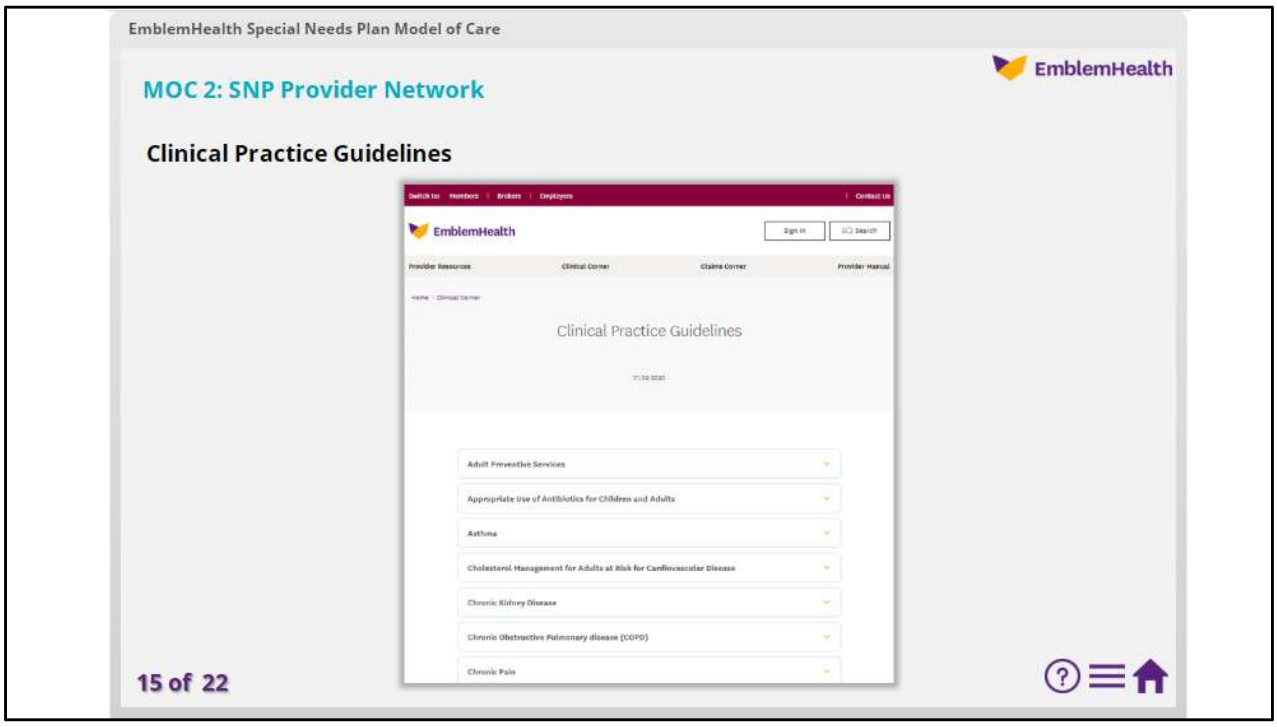
As part of our quality management program, EmblemHealth randomly audits its network providers for 24-hour access and appointment availability. Noncompliant providers are notified and audited again. Common mistakes leading to audit failures include: no answer, wrong number, number not in service, and constant busy signal. Set up your own secret shopper audit calls to ensure compliance with EmblemHealth's access to care standards. The full list of standards is available in the online Provider Toolkit on **emblemhealth.com/providers** under the Provider Resources tab.



Providers are encouraged to review and implement EmblemHealth's Medical Policies to determine the medical appropriateness of specific interventions.

Medical Policies are posted to the Clinical Corner section of **emblemhealth.com/providers**. Our provider newsletter, "In the Know," is sent via email about once a month. It will notify you of medical policy updates, so make sure we have a current email on file for you.

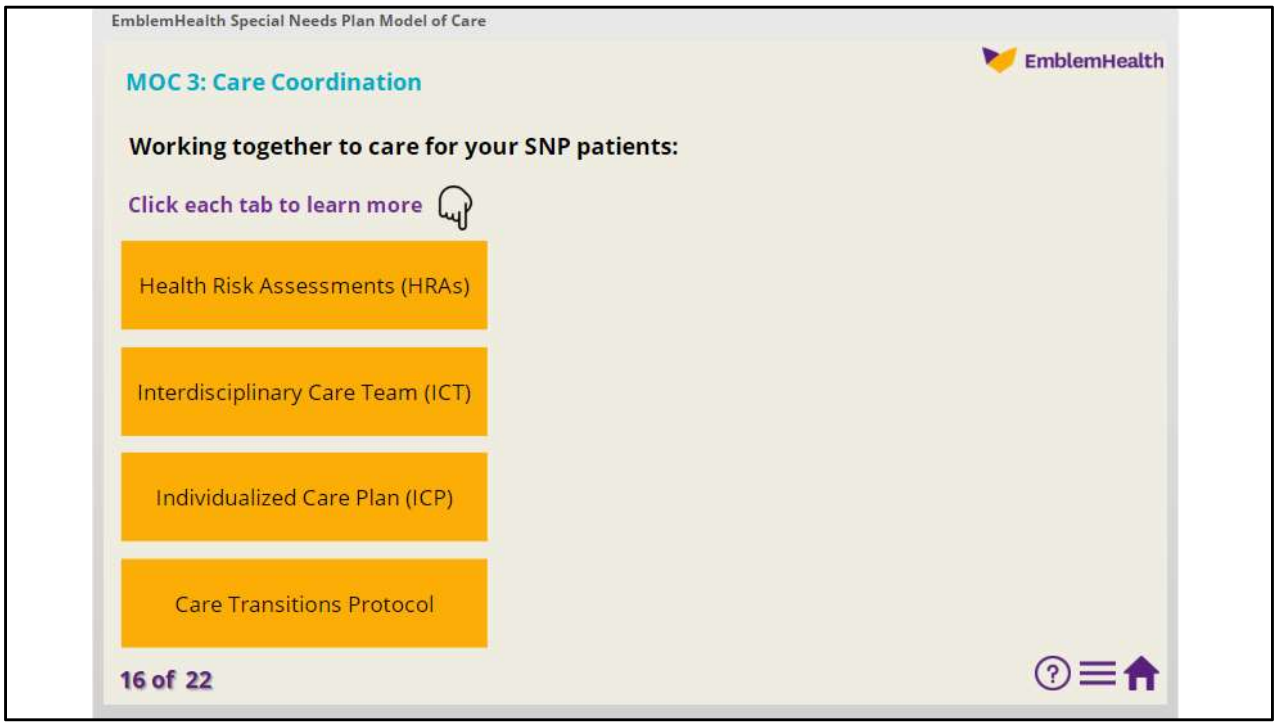
To review and make changes to your profile, sign in to the secure provider portal at **emblemhealth.com/providers**, or fax changes to Provider Modification at **877-889-9061**. If you are part of a group with delegated credentialing, have your Administrator submit changes on the dataset.



EmblemHealth's Clinical Practice Guidelines are available in the Clinical Corner section of **emblemhealth.com/providers**.

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. Again, please make sure we have a current email on file for you so you can receive timely updates.

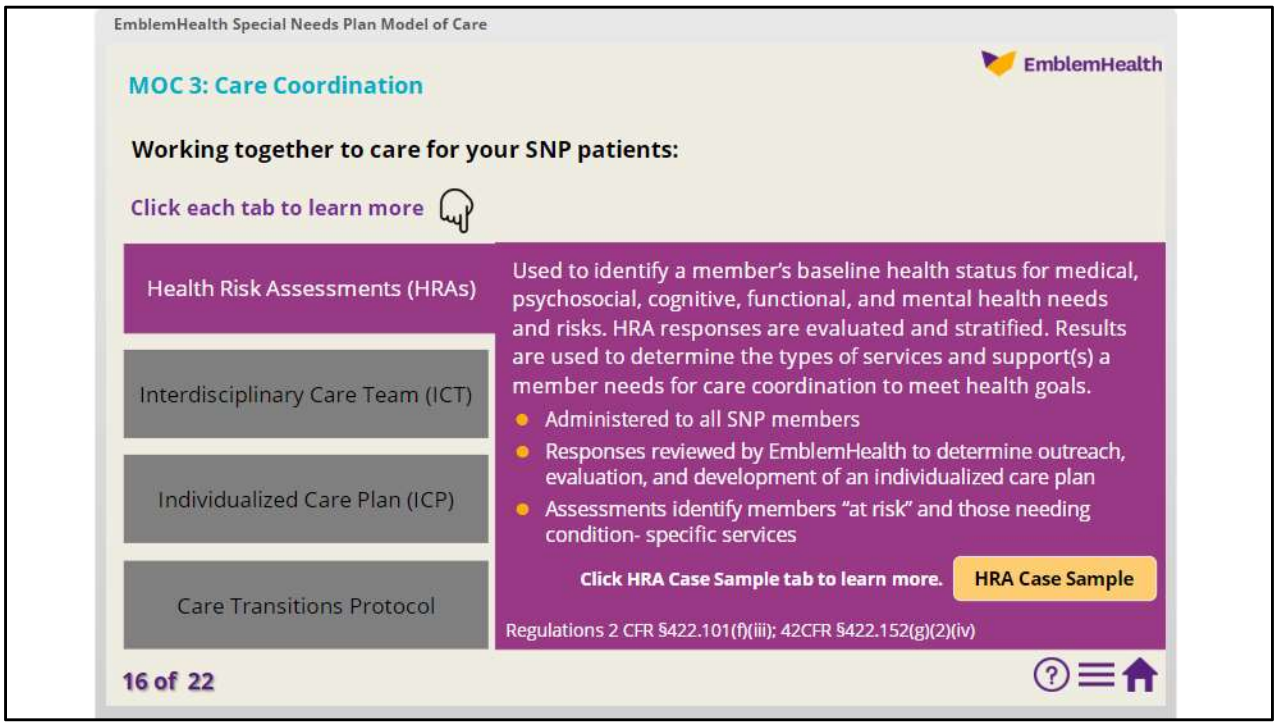


Model of Care 3 is Care Coordination. Working together to care for the special health needs of your SNP patients is important, and your participation is essential for optimal coordination of care.

There are four elements in care coordination:

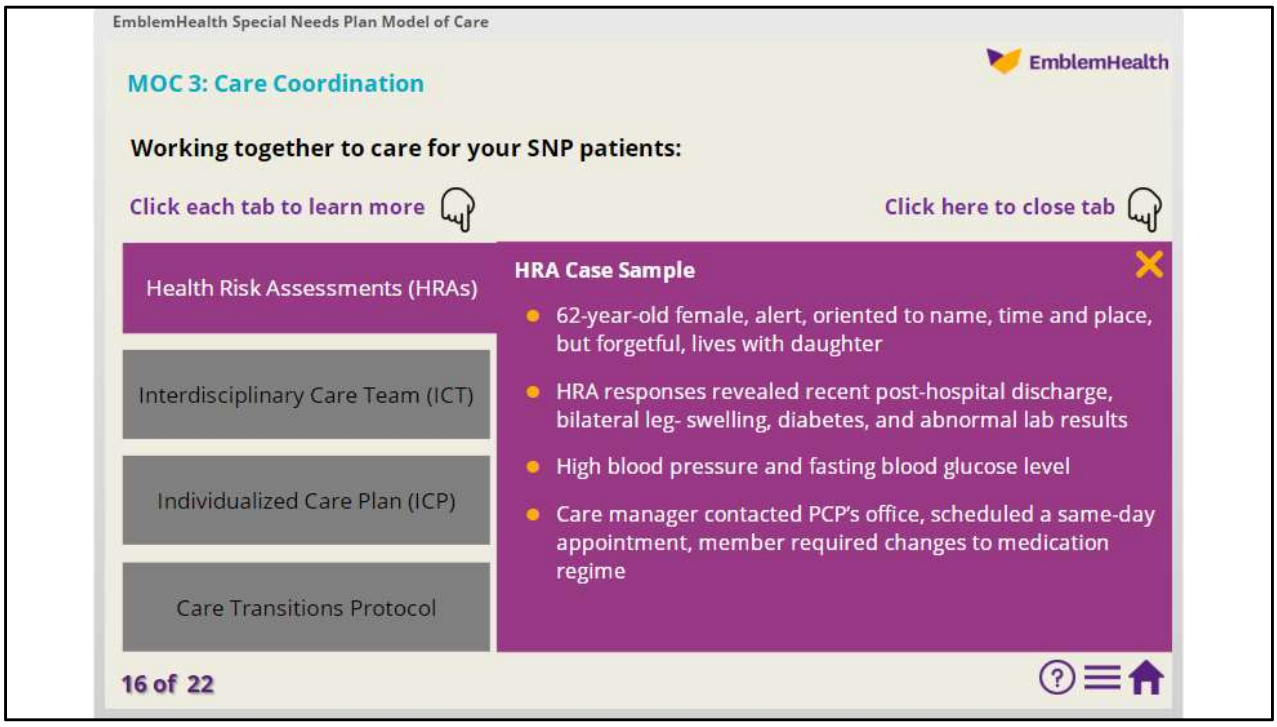
- Health Risk Assessment
- Interdisciplinary Care Team
- Individualized Care Plan
- Care Transitions Protocol

Let's look more closely at each of these elements by clicking on each of the tabs to learn more.



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.

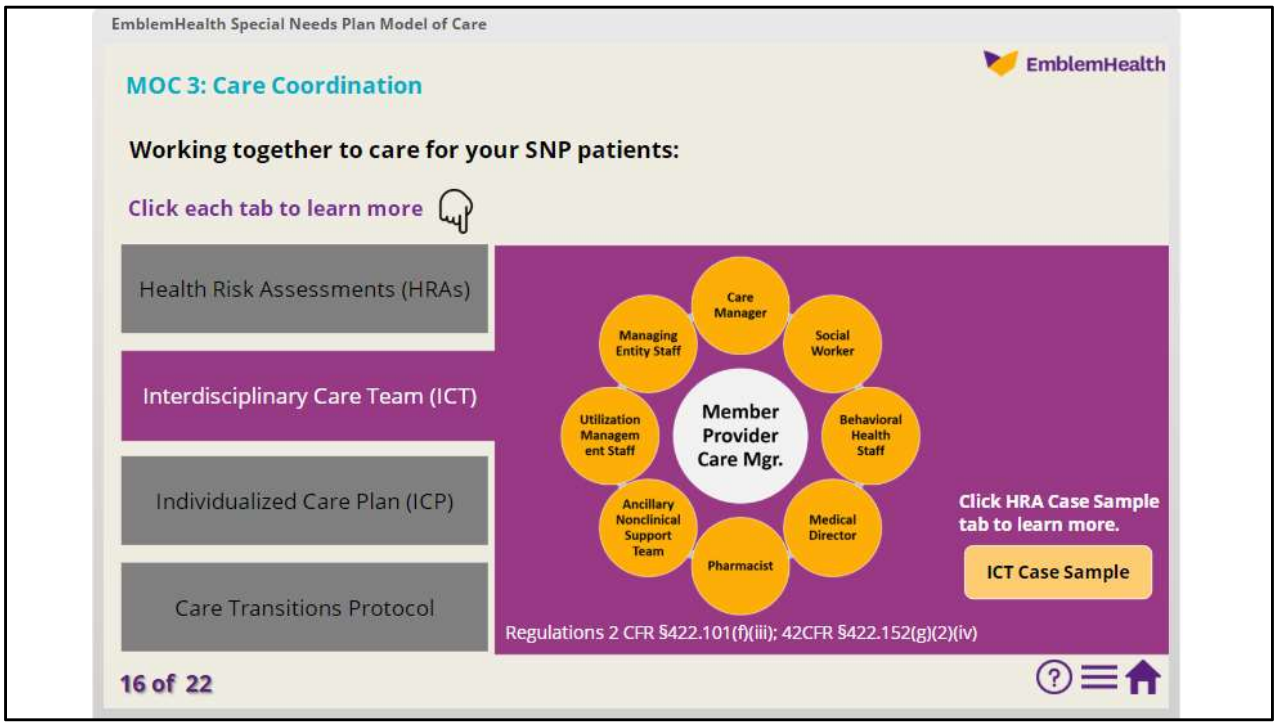
You can assist in this process by encouraging your EmblemHealth members to complete the HRA survey. The information provided in the HRA helps the EmblemHealth Care Management Department determine the types of services and supports they may need as part of their care plan. The Care Management Department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



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.

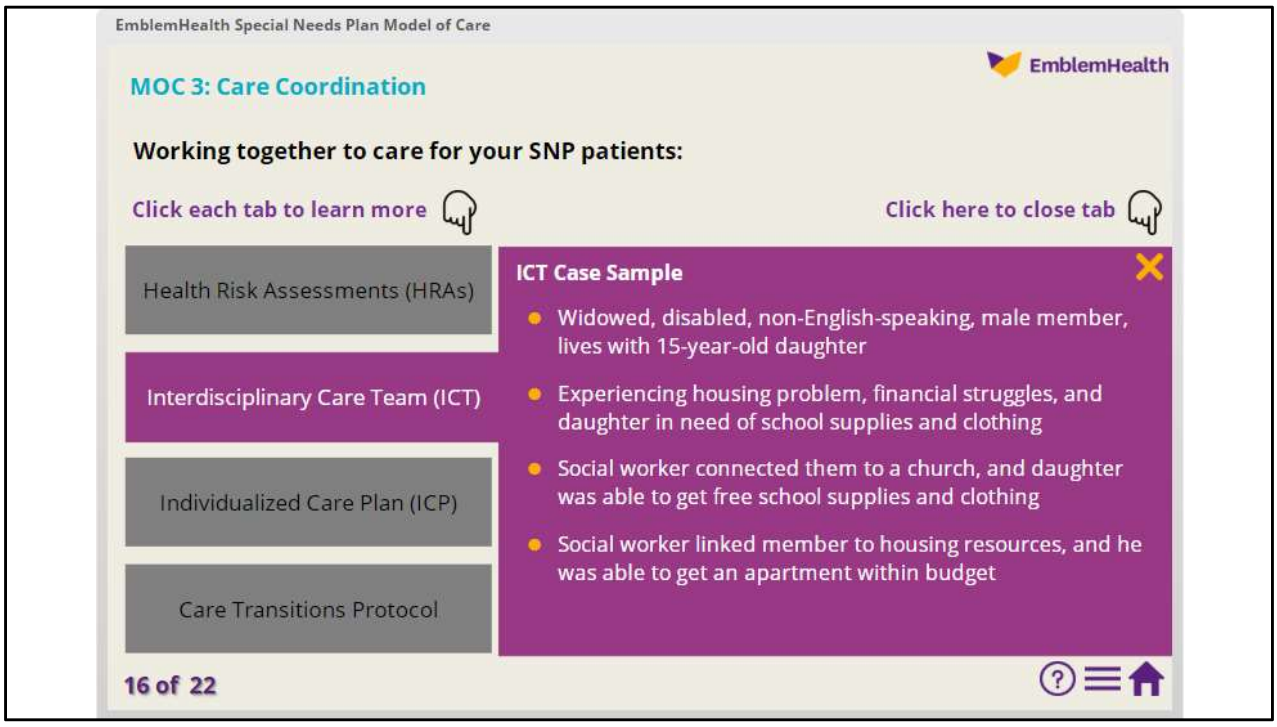
The daughter reported the member's blood pressure and fasting blood glucose level as always high. EmblemHealth's care manager immediately contacted the member's PCP office for care coordination. The PCP's office scheduled a same-day appointment. The care manager followed up with the PCP, who indicated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



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

This multidisciplinary team structure 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 monthly for 1 hour with selected SNP cases for presentation. Meetings are held in person with telephonic options for members, caregivers, and providers.

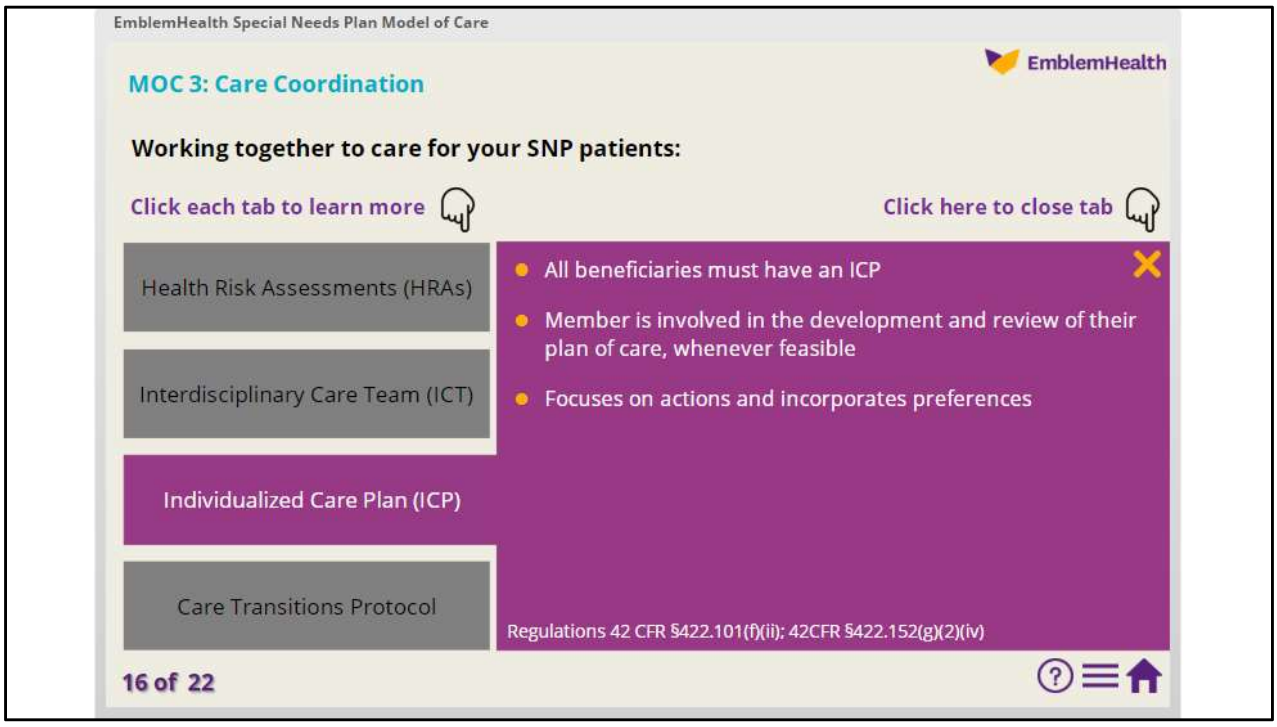
The ICT assists in the care plan development and implementation, and enables the member to have access to care coordination. The care management team proactively contacts the appropriate providers to identify the specific needs and services the member requires. Providers are encouraged to participate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



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.

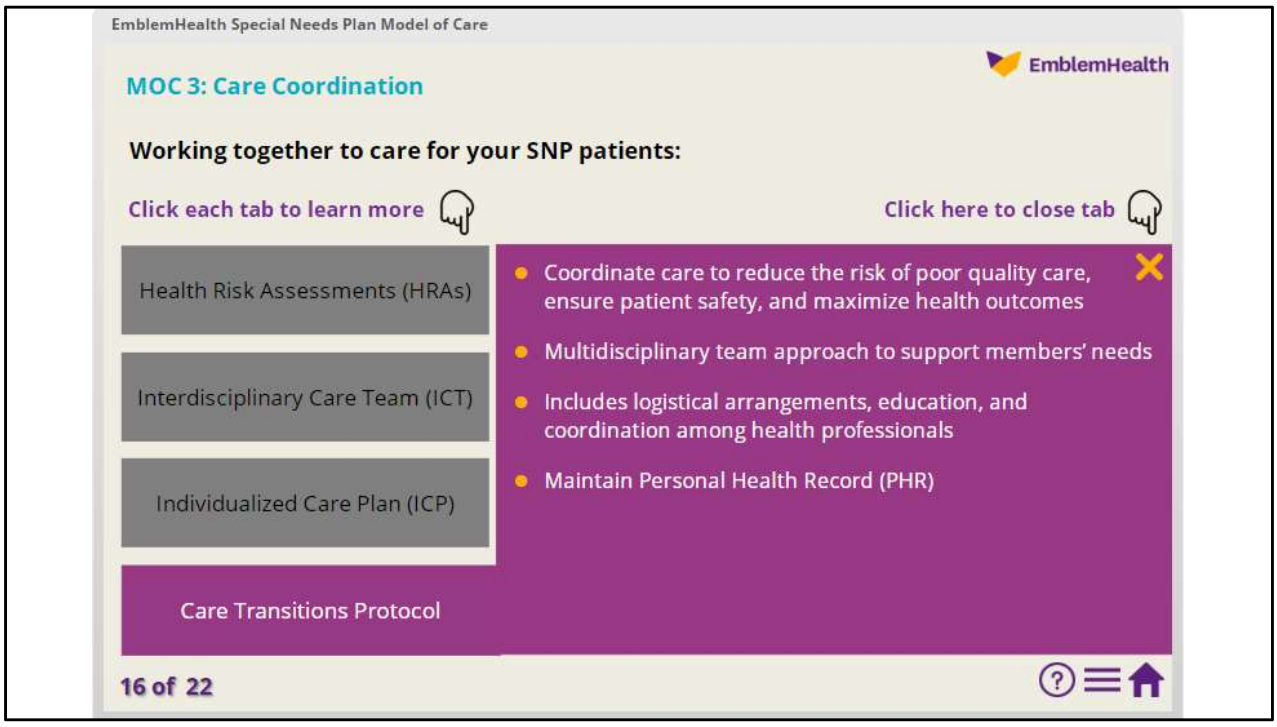


Regulations stipulate all SNPs must develop and implement an Individualized Care Plan for each individual enrolled in the SNP.

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.

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.



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. eviCore provides transitional care services for SNP members discharging from the hospital with Inpatient Post-Acute Care Services or Home Care Services. Members are managed by the eviCore Transitional Care Program for 90 days post hospital discharge.

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.

Finally, Model of Care 4 is 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.

EmblemHealth uses specific measures from claims and medical records data to evaluate the effectiveness of care SNP members receive.

Our goal is to improve performance for health outcomes measures, and as a result, improve the overall health outcomes of our SNP population.

As you care for SNP members, consider these measures and implement strategies in your practice to enhance health outcomes.

Here are some recommendations to guide discussions with patients during office visits and help better manage their health.

Physical activity in older adults:
- Ask patients about overall physical and mental well-being and quality of life.
- Ask patients about level of exercise and physical activity and make recommendations.
- Emphasize the benefits of exercise on improved physical functioning.

Management of urinary incontinence:
- Ask patients about urinary incontinence.
- Ask if patients are currently receiving any treatment.
- Educate patients on potential treatment options based on severity.

Fall risk management:
- Ask patients about falls, feeling dizzy, problems with balance or walking, blurry vision, eye exams, and updated eye prescriptions.
- Discuss risk factors and consequences of falls.
- Educate patients on how to prevent falls.

EmblemHealth uses the CAHPS and HOS tools to measure member satisfaction. CAHPS and HOS are fielded yearly per CMS requirements.

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.

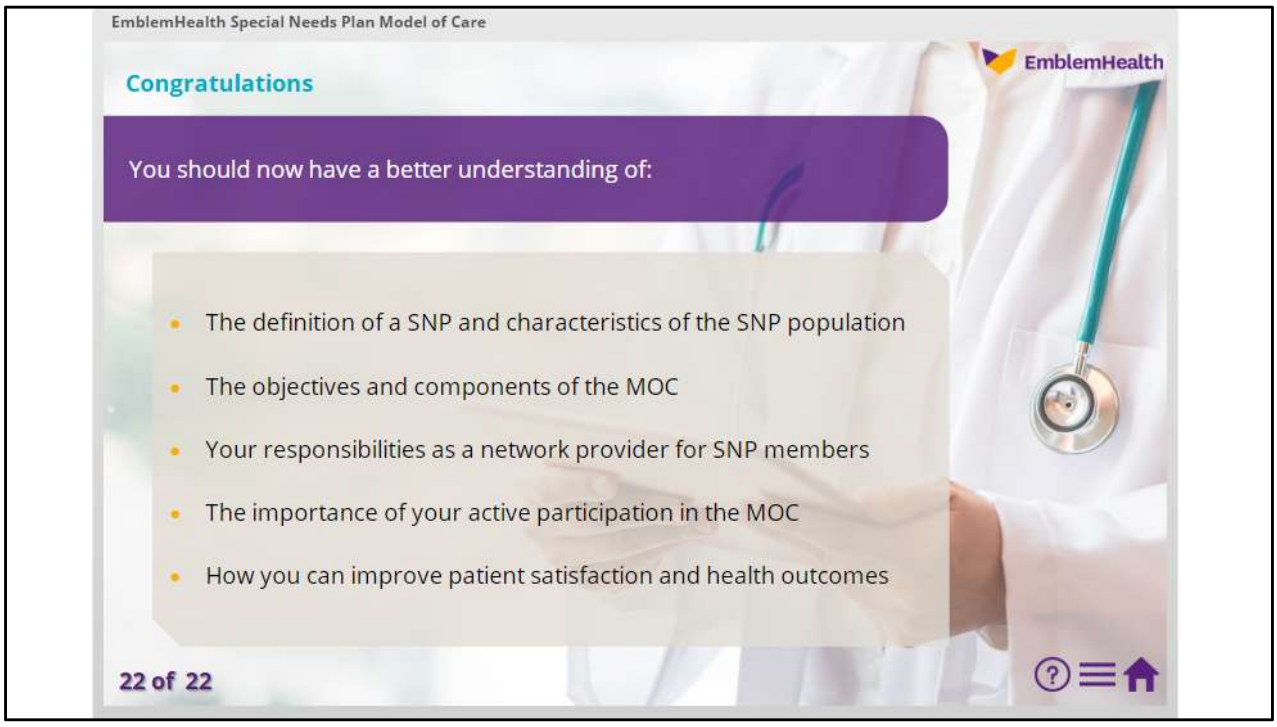
Based on these results, underperforming measures are identified, and interventions are planned accordingly as part of EmblemHealth's performance improvement plan. Results of the surveys are used to establish future threshold goals to improve performance and member satisfaction.

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.

Using these quick tips can go a long way in increasing patient satisfaction.

- Review patient's medical record before entering the exam room.
- Greet your patient by name.
- Engage your patient in conversation.
- Review test results and ask questions, like:
    - Have you been able to make the changes we talked about at your last appointment?
    - Do you feel these changes are working for you?
    - What other changes do you feel you can make to help manage your condition over the long term?

Continue these best practices so your patients feel well cared for and commit to follow-up care.



Congratulations – you have reached the end of this course. 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 model of care.
- Your responsibilities as a network provider for SNP members.
- The importance of your active participation in the model of care.
- How you can improve patient satisfaction and health outcomes.