Post-Acute Care Insourcing

December 1, 2022

EmblemHealth®

Our Mission:

To create **healthier futures** for our **customers** and **communities**.

What is changing?

- **Beginning Dec. 1, 2022**, EmblemHealth will provide post-acute care (PAC) services to all members with requests for admission to a skilled nursing facility (SNF) or acute rehabilitation facility, and for covered home health care services.
- In addition, members will be eligible for transition of care support, and care management (CM) services through EmblemHealth.
- Up until now, you have been reaching out to our partner eviCore for these authorizations. This will change on Dec. 1.

What PAC services are affected by this change?

- PAC services impacted by this change include utilization management (UM) authorizations for:
  - Home care
  - Skilled nursing facility/inpatient rehabilitation facility (SNF/IRF)
  - Long-term acute care hospital (LTACH)

- It also includes the care management (CM) functions of transitions of care, and complex case management both prior to transition from the acute care setting and during the transition through each level of care.

What won’t change?

- Your facility will continue to work with our UM team for authorization needs, and they will be happy to connect you with our CM area.
- Our goal is to partner with facilities to help members and caregivers with the transition of care prior to discharge.
- Our CM services are provided by an integrated CM team to provide education and support to members and caregivers, as well as connect them to community resources for assistance with self-management.
- eviCore will continue to manage authorizations for durable medical equipment (DME) after Dec. 1. eviCore will also manage ongoing care requests for services that began prior to Dec. 1.

Why insource these services?

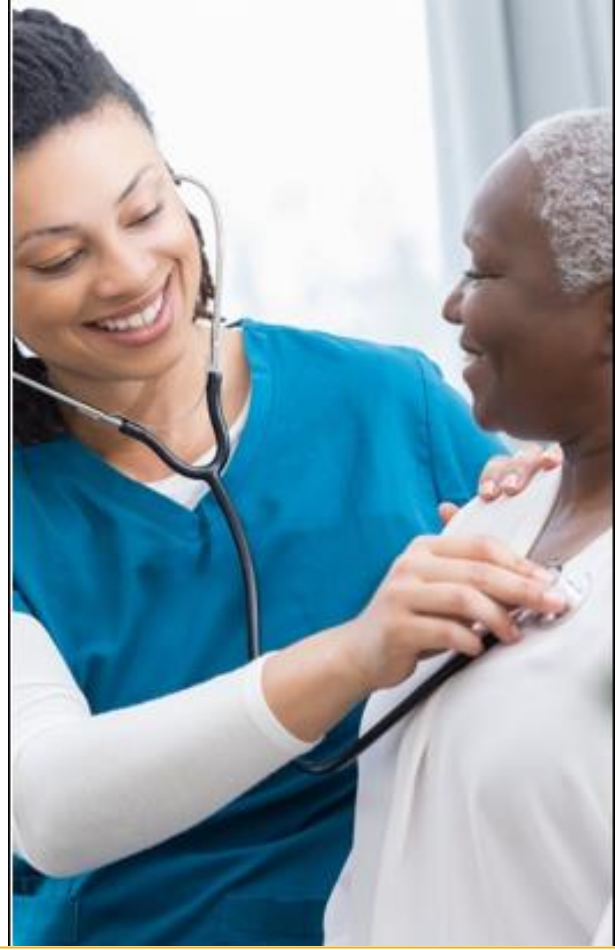
By bringing these services in-house, we strive to provide better care for our members. The EmblemHealth PAC program, in partnership with our providers, offers personalized care with an emphasis on the home, and on choosing the right path of care for the right length of stay.

For EmblemHealth members, the PAC program will aim to:

- Reduce readmission rates.
- Make the home a center of care.
- Allow us to better serve providers who need to connect our members with appropriate care.

Key Changes for Transitions of Care

- Improved care coordination between UM and CM.
- Continuity of care for members needing long-term CM services.
- Member engagement may begin while member still in facility bed.



Care Management Programs

- A1Chieve
- Complex Case Management Program
- Healthy Futures Program
- HIV/AIDS Program
- Kidney Care Companion Program
- Long-Term Services and Supports (LTSS) Program
- Medically Fragile Program
- Medication Therapy Management Program
- Palliative Care Program
- Restricted Recipient Program
- Transitions of Care Program
- Transplant Program

Transitions of Care (TOC) Approach

- We aim to help members avoid preventable hospital readmissions and other acute care utilization by providing care coordination services and a member-centered coaching intervention to empower members to better manage their health after discharge.
- The TOC program is designed to target vulnerable members who are at high risk for negative post-hospital outcomes/readmissions. We do this by ensuring discharge planning needs are met, and by offering members appropriate transitional resources for 30 days after discharge from the acute or post-acute care setting.
- Members can be referred to other eligible EmblemHealth CM programs if additional needs are identified beyond the 30-day transition period.

Transitions of Care Approach (continued)

- The interdisciplinary TOC team provides holistic, dynamic, and integrated CM and coordination services to our most vulnerable/at-risk members. The multidisciplinary team model allows for the entirety of members' care needs to be met throughout their engagement with the program by integrating both physical and behavioral health.
- Our care managers will work with our members and their attributed providers to educate and equip them with the tools they need to manage their ongoing health conditions, and ensure members have the resources in place to prevent avoidable acute care utilization in the future.

Care Management Contact Information

Beth Campbell
bcampbell@emblemhealth.com
Direct Line: **646-447-4976**
Care Management Intake Line: **800-447-0768**

Methods of Preauthorization Requests

INPATIENT REQUESTS: Submit initial requests and clinical information to support the request services via: For those hospitals that have granted EmblemHealth access to the electronic medical record, we do not require faxed clinical information. Be sure the sending facility is clearly indicated on the preauthorization request. Be sure the request specifies what level of care is being requested, e.g., SNF, acute rehabilitation facility, or LTACH.	Provider portal (preferred): **emblemhealth.com/providers/resources/provider-sign-in** Fax: **866-544-9387**, 7 days a week, including holidays Specify on fax cover sheet that request is for a weekend or holiday admission date. Phone: **877-833-2729**, Monday through Friday, 9 a.m. to 5 p.m.
OUTPATIENT REQUESTS:	Fax: Commercial & Medicare ambulance: **212-510-5112** Commercial & Medicare home care: **877-264-8675** Phone: Commercial & Medicare members: **877 833 2729**

Thank you

We are looking for the contact information for key provider partners, including discharge planners, case management departments, minimum data set coordinators, etc., so we can work with them to assist with member engagement and the sharing of pertinent information for a member's care transition.

Please email any contact names, emails, and phone numbers to Cooper Nolan (**cnolan@emblemhealth.com**).