EmblemHealth Special Needs Plan Model of Care

2026 – 2028 Provider Training

EmblemHealth

Welcome

Welcome to the 2026 – 2028 EmblemHealth Special Needs Plan (SNP) Model of Care (MOC) provider training.

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 SNP MOC. By the end of this course, you will understand:

The definition of an SNP and characteristics of the SNP population.	The objectives and components of the MOC.	Your responsibilities as a network provider to SNP members.	The importance of your active participation in the MOC.

Definitions of SNP and MOC

Let’s start with some definitions of SNP and MOC.

Medicare Advantage coordinated care plan for special needs individuals

C-SNP: a Medicare beneficiary with a severe or chronic condition

I-SNP: a Medicare beneficiary who is institutionalized or eligible for nursing home care

D-SNP: a beneficiary who is dually eligible (Medicare and Medicaid)

Definitions of SNP and MOC (continued)

EmblemHealth offers dual special needs plans (D-SNPs) in 24 counties in New York.

A D-SNP 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.

The Centers for Medicare & Medicaid Services (CMS) regulates all SNPs. CMS reviews and approves each SNP's MOC.

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 services 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:			
Description of the SNP Population	Care Coordination	SNP Provider Network	Quality Measurement and Performance Improvement

We will look closely at each of the four components of the Model of Care.

Description of the SNP Population

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

- Severe and multiple chronic conditions.
- Lower income and wealth.
- Housing instability.
- Food insecurity/poor nutritional status.
- Lower levels of education – limited health literacy.
- English language deficiency.
- Higher needs of care coordination and support.
- Social isolation.
- High utilization of care including emergency rooms visits.
- No cell/home phones available, difficult to reach.
- Cultural considerations.

Description of the SNP Population
(continued)

- SNP members have a high incidence of chronic 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 home and community-based services, intensive care coordination, and proactive monitoring of their health status.

Community Resources for the SNP Population

- EmblemHealth Neighborhood Care provides in-person and virtual customer support, connection to community resources, and programming to help the entire community learn healthy behaviors. Members and nonmembers can visit Neighborhood Care and take advantage of our classes, resources, and face-to-face support.

- Neighborhood Care has locations across New York City.

- For more information, call **800-274-2950** or email **neighborhood@emblemhealth.com**.

Care Coordination

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

There are six elements in care coordination:					
SNP Staff Structure	Health Assessment (HA)	Face-to-Face Encounters	Interdisciplinary Care Team (ICT)	Individualized Care Plan (ICP)	Care Transitions Protocol

Care Coordination (continued)

SNP Staff Structure

EmblemHealth has a comprehensive team of care management staff that performs clinical oversight functions. We also have a team of qualified clinicians who directly support our SNP members.

Clinical staff and other administrative staff work together to coordinate health care needs and preferences for health services. This staff provides critical functions to maintain a solid framework for the SNP membership and the coordination of the model of care.

Care Coordination (continued)

Health Assessments (HAs)

Used to identify a member's baseline health status for medical, psychosocial, cognitive, functional, and mental health needs and risks. HA responses are evaluated, and the results are used to determine the types of services and support(s) a member needs to meet health goals.

- Administered to all SNP members within the first 90 days of enrollment then annually.
- Responses are reviewed by EmblemHealth to determine outreach, evaluation, and development of an individualized care plan.
- Assessments identify members who are at risk and those needing condition-specific services.

Care Coordination (continued)

Health Assessments (HAs)

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

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

CMS Requirements - Regulations 42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv)

Care Coordination (continued)

Here's a case that demonstrates the importance of an HA.

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 who lives with her daughter. The member was an HA non-responder. Our team was able to complete the HA. 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 that the member's blood pressure and fasting blood glucose level are always high. Our 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 regimen.

Care Coordination (continued)

Face-to-Face Encounters

Providers are required to conduct face-to face encounters with SNP members for the delivery of health care services at least annually, beginning within the first 12 months of enrollment, as feasible, and with the member's consent. A face-to-face encounter must either be in-person or through a virtual (visual, real-time, and interactive) telehealth visit. The intent of the face-to-face encounter is to ensure providers use visual clues to support a more positive member outcome.

When a provider reaches out to conduct a face-to-face encounter, consent must be obtained from the member either when scheduling or prior to the encounter. At the time of the scheduled face-to-face encounter, the provider must educate the member on the purpose of the visit and intended goals for anticipated outcomes to support their delivery of care.

Care Coordination (continued)

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.

As part of the member's ICT, we routinely reach out to providers for care coordination and collaboration.

Regulations 42 CFR §422.101(f)(iii); 42CFR §422.152(g)(2)(iv)

Care Coordination (continued)

Interdisciplinary Care Team (ICT)

Multidisciplinary team structure that 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 composed of clinicians representing various disciplines based on the member's specific clinical needs.

The ICT meets regularly with selected SNP cases for presentation. Meetings are held telephonically with video options for members, caregivers, and providers to participate.

Care Coordination (continued)

Interdisciplinary Care Team (ICT)

The ICT assists in 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.

Care Coordination (continued)

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 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.

Our social worker informed them of and connected them with a church activity in 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.

Care Coordination (continued)

Individualized Care Plan (ICP)

Regulations stipulate that 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 HA, 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)

Care Coordination (continued)

Individualized Care Plan (ICP)

Development of the member-centric care plan is a collaborative effort. The member's health care needs are incorporated into the member's care plan. Information from providers, and other ICT members, helps to ensure a comprehensive care plan is developed. This ICP helps support 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 needs, and your feedback as a provider.

CMS requires all care plans to be shared with members and providers.

Regulations 42 CFR §422.101(f)(ii); 42CFR §422.152(g)(2)(iv)

Care Coordination (continued)

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, or home health. Based on a comprehensive plan of care, transitional care is the special effort to coordinate care which reduces the risk of poor-quality care, ensures patient safety, and maximizes health outcomes.

Partnership from providers and facilities is essential.

CMS requires all care plans to be shared with admitting facilities.

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.

Care Coordination (continued)

Care Transition Protocol

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. The Care Manager ensures the member's care plan is 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.

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 offer three Dual Special Needs Plans in certain New York counties.

VIP Bold Network

- EmblemHealth VIP Dual (HMO D-SNP).
- EmblemHealth VIP Dual Enhanced (HMO D-SNP).

Integrated Benefits Dual eligibles plan with access to care from Enhanced Care (Medicaid) and Enhanced Care Plus (HARP) networks.

VIP Reserve Network

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

SNP Provider Network (continued)

CMS requires all Medicare providers to complete Model of Care training for each of the SNPs with which they participate.

Providers are notified about the importance of completing SNP Model-of-Care training for EmblemHealth as per the MOC approval timeframe.

SNP Provider Network (continued)

The EmblemHealth SNP Model-of-Care training module is available year-round on the EmblemHealth provider portal.		
Individual and group practices must download this training and submit an attestation certifying the materials have been reviewed.	While one attestation may be returned for a group practice sharing the same tax identification number (TIN), each provider is individually responsible for completing 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.

SNP Provider Network (continued)

Medical Policies

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

- EmblemHealth's Medical Policies.

- Our provider newsletter is sent via email about once a month. It will notify you of medical policy updates.

SNP Provider Network (continued)

Clinical Practice Guidelines

- EmblemHealth's Clinical Practice Guidelines.

- 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.

Quality Measurement and Performance Improvement

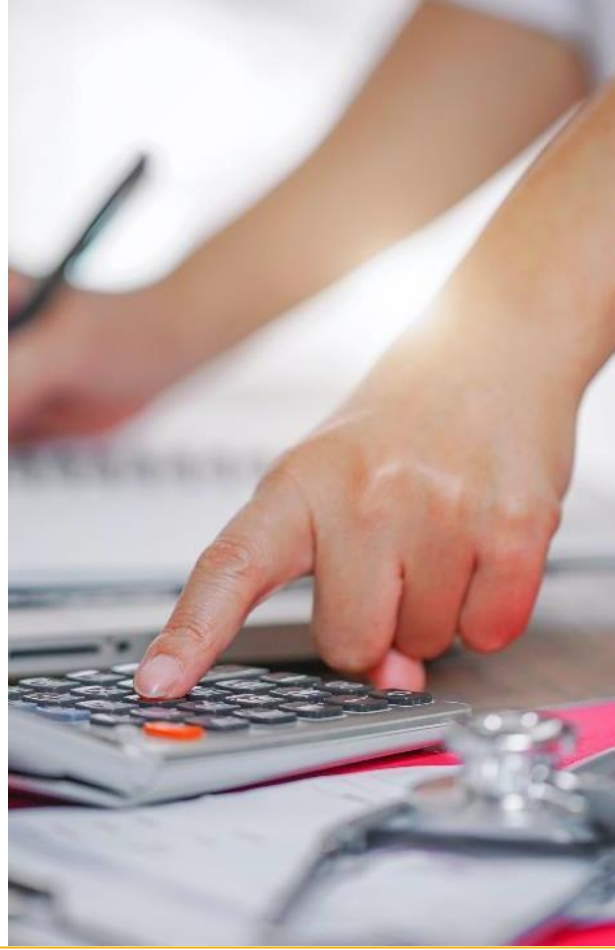
EmblemHealth focuses on quality measures to improve and monitor health outcomes for SNP members.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Health Outcomes Survey (HOS)	Healthcare Effectiveness Data and Information Set (HEDIS®) Measures	Patient Safety – Medication
Survey measures the patient's perception of both their health insurance plan and their doctor.	Survey measures patient outcomes: physical and mental health, fall risk prevention, physical activity, urinary incontinence.	Clinical measures focus on health plans' ability to drive compliance with preventive care and evidence-based medical treatment guidelines.	Pharmacy measures focus on ensuring members are taking medications as appropriate. **Key medication measures:** diabetes, hypertension, cholesterol.
Our provider network plays an integral role in this effort. Here's how providers can help support our members:			
Build relationships with patients and ensure timely access to care that is well-coordinated. ▪ Assess the need for **increased appointment availability**. Consider same-day or evening and weekend availability. ▪ **Communicate in plain language.** Avoid medical jargon. ▪ **Discuss test results** and specialist reports. ▪ Implement **reminder systems** and provide members access to their health records. ▪ **Consider timeliness**. Limit telephone hold times. Limit wait time to under 15 minutes. Keep patients informed if you are running behind schedule	Work with patients to impact their quality of life. ▪ **Mental health:** Assess your patients' symptoms of mental health. ▪ **Physical health:** Ask your patients questions about their overall physical well-being. ▪ **Bladder health:** Initiate discussion with patients around urinary symptoms and impact on quality of life. ▪ **Slips and falls:** Review your patients' fall risk by conducting a fall risk assessment ▪ **Physical activity:** Assess your patients' physical activity levels, including both aerobic and strength training activity.	Help members get important preventive screenings and receive treatment. **Address preventative health** ▪ Annual wellness/preventive visit. ▪ Breast cancer screening. ▪ Colorectal cancer screening. ▪ Social determinants of health assessment. **Address chronic disease management** ▪ Controlling high blood pressure. *For patients with diabetes:* ▪ Eye exam. ▪ Blood sugar control. ▪ Kidney health evaluation.	Ensure members are adherent to their medications 80% of the year. ▪ **Educate patients** and their caregivers on the importance of medication adherence. ▪ Discuss **common medication side effects** with patients and when to call the provider. ▪ **Address barriers** (cost, side effects, coordination of refills, doctor appointments).

Important Reminders

Do not balance bill dual members with Medicaid and the Qualified Medicare Beneficiary program.

- Providers must bill Medicaid or the Medicaid managed care 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 an SNP and characteristics of the SNP population.
- The objectives and components of the MOC.
- Your responsibilities as a network provider to SNP members.
- The importance of your active participation in the MOC.

Complete Your Attestation

To receive credit for completing this training, your attestation is required.

- Complete your EmblemHealth attestation.

Please note: If you are attesting as a group, all providers must share a valid TIN. The TIN identifies all individuals within your group who completed the training.

Thank You!