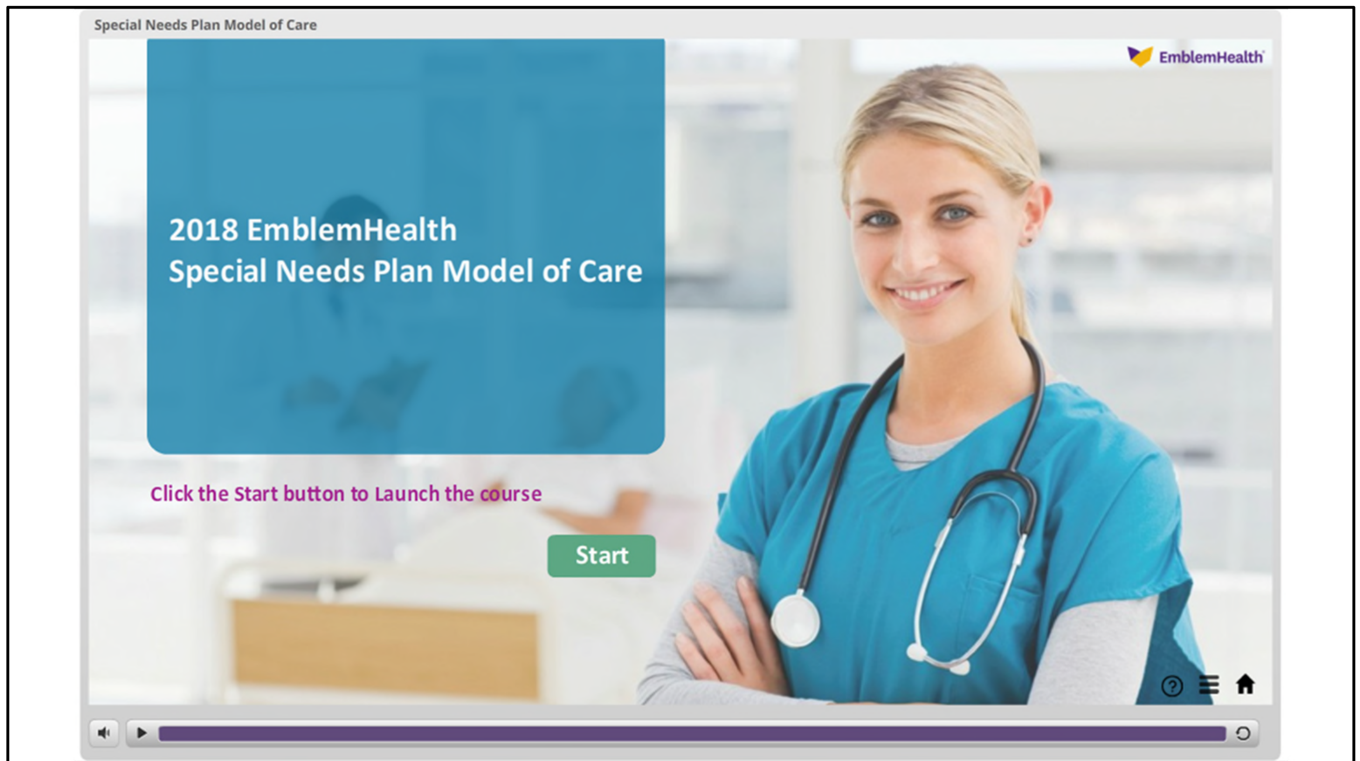
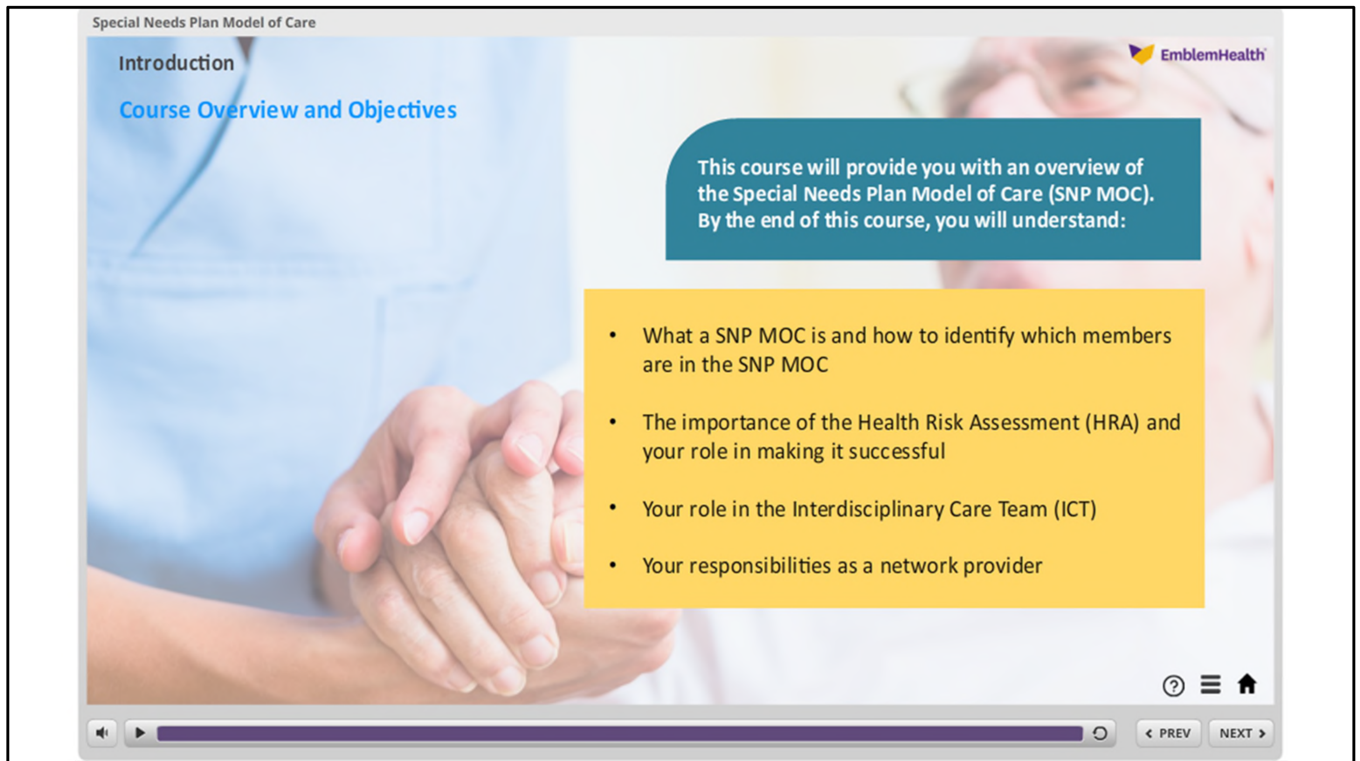


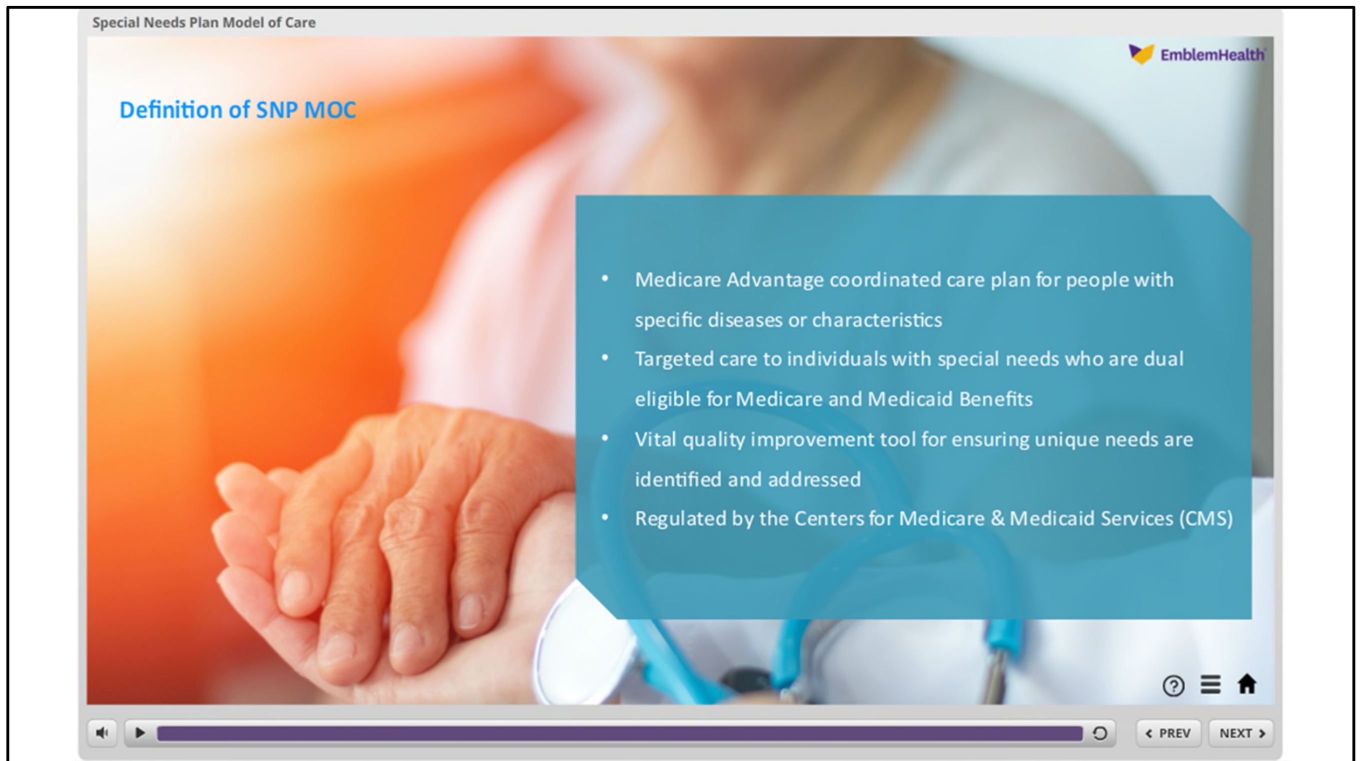
Welcome to the 2018 EmblemHealth Special Needs Plan Model of Care training for providers.

This year's course is designed to help you provide coordinated and quality care for your patients.



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

- What an SNP MOC is and how to identify which members are in the SNP MOC.
- The importance of the Health Risk Assessment and your role in making it successful.
- Your role in the Interdisciplinary Care Team.
- Your responsibilities as a network provider for EmblemHealth, and if applicable, for EmblemHealth's clients – ArchCare and GuildNet.



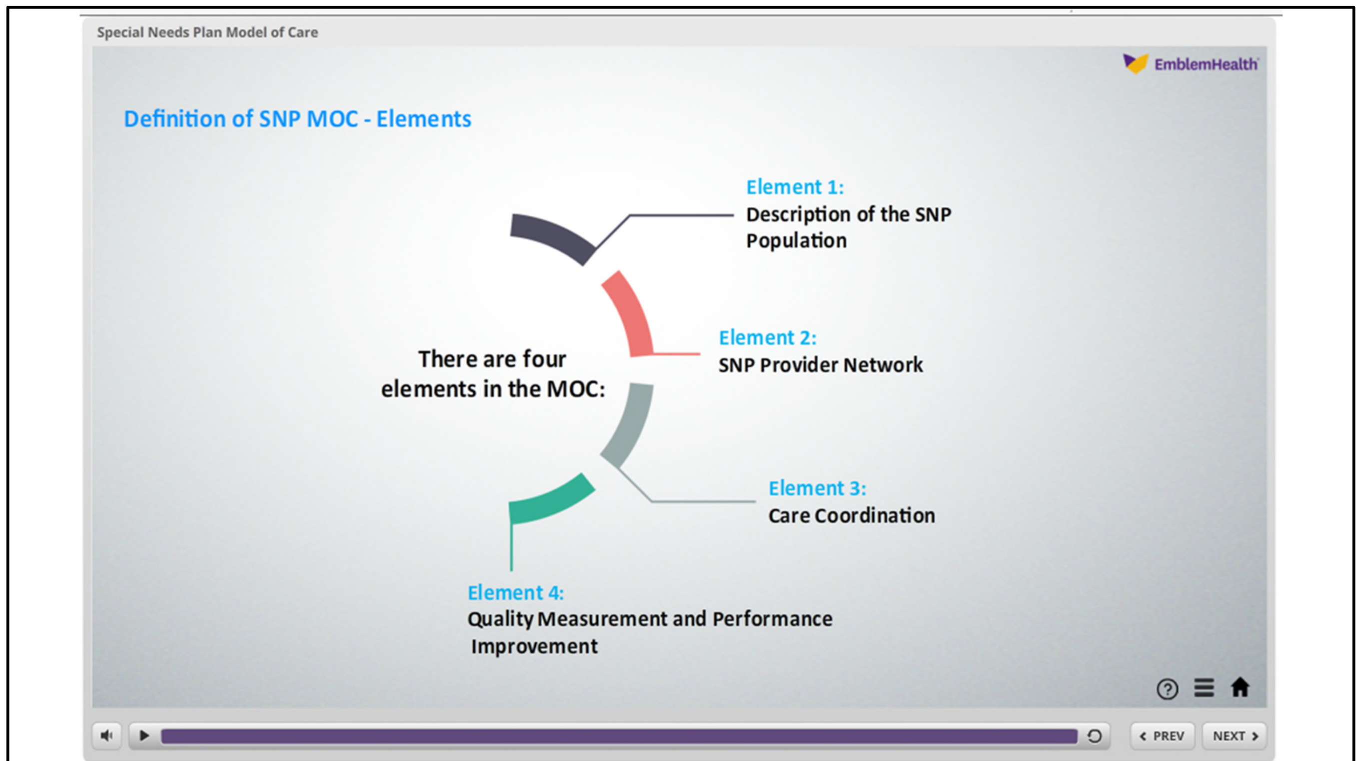
Let's start by defining SNP MOC.

SNP is a type of Medicare Advantage coordinated care plan that limits enrollment to people with specific diseases or characteristics.

SNP is designed to provide targeted care to individuals with special needs who are dual-eligible for Medicare and Medicaid Benefits.

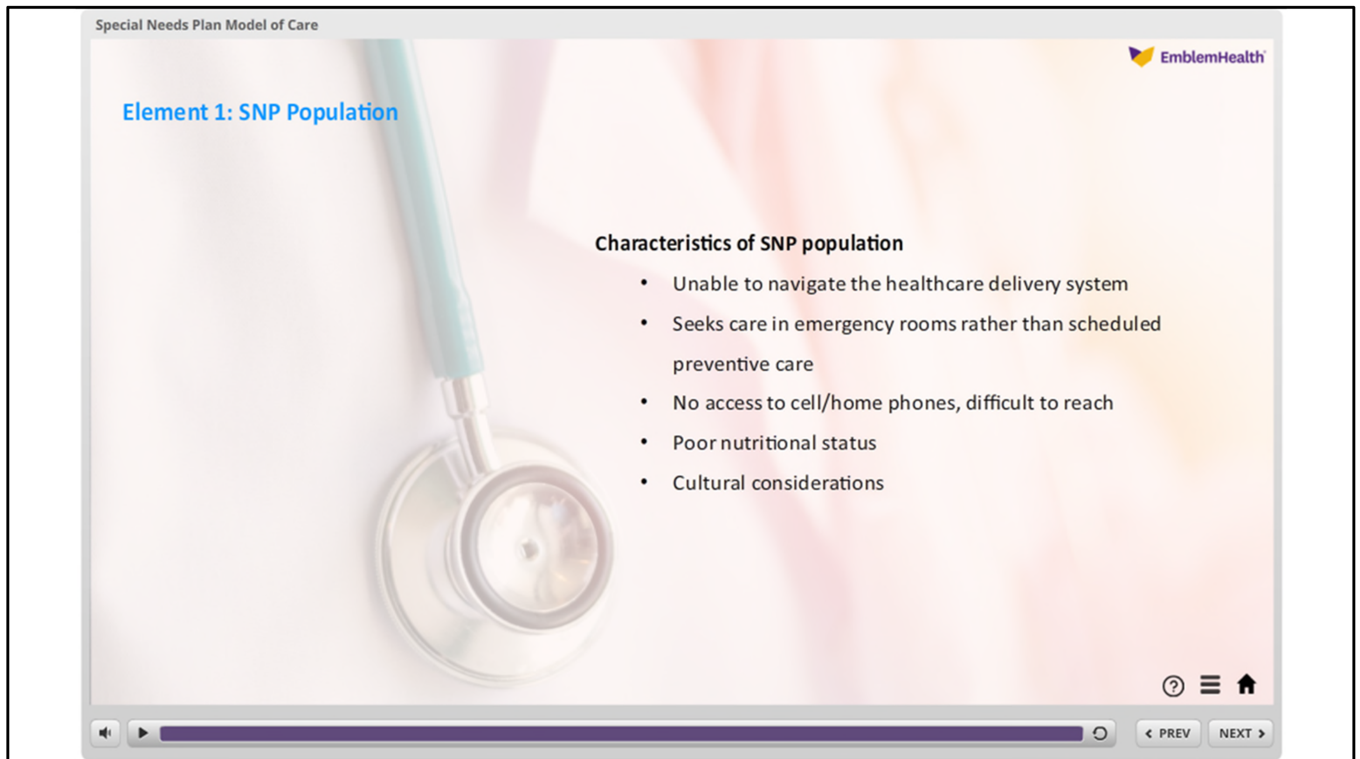
EmblemHealth's SNP MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in an SNP are identified and addressed.

The Centers for Medicare & Medicaid Services regulate all SNPs. CMS does an initial and then periodic review and approval of each SNP's model of care. The SNP MOC is scored using a CMS-approved Reviewer Guide that identifies the types of evidence required.



There are four elements in the MOC:

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



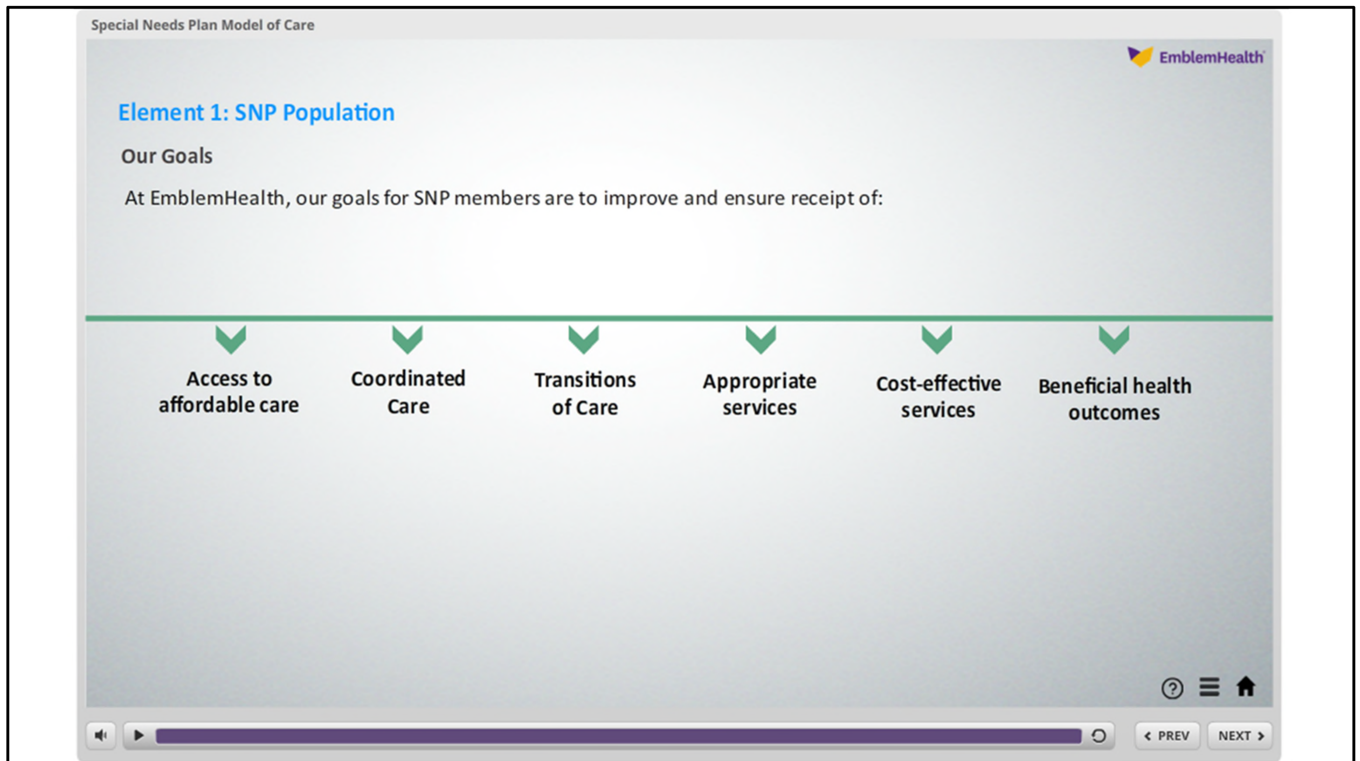
Now let's look more closely at each of the four elements of the MOC. Element one is the SNP Population.

Often because of educational and economic factors, this population does not successfully navigate the health care delivery system and seeks care in emergency rooms rather than having regularly scheduled preventive care visits.

Due to financial considerations, eligible members often do not have cell phones or home telephones, which can make it difficult to reach them to coordinate care and help them to manage their benefits.

Based on income and education, these members may have poor nutritional status and have issues with obesity and high blood pressure, which can set the stage for diabetes, heart disease and stroke.

In addition, cultural considerations, such as prevalence of smoking in certain populations, are also a factor.

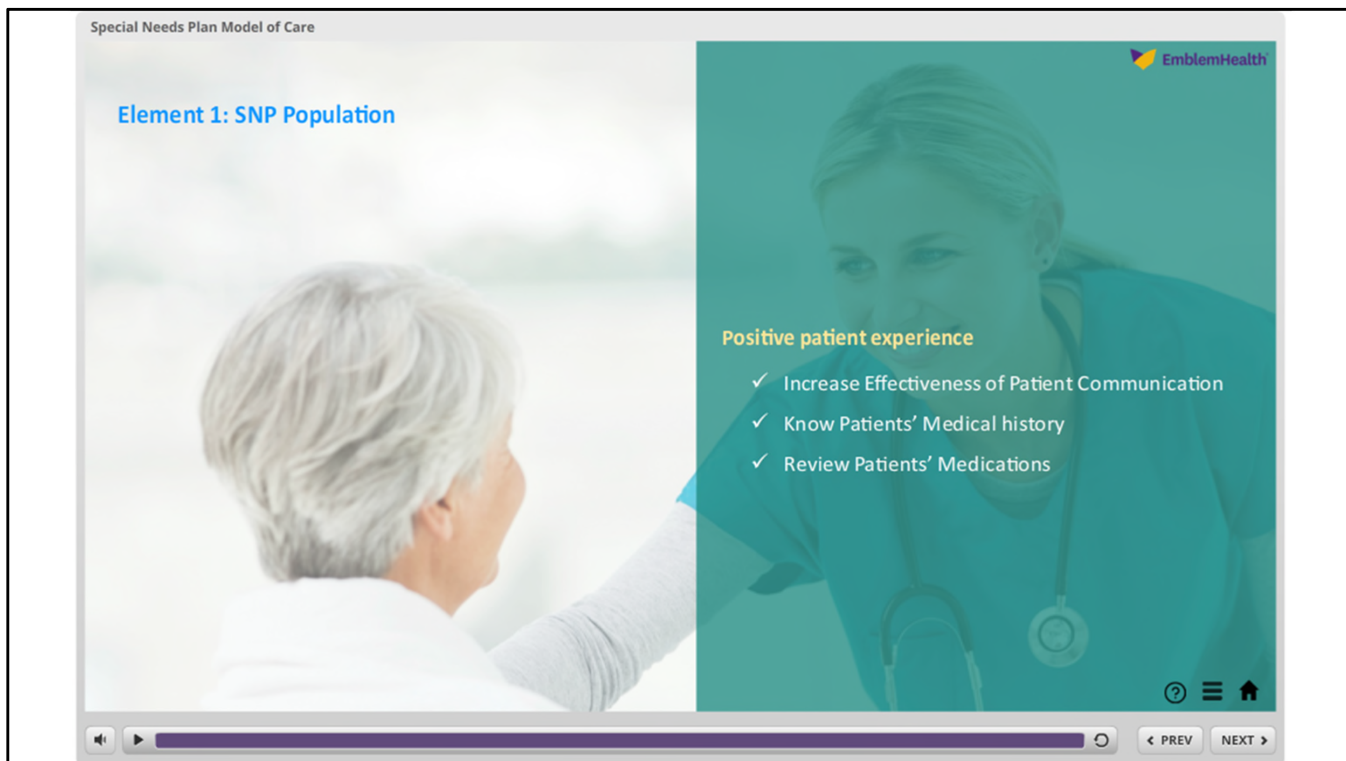


At EmblemHealth, our goals for SNP members are to improve and ensure receipt of:

- Access to affordable medical, behavioral, social and preventive health care and services.
- Coordinated care through an identified point of contact.
- Transitions of care across health care settings and practitioners.
- Appropriate services.
- Cost-effective services.
- Beneficial health outcomes.

In providing targeted care to individuals with special needs, it's important to:

- Understand the various illnesses and life-circumstances with which they are challenged.
- Appreciate cultural dynamics and how cultural competence impacts health care relationships.
- Identify practical tools that can be actively applied to improve cultural competency when interacting with the individuals you serve. Resources are available by logging into the secure provider portal on the EmblemHealth website. Some of these resources include:
    - The Medical Manual for Religio-Cultural Competency,
    - Continuing Education in Cultural Competency and Diversity Awareness, and
    - Language interpreter services. For assistance, contact our Provider Call Center by phone at 866-447-9717 or by Teletypewriter at 1-800-874-9426.

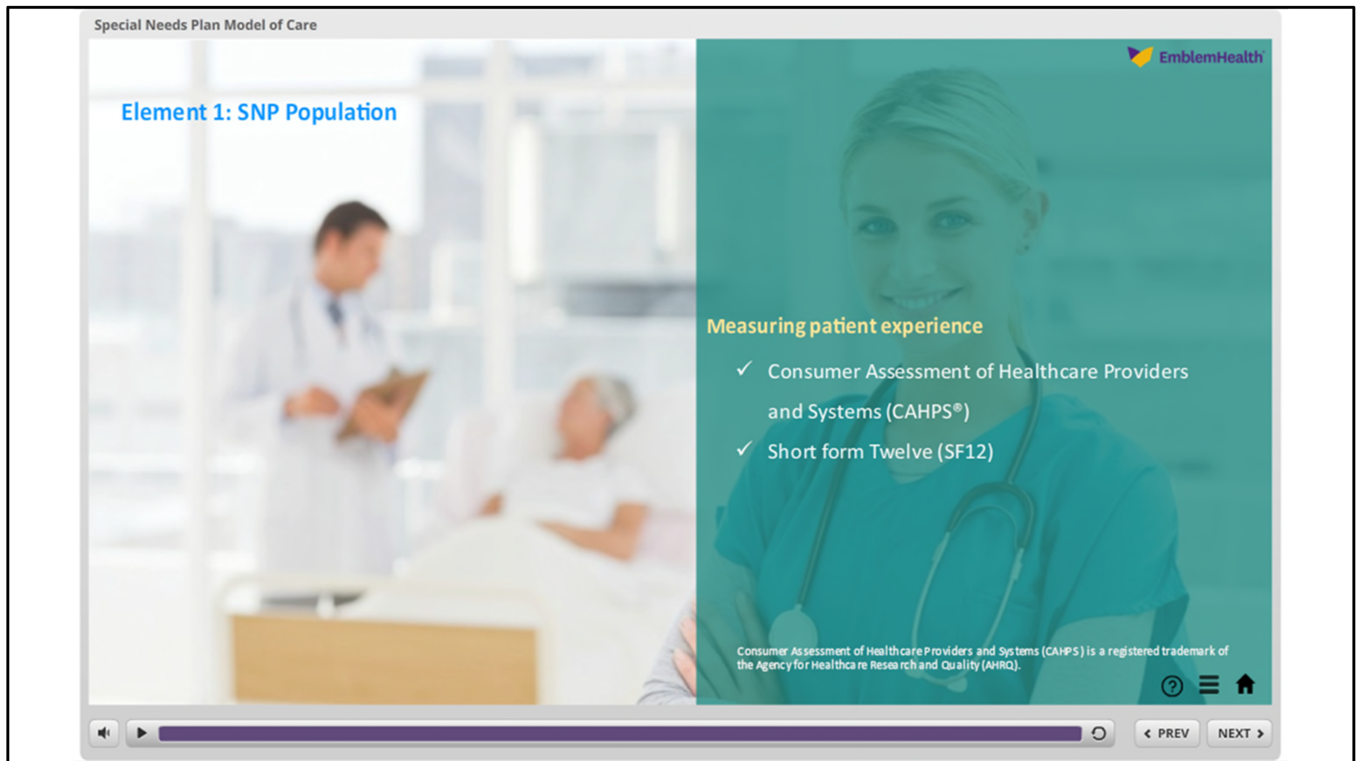


The patient–physician relationship is the cornerstone of patient engagement, thus patient satisfaction has become a growing priority for medical practices. Satisfied patients are more likely to comply with your treatment and follow-up recommendations. Improving the patient–physician experience will enhance your patients' satisfaction, thereby improving clinical outcomes and patient safety.

- Spend enough time with patients and be an active listener.
- Use clear language that is tailored to the patients' understanding.
- Conclude the visit with "Do you have any questions?"

- Review patients' medical records before entering the exam room.
- Ask patients if they are under a specialist's care.
- Ask patients if they have been to the ER or Urgent Care Center.

- Review patients' medications during their office visit.
- Collaborate with patients regarding treatment expectations.
- Reconcile medications with patients who were recently discharged.

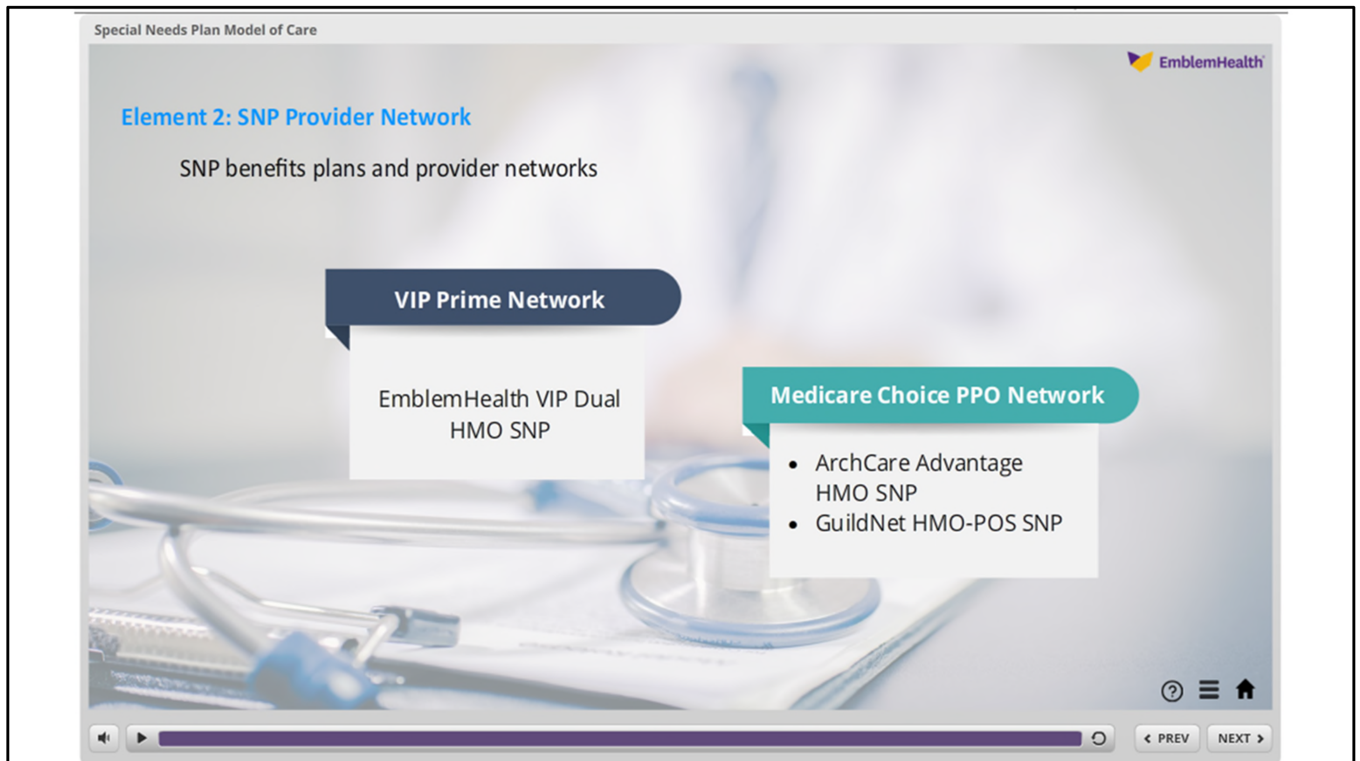


EmblemHealth uses CAHPS to measure member satisfaction.

Through the Care Management Committee, or CMC, members' satisfaction with care and services, as evidenced by the CAHPS results, are compared to the EmblemHealth and CMS national benchmarks. Measures that fall below the goals are analyzed for root causes, and opportunities to raise measures are ranked. Quality improvement initiatives are recommended, developed, and implemented to address measures that do not meet the goals. CMC includes EmblemHealth leaders and clinical staff who work with the SNP Population.

EmblemHealth also uses SF12 to measure member satisfaction.

This measurement will capture the results of the SF12 over time for SNP members receiving case management services. The SF12 assesses how members feel about their quality of life in relation to their health. This assessment is based on self-reported data provided by the member. The SF12 is administered at the time the member is enrolled in the case management program, and every six months after initial enrollment.



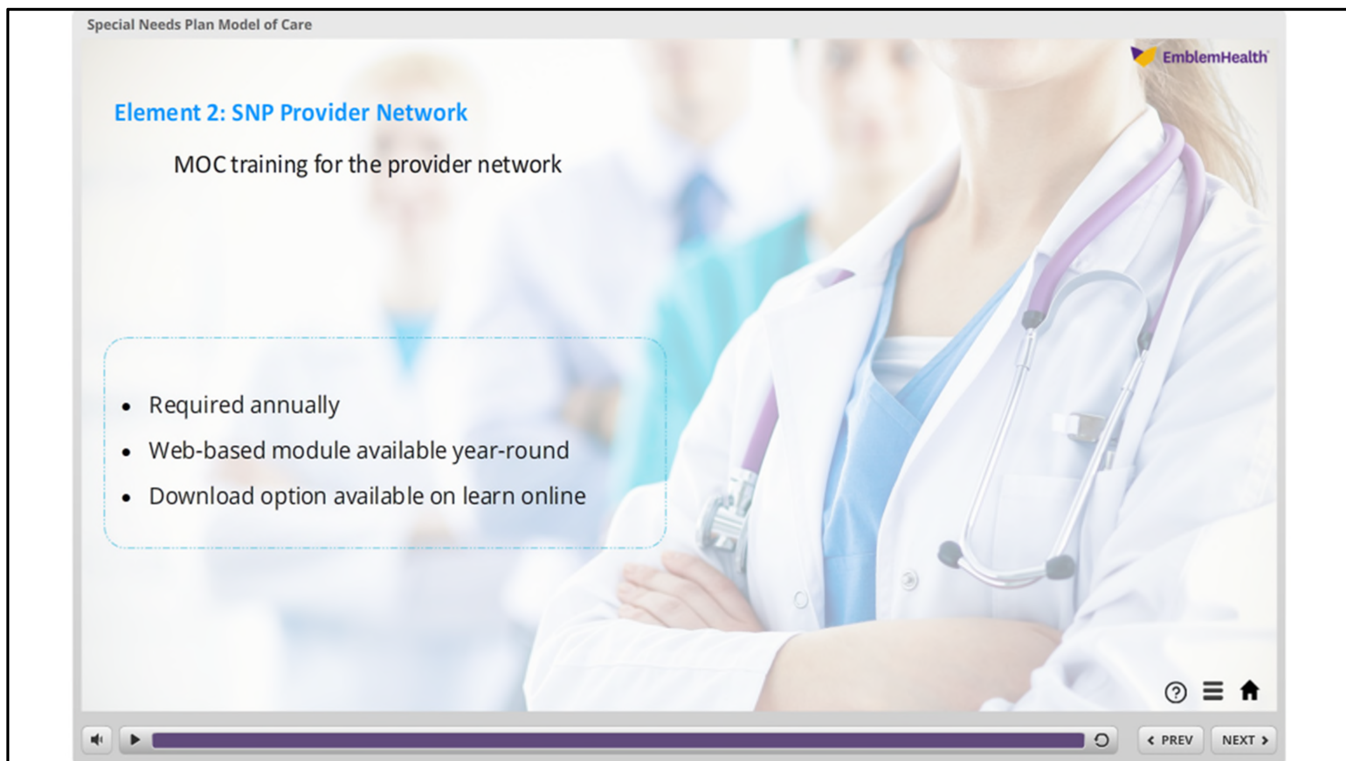
Element two of the MOC is the SNP Provider Network.

EmblemHealth supports three SNP benefit plans with two provider networks.

EmblemHealth offers one type of Dual-Eligible Special Needs Plan - HMO SNP. EmblemHealth VIP Dual HMO SNP members have access to providers in the VIP Prime Network.

EmblemHealth also leases its Medicare Choice PPO network to ArchCare and GuildNet, and administers the Medicare portion of the benefits they offer to their members.

If you are a network provider for their plans, you are required to take their SNP MOC training in addition to this training. Their training can be found on our website's Learn on Line page under Required Training.



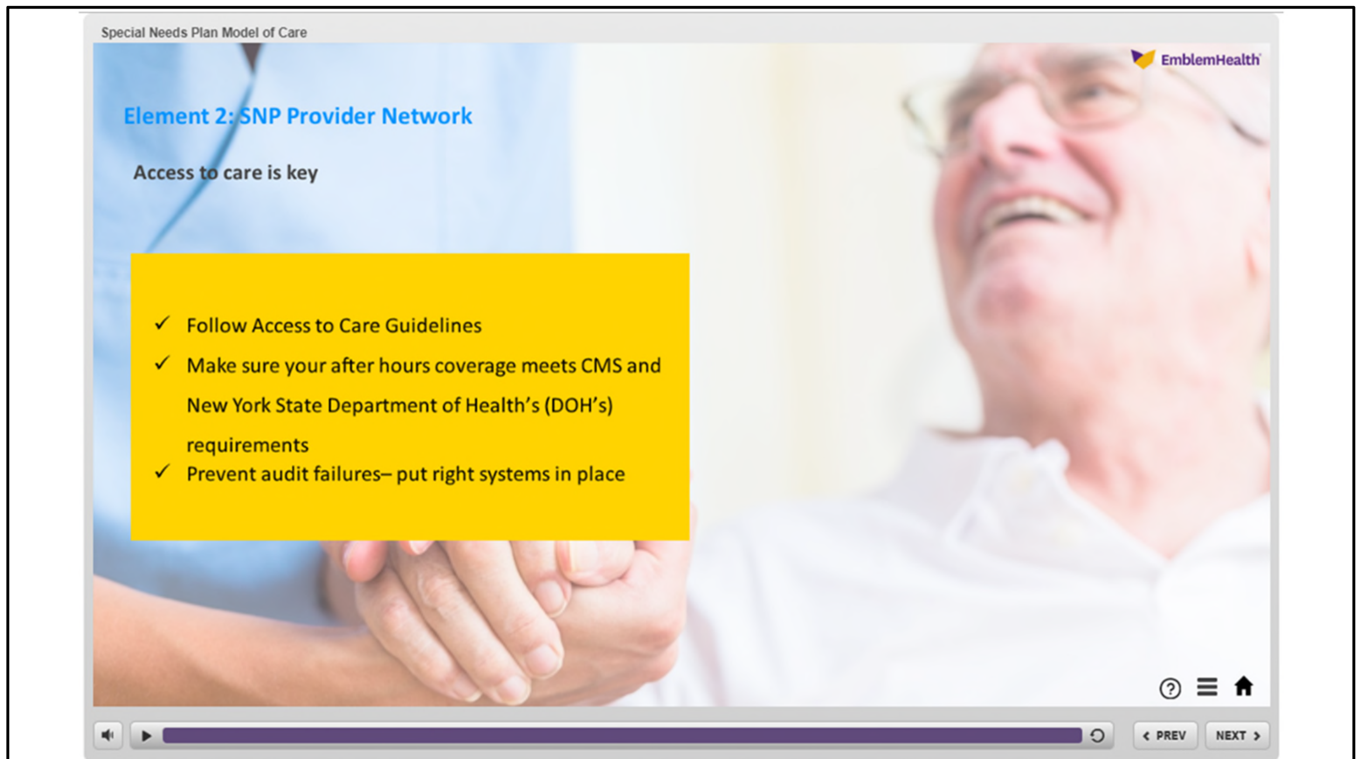
MOC training is made available to the provider network.

On an annual basis, providers are notified via email and a brochure mailing about the importance of completing SNP MOC training for EmblemHealth, ArchCare and GuildNet.

EmblemHealth's web-based SNP MOC training module is available year-round on our Learn Online page, accessible from the Providers Resources page of the EmblemHealth website.

As an alternative to completing this training online, the Learn Online page also offers an option for individual and group practices to download this training along with an attestation form. Providers can review the training material, complete the attestation, and return it as instructed on the form.

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.

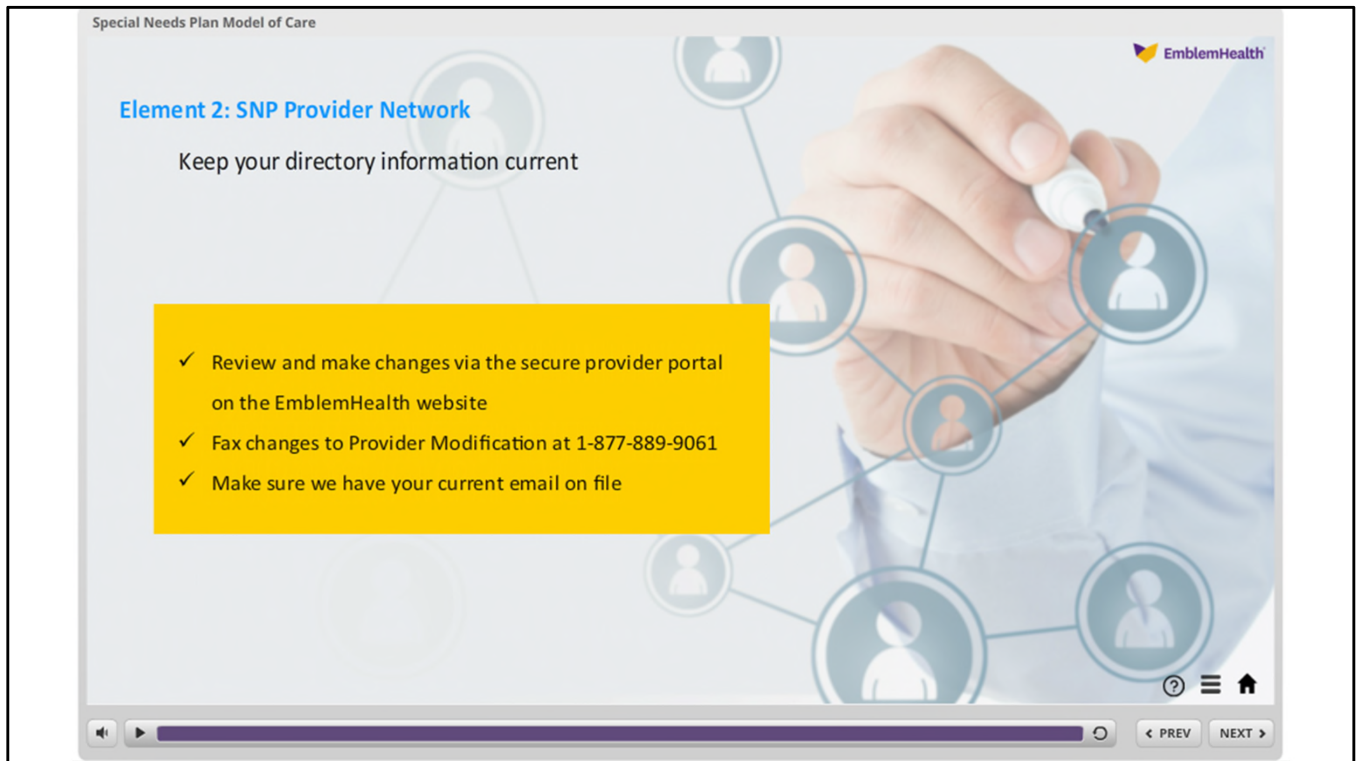


It's important for our members to get the right care at the right time. It's a part of your commitment to quality patient care.

Providers are expected to adhere to EmblemHealth's appointment availability and 24-hour access standards for services such as: sick visit, routine primary care, and oncology specialist visit. The full list of standards is available in the online Provider Manual on the EmblemHealth website.

Make sure your after-hours coverage meets CMS and DOH's requirements of access to 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 conducts annual surveys of 24-hour access and appointment availability by calling provider offices. Noncompliant providers are notified and resurveyed approximately six months after the initial survey. Prevent audit failures – put the right systems in place to follow access to care guidelines. Avoid mistakes that can lead to failing an audit like: no answer, wrong number, number not in service, and constant busy signal.



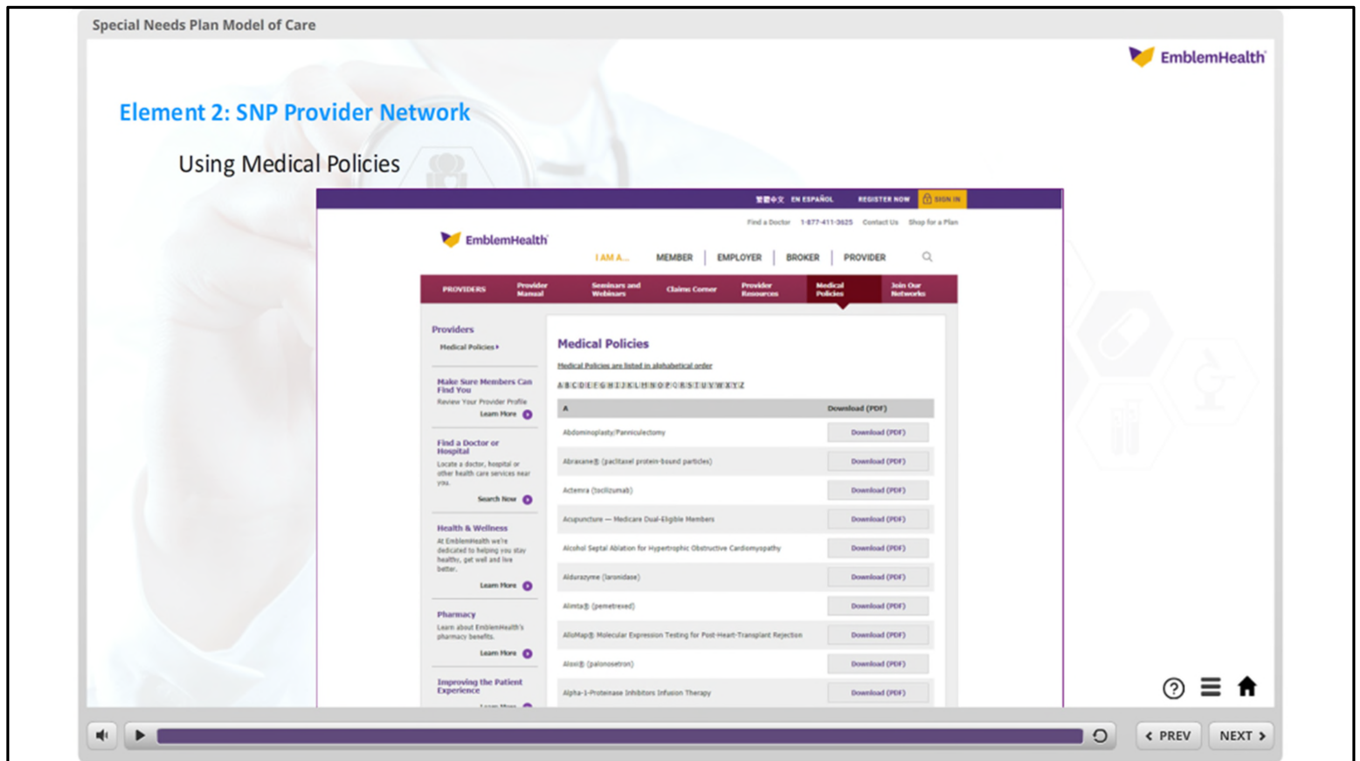
Remember to keep your directory information up to date so patients can find your office.

Review and make changes to your profile by signing into the secure provider portal on the EmblemHealth website.

Or, let us know if your directory listing needs to be updated. You can 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.

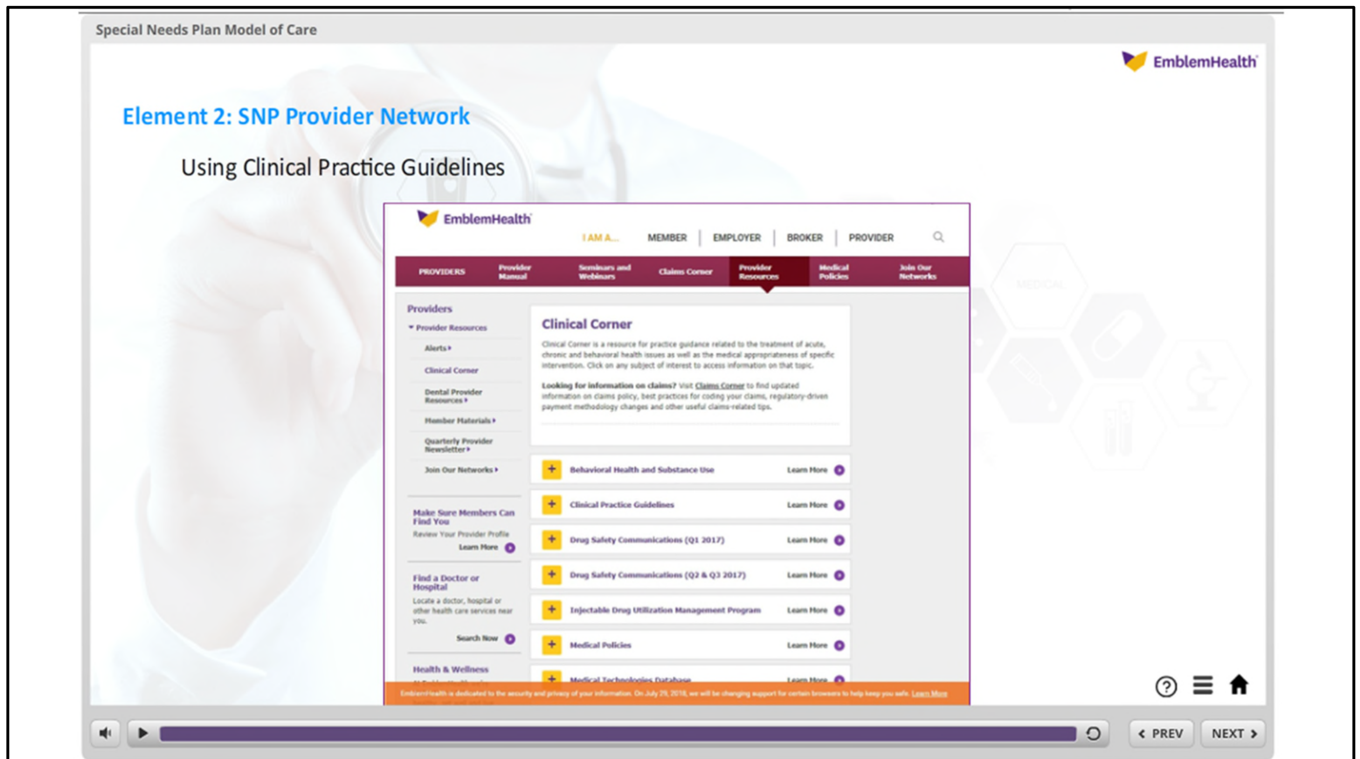
Make sure we have a current email on file for you – updates are sent via email and posted to the provider portal.



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

EmblemHealth's Medical Policies are available in the Provider section of the EmblemHealth website.

Updates to Medical Policies are also posted to the Clinical Corner section of our provider portal, and included in our monthly Provider eNewsletter, which is sent via email, so make sure we have a current email on file for you.

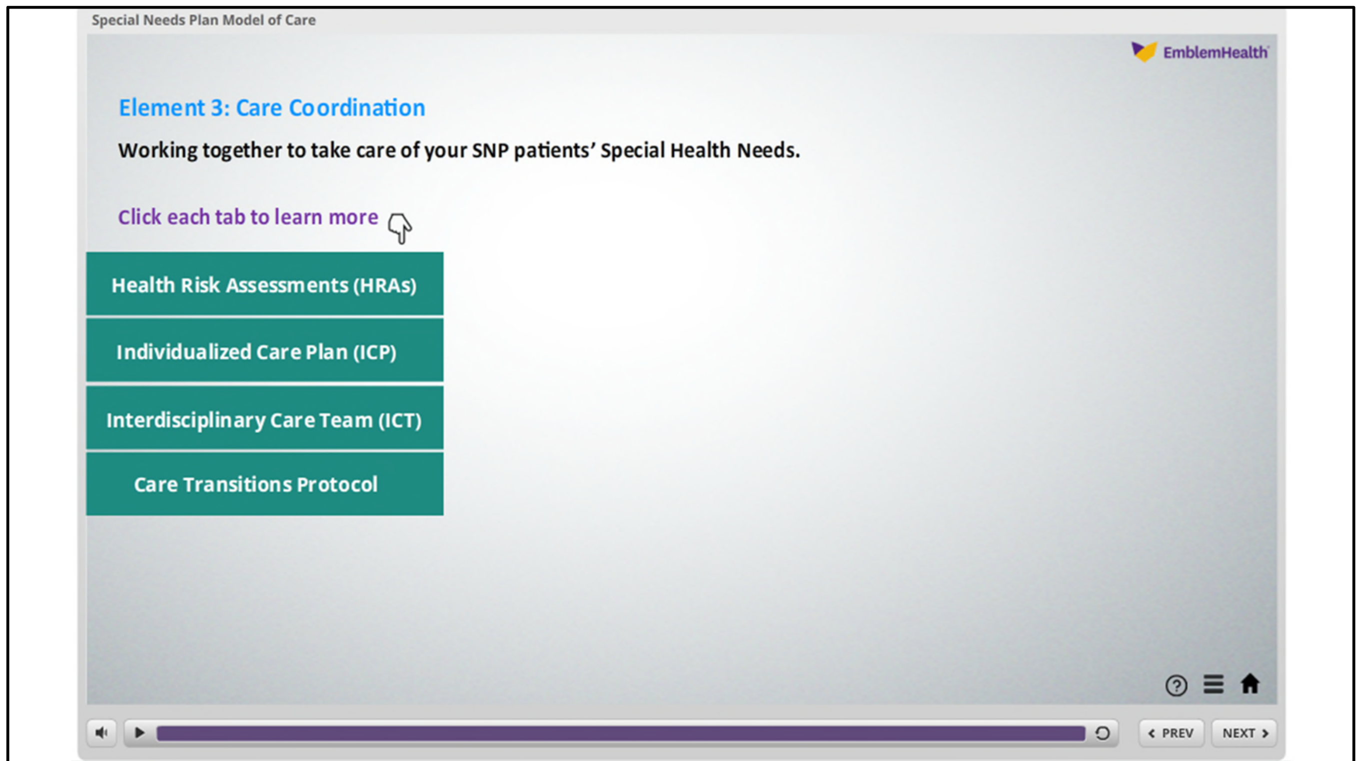


EmblemHealth's adopted Clinical Practice Guidelines are also available in the Clinical Corner section of the EmblemHealth website under the Provider Resources tab.

EmblemHealth uses preventive and condition-specific Clinical Practice Guidelines related to the treatment of acute, chronic and behavioral health issues to help practitioners and members make appropriate health care decisions.

EmblemHealth established a clinical basis for its guidelines by identifying and adopting evidence-based guidelines that employ nationally recognized protocols for assessment, care and maintenance of health. All Clinical Practice Guidelines are reviewed and updated as needed.

Paper copies of Clinical Practice Guidelines are made available upon request. Updates are included in the monthly Provider eNewsletter, which is sent via email – again, please make sure we have a current email on file for you.



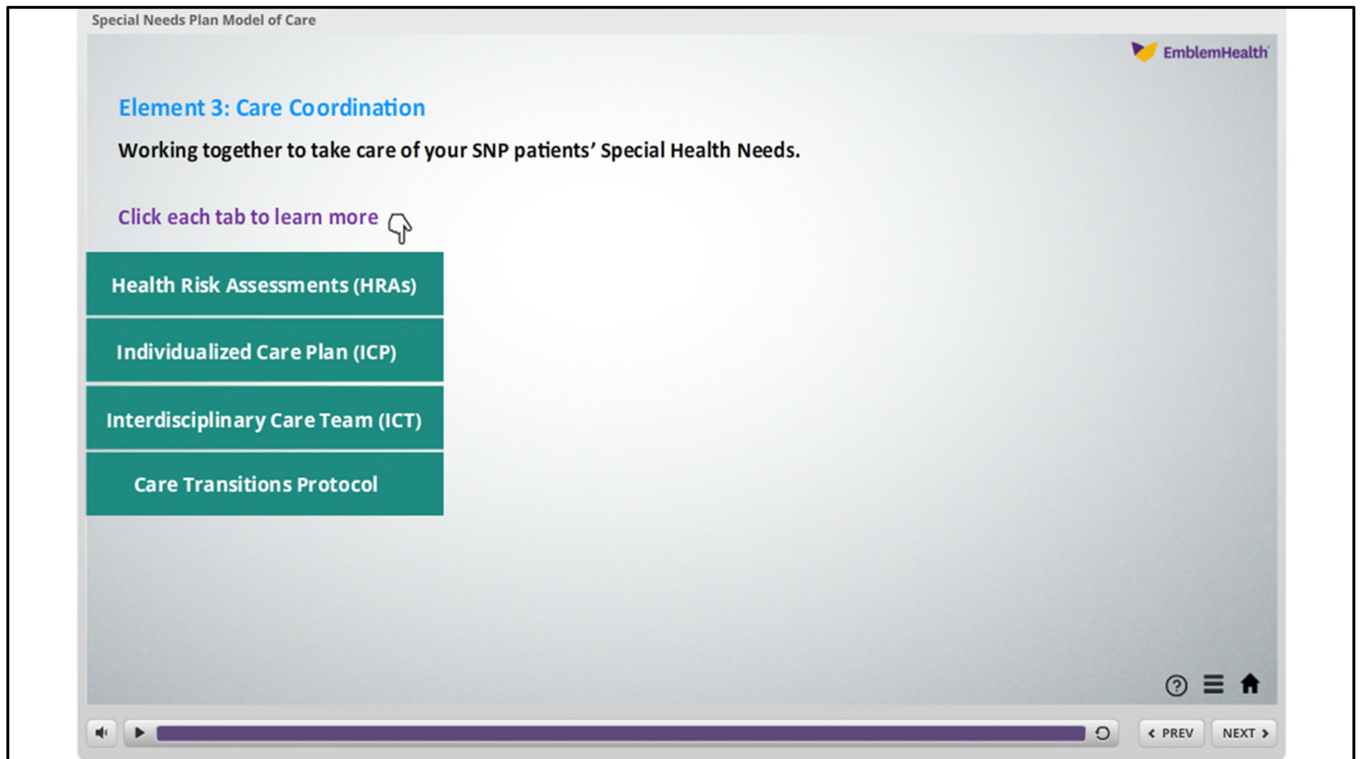
Element three of the MOC is Care Coordination.

Working together to take care of your SNP patients' special health needs is important and the provider role is essential in the success of the model of care.

EmblemHealth is required by CMS to conduct an HRA, which is used to create the patient's/member's ICP.

EmblemHealth's care manager, in coordination with the member and treating providers, helps to develop a comprehensive ICP. Please review the ICP for each member for whom you provide medical or behavioral health services to ensure it meets the patient's/member's needs.

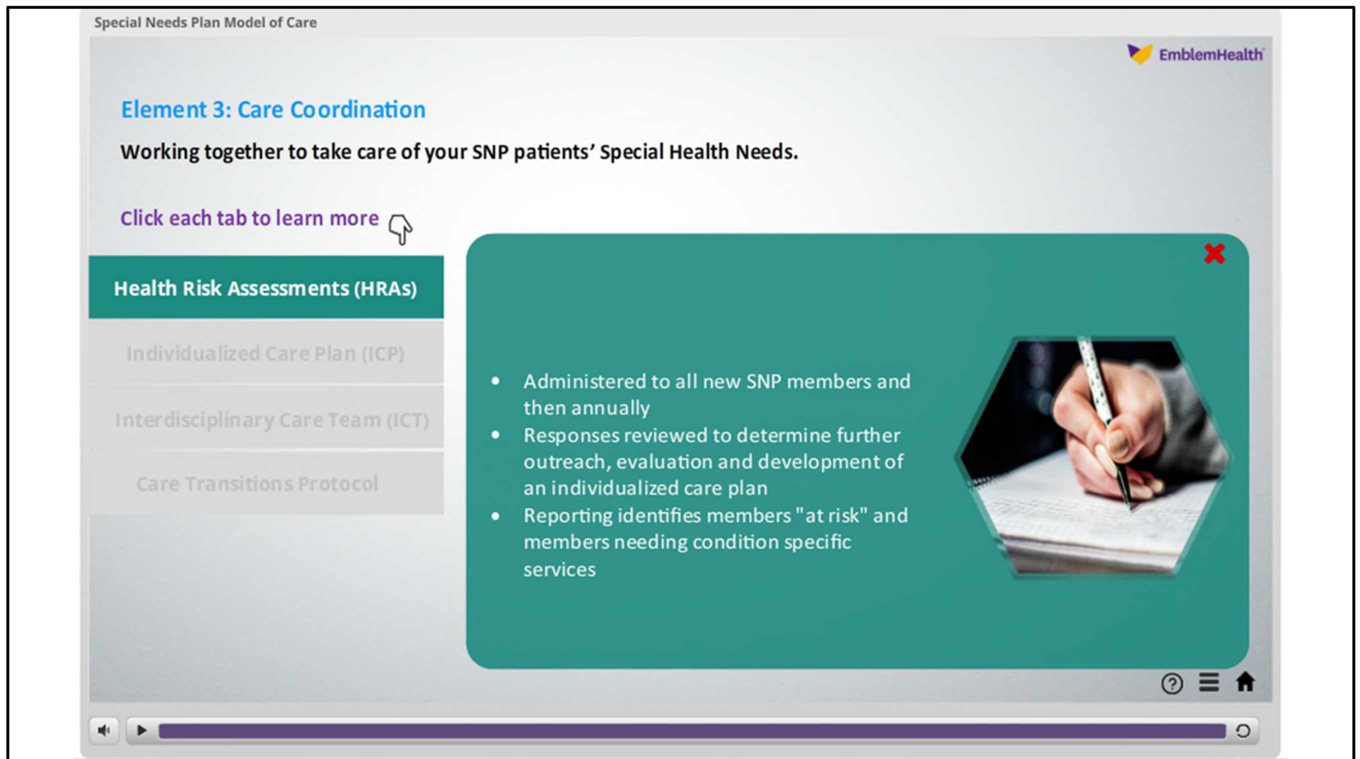
The ICT drives the care management process through analysis, communication and coordination of services. Participation in the ICT by you is important to the success for optimal coordination of care.



Your ongoing exchange of information and communication with the member, member's family, other treating providers and Care Management is needed to modify the care plan. Please ensure timely submission of documents (such as the treatment plan, discharge plan, new orders, changes to the care plan, etc.).

When a patient/member has a transition of care by moving from one care setting to another, whether planned or unplanned, we need to ensure care and coordination of services for the member are aligned and a follow-up appointment is in place 7 days post-discharge.

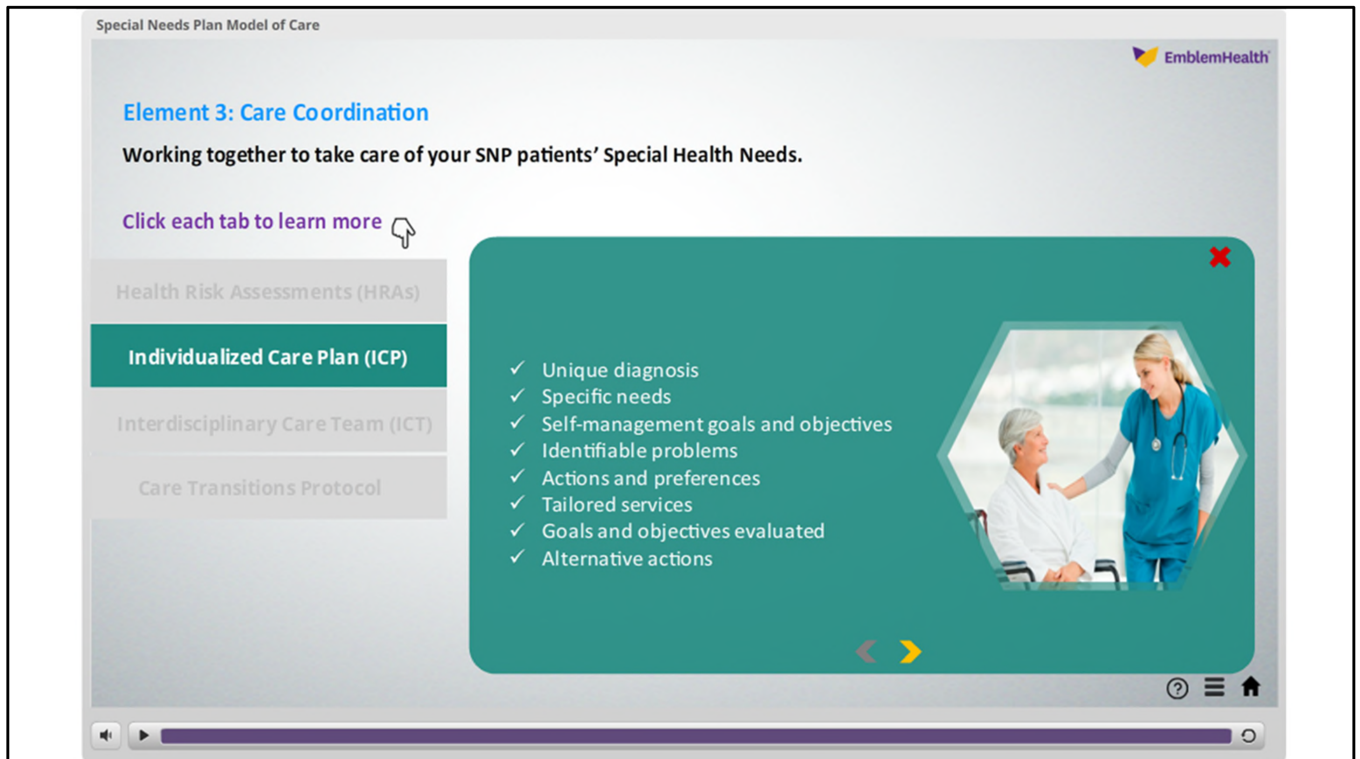
Together, we can ensure the model of care is a success for optimal coordination of care for our patients/members.



A Health Risk Assessment survey is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks. Attempts to complete the initial HRA are conducted by mail and telephone within 90 days of enrollment and annually thereafter. Multiple attempts are made to contact the member.

Providers can assist in this process by encouraging EmblemHealth members to complete the HRA survey when they are called or when it is mailed to them. And explain to the member that the information provided in the HRA helps the EmblemHealth Care Management Department identify needs and incorporate them into the member's care plan.

Based on HRA responses received, the member is involved in development of and agrees with the care plan and goals.



ICP is a plan of care that originates from each member's unique list of diagnoses and is organized by the individual's specific needs.

It includes the member's self-management goals and objectives. It is based upon identifiable physical, functional, psychosocial, behavioral, environmental, residential, family dynamics and support, spiritual, and cultural needs.

It focuses on actions that address the existing problem, and incorporates the member's health care preferences. It includes a description of services specifically tailored to the member's needs that can result in a desired outcome or change in the member's condition.

Goals and objectives are reviewed and evaluated periodically. If the ICP goals are not met, the nurse case manager reviews the goals with the member, his/her health care provider, interdisciplinary care team, and caregiver to determine likely barriers, and develops appropriate alternative actions.

Special Needs Plan Model of Care

EmblemHealth

Element 3: Care Coordination

Working together to take care of your SNP patients' Special Health Needs.

Click each tab to learn more

Health Risk Assessments (HRAs)

Individualized Care Plan (ICP)

Interdisciplinary Care Team (ICT)

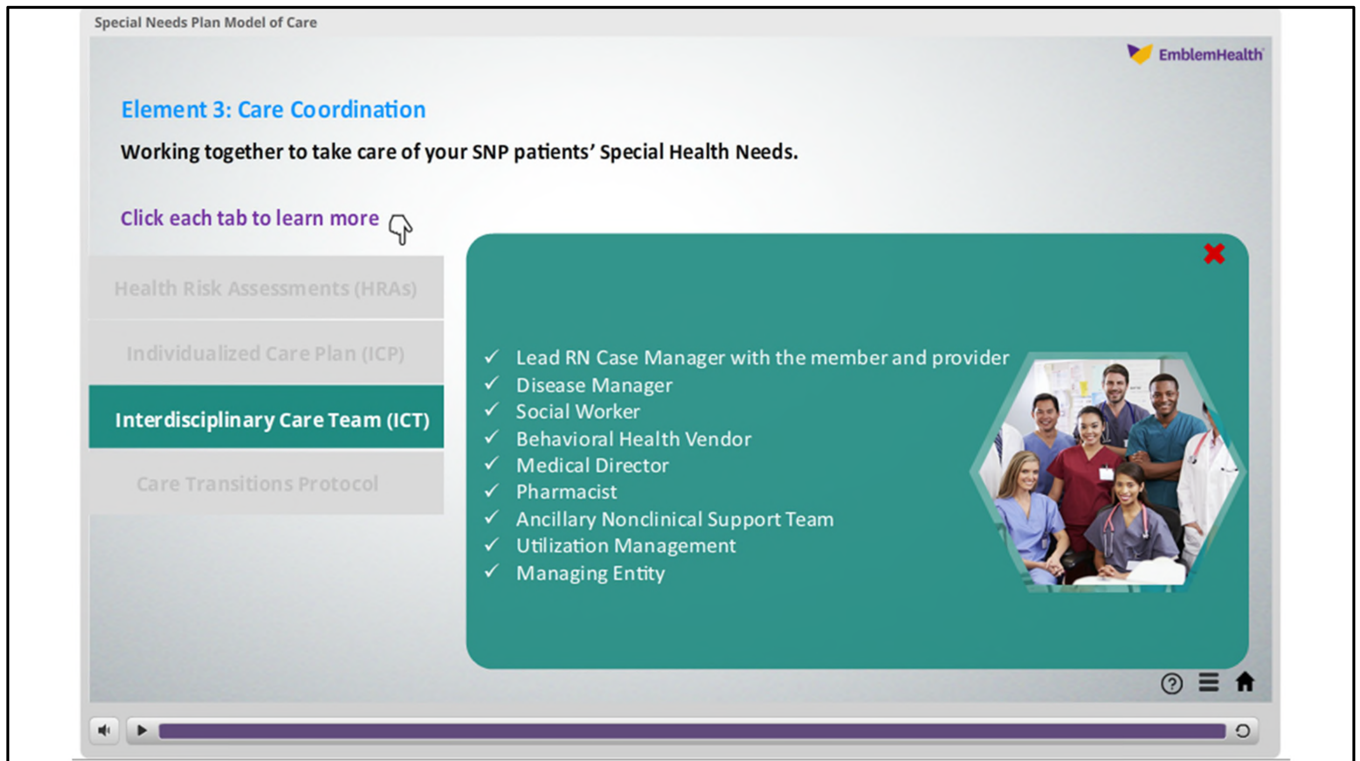
Care Transitions Protocol

- Customized to the member's needs
- Written document of the case management process to address member's needs
- Developed when needs are identified
  - During administration of HRA
  - During interactions with members
  - During telephonic assessment
  - Speaking with providers

The ICP is the comprehensive care planning document that is customized to the needs of the member. A plan of care is the written documentation of the case management process used to address one or more of a member's needs.

The ICP development begins when needs are identified. This identification of needs can begin during the administration of the HRA, during interactions with the members and/or during the telephonic assessment of the member. Additionally, needs can be noted from indirect sources when viewing the patient profiler, evaluating the member's lab results or speaking with providers.

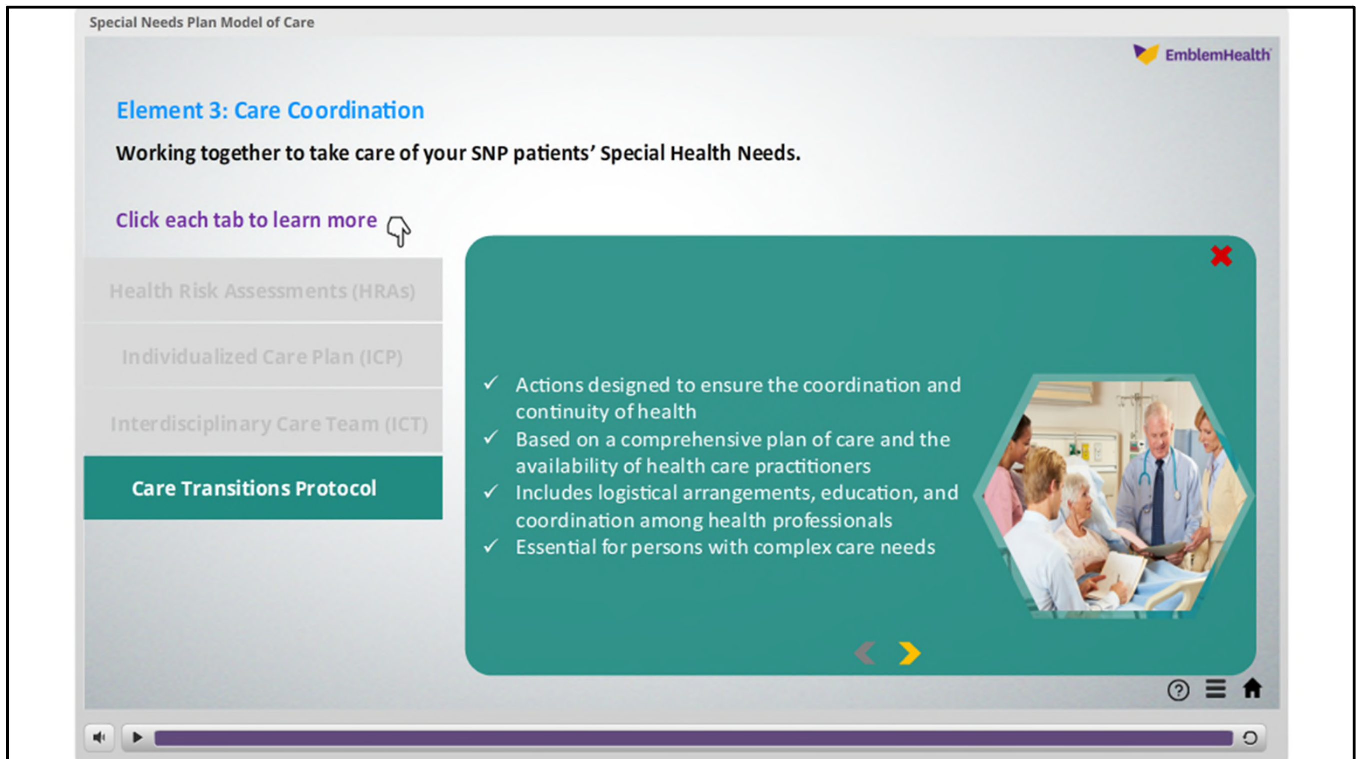
Development of the care plan is a collaborative effort. The health care needs of the member as identified by providers and shared with the care manager will be incorporated into the member's care plan. The information incorporated from providers will help in the management of the member's health care needs, coordination of care, and supportive services.



The interdisciplinary care team includes:

- Lead Registered Nurse Case Manager with the member and provider
- Disease Manager
- Social Worker
- Behavioral Health Vendor
- Medical Director
- Pharmacist
- Ancillary Nonclinical Support Team
- Utilization Management
- Managing Entity

This multidisciplinary team approach is member-centric and provides access to care.



Members are at potential risk of adverse outcomes when there is transition between settings. For example, in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health. Patients experiencing an inpatient transition are identified and managed.

EmblemHealth follows Dr. Eric Coleman's model that defines transitional care as a set of actions designed to ensure the coordination and continuity of health. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status.

It includes logistical arrangements, education of the patient and family, and coordination among health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

Special Needs Plan Model of Care

EmblemHealth

Element 3: Care Coordination

Working together to take care of your SNP patients' Special Health Needs.

Click each tab to learn more

- Health Risk Assessments (HRAs)
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- **Care Transitions Protocol**

- Coordinate care to reduce the risk of poor quality care, ensure patient safety and maximize health outcomes
- Multidisciplinary team approach to support members' needs
- Member outreach to ensure they understand their discharge plan, arrange for post discharge services, and educate on self-management techniques
- Individualized care plans are developed with the member's input following an assessment

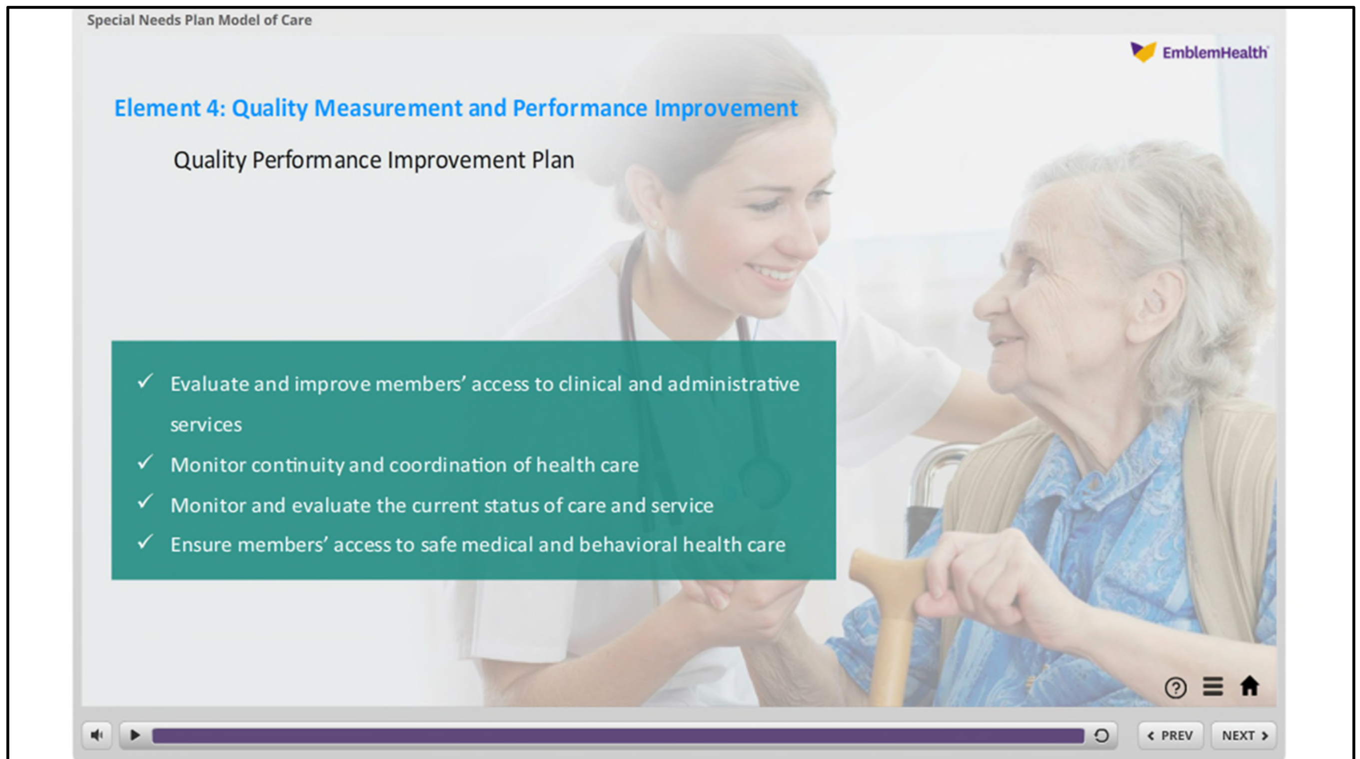
PREV NEXT

Special effort is made to coordinate care when SNP members move from one setting to another, such as when they are discharged from a hospital, to reduce the risk of poor quality care, ensure patient safety, and to 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 systems to coordinate care and services.

Outreach is performed to members newly discharged from the hospital to ensure they understand their discharge plan, to arrange for post-discharge services as needed (such as homecare, durable medical equipment, transportation, etc.) and to educate beneficiaries on self-management techniques.

Individualized care plans are formulated with the SNP member's input following an assessment and contains, but is not limited to, the following components: member self-management goals and objectives; the member's personal health care preferences; services specifically tailored to the member's needs; and identification of goals met or not met.

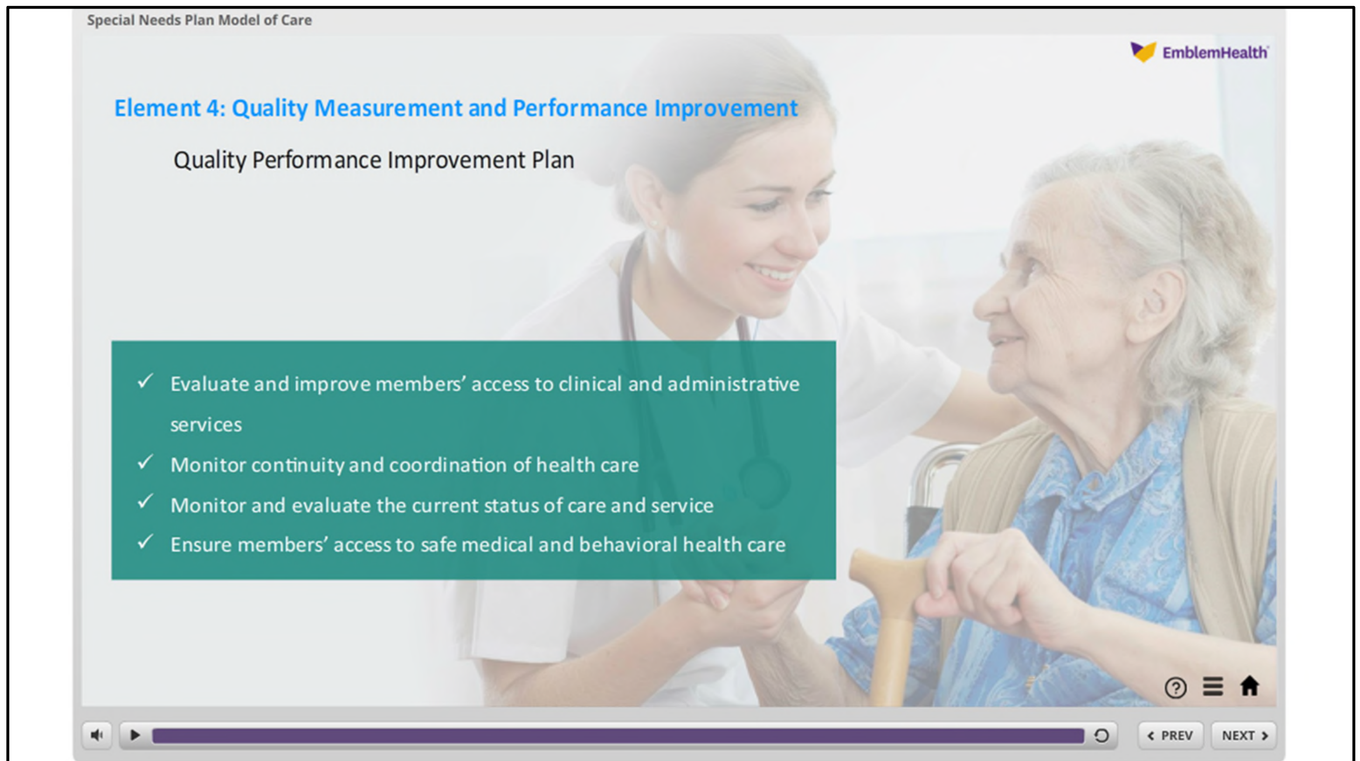


The fourth and final MOC element is Quality Measurement and Performance Improvement.

The Quality Performance Improvement Plan is designed to monitor and evaluate the MOC's structure to ensure that it effectively accommodates members' unique health care needs. The MOC structure provides coordinated and appropriate care for our special needs members.

Key objectives of the Quality Improvement Plan are to:

- Evaluate and improve members' access to clinical and administrative services.
- Monitor continuity and coordination of health care.
- Monitor and evaluate the current status of care and service against regional and national requirements and benchmarks.
- Ensure members' access to safe medical and behavioral health care.



EmblemHealth regularly collects data from internal and external sources to evaluate MOC quality performance against measurable goals.

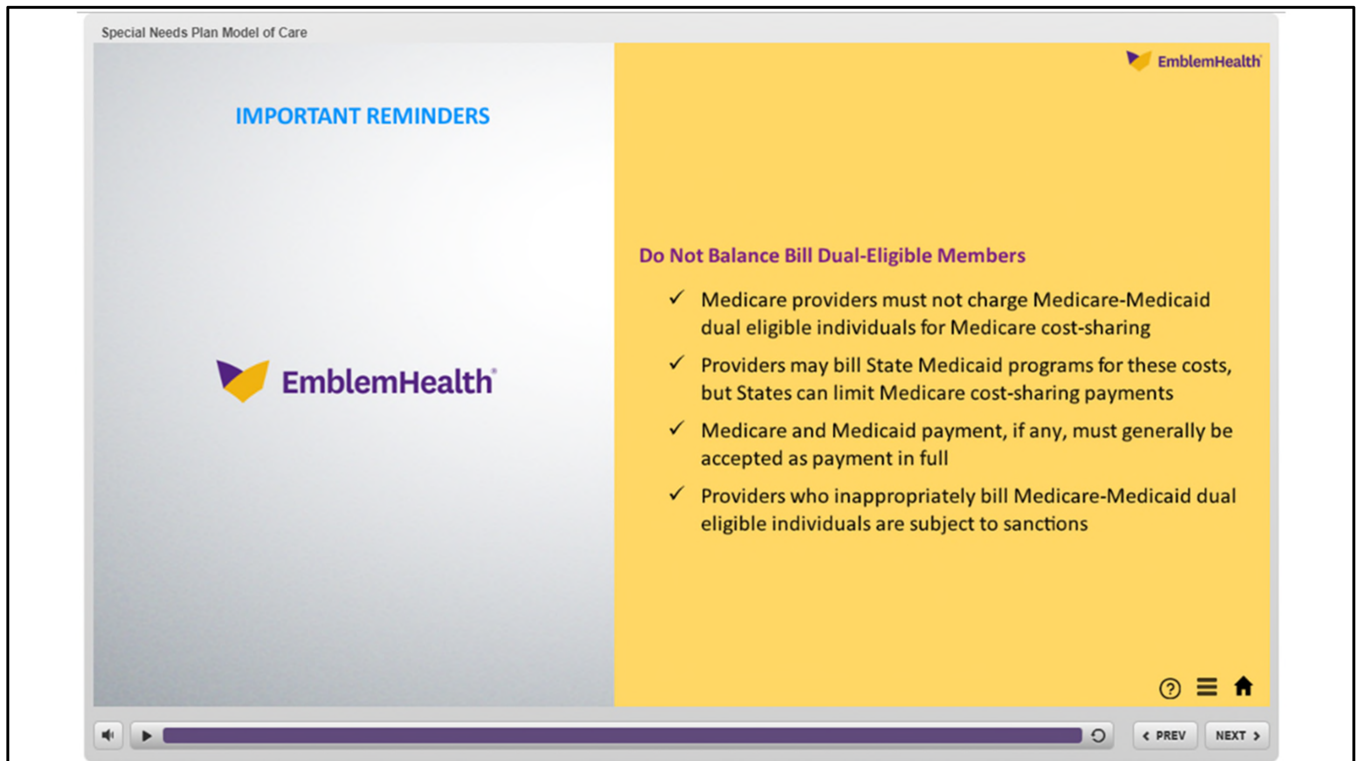
EmblemHealth systematically selects and prioritizes SNP quality improvement projects in an effort to achieve the greatest benefit to members. Topics are relevant to and affect a significant portion of SNP members, and have a potentially significant impact on member health status and/or satisfaction.

Quality measurement goals are to:

- Improve access to essential services such as medical, mental health, and social services.
- Improve access to affordable care and preventive health services.
- Improve coordinated care through an identified point of contact.
- Improve seamless transition of care across health care settings, practitioners, and health services.
- Ensure appropriate utilization of services and cost-effective services.
- Improve beneficiary health outcomes.

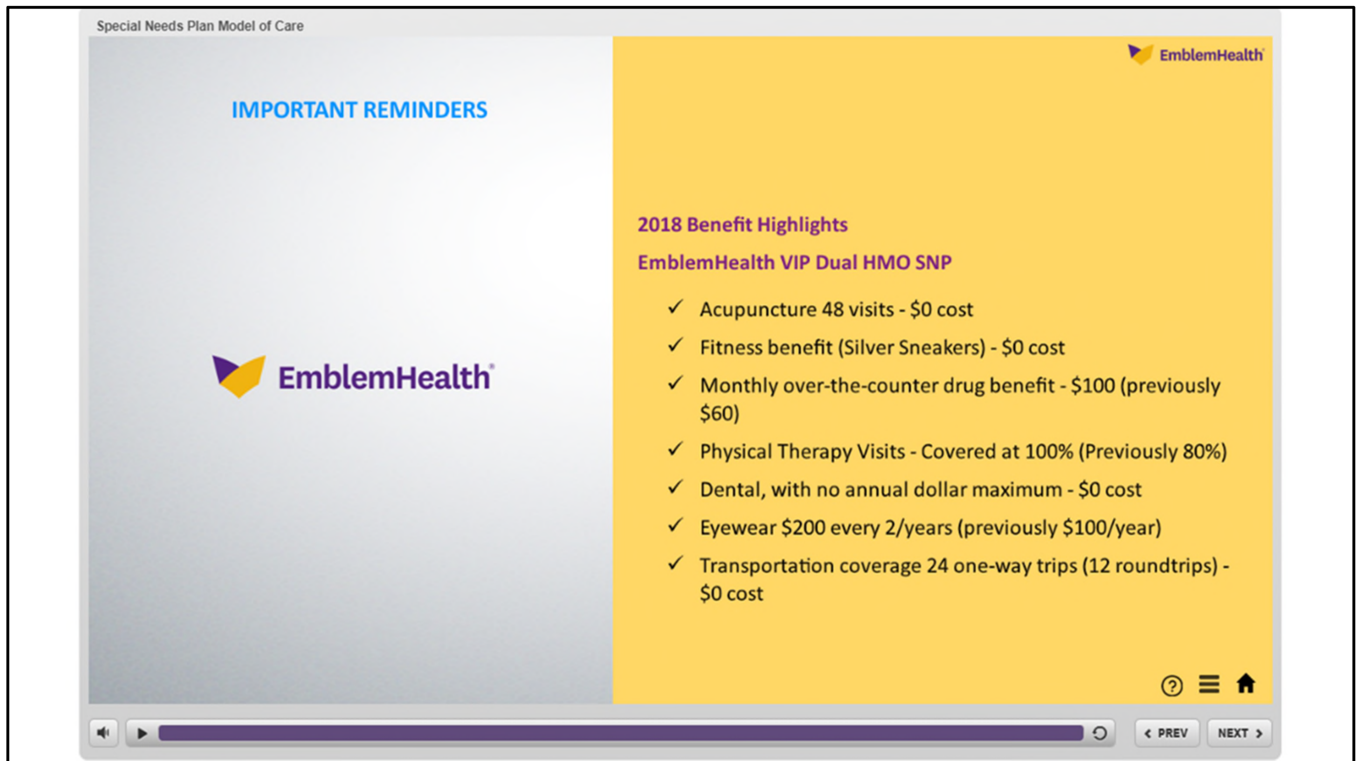
Quality measurement outcomes are to:

- Reduce the risk of falling.
- Improve or maintain mental health.
- Improve bladder control.
- Monitor physical activity.
- Improve or maintain physical health.



Before we conclude, let's review a couple of important reminders about billing and benefits.

Federal law prohibits Medicare providers from billing Medicare-Medicaid dual-eligible individuals for Medicare Part A and Part B cost-sharing under any circumstances. Providers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states can limit Medicare cost-sharing payments, under certain circumstances. Medicare and Medicaid payment, if any, must generally be accepted as payment in full. Regardless, Medicare-Medicaid dual-eligible individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

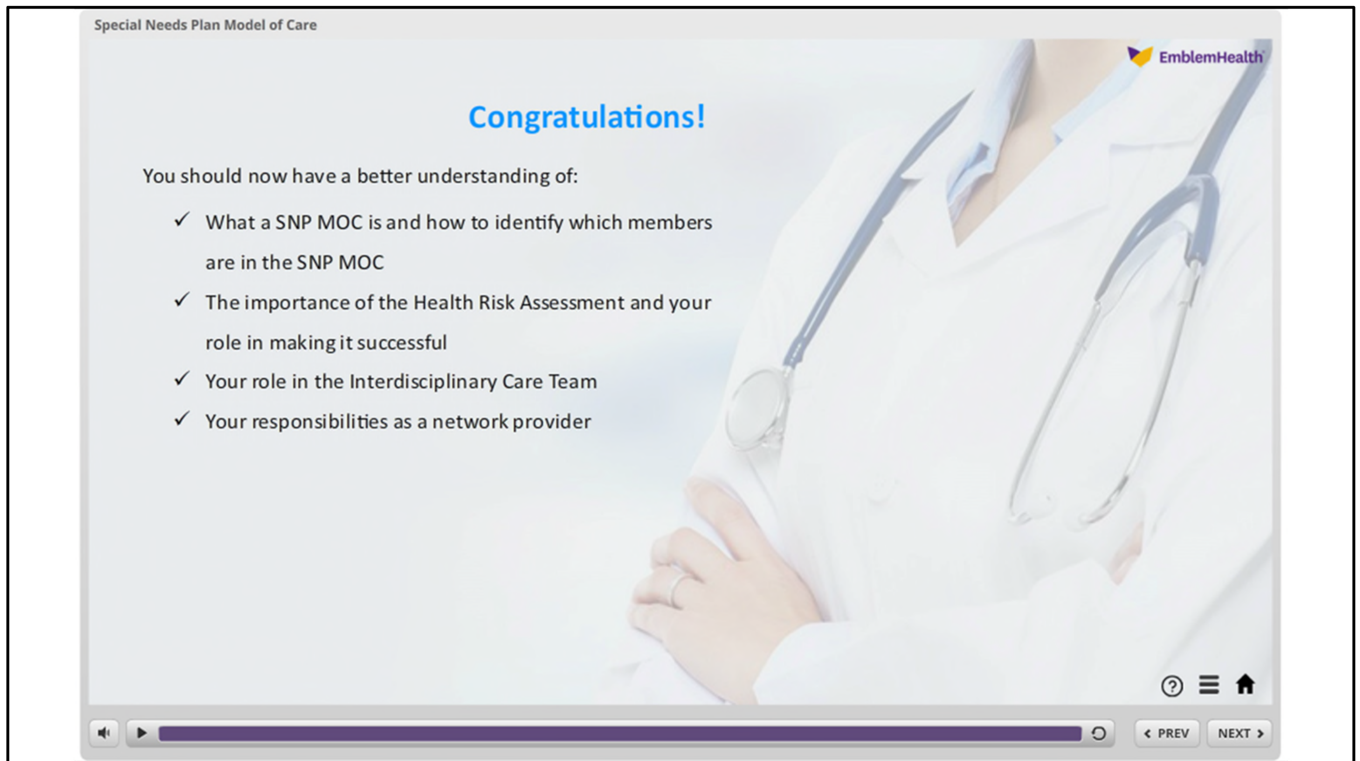


At EmblemHealth, we make it easy for VIP Dual HMO SNP members to take advantage of non-invasive options to address common complaints like back pain.

We provide no-cost acupuncture visits, a fitness benefit, greater coverage for over-the-counter medications, and eliminate the out-of-pocket cost for physical therapy. Physical therapists receive 100% of claims reimbursement and no longer need to bill fee-for-service Medicaid or write off the portion of the member's cost share.

We also offer no-cost dental, generous eyewear coverage, and transportation coverage so members can get to their appointments with you.

Please make sure your EmblemHealth VIP Dual HMO SNP members know about these benefits and take advantage of them. Thank you for your partnership in caring for our members.



You have reached the end of this course. You should now have a better understanding of:

- What an SNP MOC is and how to identify which members are in the SNP MOC.
- The importance of the Health Risk Assessment and your role in making it successful.
- Your role in the Interdisciplinary Care Team.
- Your responsibilities as a network provider.