EmblemHealth®

Special Needs Program (SNP)

The Special Needs program (SNP) is a free Medicare Advantage-coordinated care plan specifically designed to provide targeted care management to special needs individuals with vulnerable issues. This comprehensive program promotes quality of care through available resources, integration of services, and an interdisciplinary team approach for delivering coordinated care using Medicare and Medicaid physical health, behavioral health, pharmacy, and community-based services.

Who is eligible for the program?
All SNP members are eligible for our Care Management (CM) program.*

A special needs individual can be a dual eligible (Medicare Part A and Part B, and Medicaid through the New York State Department of Health), institutionalized individual, or individual with severe or disabling chronic condition(s).

Members are referred by various sources including Health Assessments (HAs), pharmacy, claims and utilization data, and internal EmblemHealth referrals.

How do members enroll?
SNP members identified for the program through an HA should call Care Management at **800-447-0768** (TTY **711**), Monday through Friday, 9 a.m. to 5 p.m. Those identified via claims, pharmacy, utilization management, behavioral health, and providers will receive a call from Care Management.

How does the program benefit the member?

- Provides a comprehensive initial assessment for the member.
- Provides members with access to a multidisciplinary team consisting of registered nurse care managers, social workers, nonclinical care specialists, pharmacists, and a medical director.
- Coordinates community resources and addresses social determinants of health.

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- Develops and implements a customized, individual care plan based on the goals of the member and/or caregiver.
- Provides education including identification of red flag events.
- Identifies key issues, problems, and barriers. Referrals to resources are provided to address those issues.
- Schedules needed health services.
- Promotes communication between member and/or caregiver, PCP, and specialist.
- Provides coordination, education, and support that can improve health outcomes.
- Facilitates the flow of information to ensure continuity of care across providers and health care settings.
- Coordinates with managed long-term care to get services covered under Medicaid benefit.

How can you support members/your patients in the program?

- Reinforce adherence to care plan, importance of scheduling and attending follow-up appointments, and acquiring education including actions to be taken for red flag events.
- Refer members to community resources and other EmblemHealth programs from which they could benefit.

Are there additional considerations?

SNP members are often high-risk individuals with complex care management needs. Members have a high incidence of chronic conditions such as asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, and behavioral health conditions including substance use disorders.

Many of these members have comorbidities, higher medical costs, the need for access to home and community-based services, intensive care coordination, and require proactive monitoring of their health status.

How long is the program?

Members remain enrolled in the program until their goals are met.

How do I find out more?

Call our Care Management department at **800-447-0768** (TTY **711**), Monday through Friday, 9 a.m. to 5 p.m.

* Some managing entities (delegates) offer their own care management programs for EmblemHealth members under their care. For more information about their care management programs, go to **emblemhealth.com/providers/manual/health-promotion-and-care-management**, under the "Care Management Programs" drop-down, at the bottom.

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