

Provider Model of Care (MOC) Training

Hamaspik Managed Care
2026 Training



Provider Network Education



Model of Care Overview

The Model of Care (MOC) is a continuous cycle of quality, accountability, and improvement focused on better outcomes for our members.



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Training Purpose

This training is designed to help providers understand Hamaspik Managed Care's Model of Care and their role in supporting coordinated, culturally competent, member-centered care.



Understand the Model of Care

Review the goals, structure, and core components of the Model of Care, including how it supports quality, care coordination, and member outcomes.



Clarify the Provider Role

Explain provider responsibilities in communication, documentation, care planning, transitions of care, and participation in the interdisciplinary care team.



Support Better Outcomes

Show how provider engagement helps improve access, coordination, member experience, and overall health outcomes for the SNP population.



Introduction

This training provides an overview of Hamaspik Managed Care's Model of Care, the population we serve, and the provider's role in coordinated, member-centered care.



Purpose

Explain the Model of Care framework and how it supports quality, coordination, and member outcomes.



What you'll learn

Review the SNP population, interdisciplinary care approach, care planning, transitions of care, and provider responsibilities.



Why it matters

Providers play a key role in delivering culturally competent, coordinated, and person-centered care.



Mission

Hamaspik Managed Care is committed to excellence in providing access to quality-driven health care coverage in a culturally sensitive, timely, and responsible manner.



Culturally sensitive

Care and communication reflect member language, preferences, and support needs.



Timely

Needs are identified early and acted on through care coordination.



Responsible

Staff and providers document, collaborate, and close the loop.

Approval Process

The Model of Care approval process shows how SNP requirements are evaluated, approved, and renewed through the NCQA review framework.

1 MOC content

Clinical and non-clinical elements define how the SNP identifies and meets member needs.

2 NCQA review

Elements are evaluated through a scoring process derived from CMS/HHS requirements.

3 Approval period

SNPs may be approved for one-, two-, or three-year periods. Hamaspik has been approved for a three-year period expiring 12/31/2026.

4 Renewal posture

The current MOC submission is treated as a renewal submission.



- The MOC is both a regulatory requirement and an operating playbook.
- Evidence matters; assessments, care plans, outreach, ICT activity, transition documentation, and training records all support the model.
- The goal is not just approval; it is consistent, coordinated care for members with complex needs.

Model of Care Framework

Hamaspik's Model of Care is organized into four key domains that work together to deliver coordinated, high-quality, member-centered care.



MOC 1

Description of SNP Population

General population, most vulnerable population, eligibility, demographics, health status, and needs.



MOC 2

Care Coordination

Staff structure, HRA/HRAT, face-to-face encounters, ICP/PCSP, ICT, and care transitions.



MOC 3

Provider Network

Specialized expertise, clinical practice guidelines, transition protocols, and provider training.



MOC 4

Quality Measurement

Quality improvement plan, goals, member experience, evaluation, and dissemination.

MOC 1

Description of the SNP Population

Who Hamaspik serves, how vulnerability is identified, and what the data tells us about member needs.

Plan Portfolio Overview

Hamaspik operates two Medicare Advantage Special Needs Plans (SNPs) under CMS Contract H0034.



H0034-001

Hamaspik Medicare Select (HMS)

HMO D-SNP | MA-PD
Inception: 2020



H0034-002

Hamaspik Medicare Choice (HMC)

D-SNP / FIDE SNP | MA-PD + MAP
Inception: 2021



Integration Note

PBP 001 functions as a D-SNP and PBP 002 functions as a Fully Integrated Dual Eligible MAP D-SNP / FIDE SNP; CMS ultimately determines final D-SNP integration designation.



Training Implication

Staff and providers should understand which plan a member is enrolled in, because benefits, LTSS requirements, and coordination pathways may differ by product.



Enrollment Snapshot



1,965

Total Medicare SNP enrollees as of 4/23/26



257

PBP 001 enrollees as of 4/23/26



1,708

PBP 002 enrollees as of 4/23/26

Eligible Medicaid Categories



Enrollment eligibility requirements

Hamaspik offers enrollment to individuals who meet Medicare requirements, live in the plan service area, and have active New York Medicaid eligibility in one of the approved categories.



Staff/provider lens

Eligibility categories are not just enrollment details; they shape coverage navigation, benefit coordination, member education, and referrals to Medicaid-covered services.



Members must have qualifying New York Medicaid coverage

Enrollment requires active New York Medicaid eligibility in an approved category, such as Full Benefit Dual Eligible, Qualified Medicare Beneficiary Only, Qualified Medicare Beneficiary Plus, Specified Low-Income Medicare Beneficiary Only, Specified Low-Income Medicare Beneficiary Plus, Qualifying Individual, or Qualified Disabled and Working Individual.

Eligible Medicaid categories include QMB Only, QMB Plus, SLMB Only, SLMB Plus, QI, QDWI, and FBDE. Staff confirm active New York State Medicaid eligibility and plan-specific requirements before enrollment.

Eligibility: Who Can Enroll?

1 Medicare

Entitled to Medicare Part A and enrolled in Medicare Part B.

2 Medicaid

Active New York State Medicaid eligibility in an approved category.

3 Service area

Permanent residence in the approved county service area.

4 Plan-specific

For PBP 002, member must also meet LTSS functional eligibility criteria.



Member status is verified before enrollment

Eligibility is validated using CMS enrollment systems and New York State Medicaid data sources to confirm dual-eligible status and plan-specific requirements.



Eligibility must be tracked

Enrollment teams document residence, date of birth, citizenship/legal residency, LIS status, Medicare Part B, legal representation when applicable, and best available evidence when warranted.

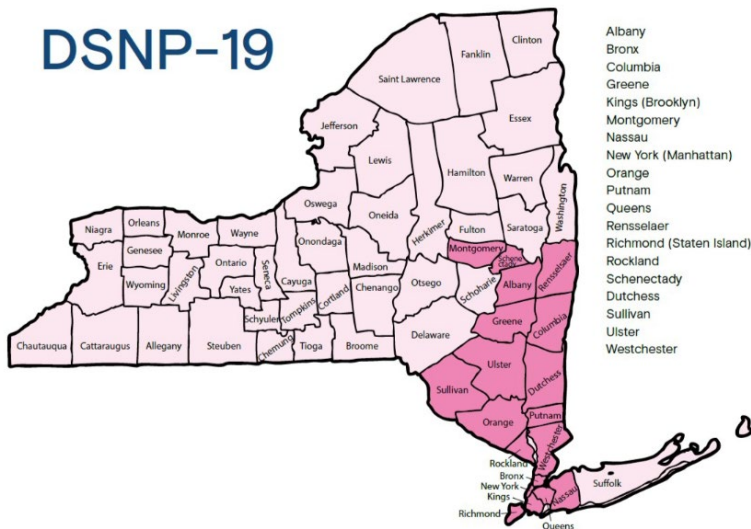
Service Areas

HMS / PBP 001

19 New York counties: Albany, Bronx, Columbia, Dutchess, Greene, Kings (Brooklyn), Montgomery, Nassau, New York (Manhattan), Orange, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Schenectady, Sullivan, Ulster, Westchester.



DSNP-19

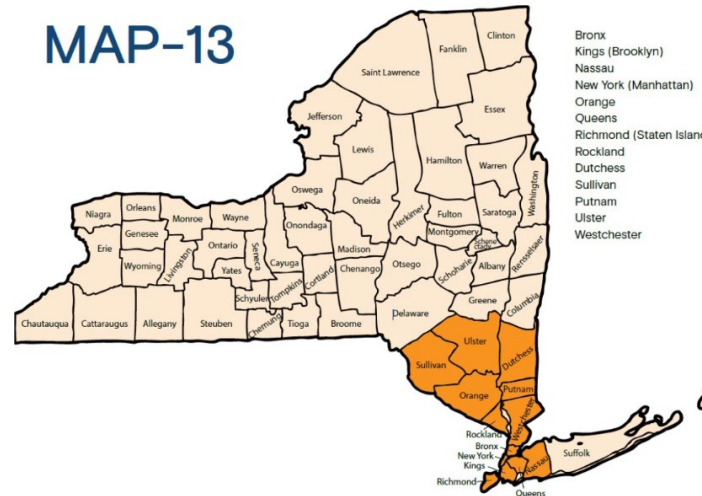


HMC / PBP 002

13 New York counties: Bronx, Dutchess, Kings (Brooklyn), Nassau, New York (Manhattan), Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Sullivan, Ulster, Westchester.



MAP-13



Operational takeaway

Service-area awareness matters for eligibility verification, network access, home and community-based services, and community resource referrals.

Hamaspik Medicare plans cover the NYC (downstate), Hudson Valley, and upstate as far as Montgomery and Rensselaer counties.

Hamaspik's Provider Relations department continually expands the network to support the needs of the members.

MAP / LTSS Criteria

HAMASPIK MEDICARE SELECT PBP 001: D-SNP

Members without LTSS needs may enroll in the D-SNP product, subject to Medicare, Medicaid, and service-area eligibility.

HAMASPIK MEDICARE CHOICE PBP 002: MAP / FIDE SNP

Members with Medicaid-covered Long-Term Services and Supports needs enroll in the MAP product when they meet LTSS functional eligibility criteria.

Both plans

Members receive integrated care coordination through Hamaspik's Interdisciplinary Care Team, with support for covered and non-covered benefits as applicable.



Key takeaway

LTSS need is a defining difference for the MAP/FIDE SNP product. The MOC translates that difference into assessment, service planning, provider coordination, and ongoing monitoring.

Enrollment & Verification Workflow

1 Identify

Marketing events, educational events, referral accounts, field marketing, online enrollment center, or MLTC members aging into Medicare.

2 Consent

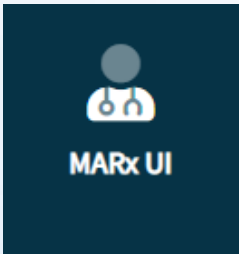
Prospects complete CMS-approved consent to contact verbally on a recorded line or in person.

3 Verify

Medicare verified through MARx; Medicaid verified through ePACES; BAE used when warranted.

4 Track

Each step and required data point is documented in the sales portal.



 **Yes, I'd like an outreach representative to contact me to discuss Hamaspik plans. And to schedule an appointment.**

Phone Number

Email

* All information provided on this form will remain confidential. By submitting this form, you consent to allow a Hamaspik staff member to contact you regarding our health plans and your plan eligibility.

 **Hamaspik Medicare SELECT**

*Hamaspik Medicare Select is a Medicare Advantage and Prescription Drug Plan (HMO D-SNP) with a Medicare contract. Hamaspik Choice is a Managed Long-Term Care Plan (MLTC) with a Medicaid contract. Enrollment in a Hamaspik Health plan depends on contract renewal. This information is not a complete description of benefits. For a complete list of covered services and other important information, call 855-426-2774. TTY users, please call 711.

1.888.Hamaspik 1.888.426.2774
TTY/TTD Users Call 711

Customer Service Hours:
Oct 1 - Mar 31, Mon - Sun, 8AM - 8PM
Apr 1 - Sept 31, Mon - Fri, 8AM - 8PM

Hamaspik.com H0034_REPLY0920.M

Enrollment periods

Members may enroll during fixed annual periods or individual-circumstance enrollment periods such as initial election periods, special election periods, and continuous open enrollment for institutionalized individuals.

General SNP Population

Dual-eligible population

Hamaspik Medicare Select and Hamaspik Medicare Choice serve Medicare-Medicaid dually eligible individuals who reside in approved NY service areas and meet Medicare and Medicaid eligibility requirements.

Why needs are complex

Dual eligible members may experience age-related changes, multiple chronic physical and mental conditions, functional limitations, and social resource constraints.

Coverage navigation

Members may receive Medicare and Medicaid benefits through multiple coverage pathways; care coordination helps reduce gaps, confusion, and fragmentation.



A Medicare plan built around you.

The Medicare plan you need.
The benefits you deserve.

\$0 premiums
Extensive Benefits

Contact Hamaspik to get signed up in just a few, quick steps.
We're looking forward to taking care of you!

1.888.Hamaspik 1.888.426.2774
TTY/TTD Users Call: 711
Customer Service Hours:
Oct 1 - Mar 31 Mon - Sun 8AM - 8PM; Apr 1 - Sept 30 Mon - Fri 8AM - 8PM

Hamaspik Medicare SELECT

Hamaspik.com

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Most Vulnerable Population

What Differentiates VP Members: Hamaspik defines its most vulnerable enrollees as a distinct subpopulation within an already high-risk D-SNP/MAP membership.

Functional limits



Severe ADL/IADL or mobility limitations

Clinical complexity



Multiple chronic conditions, cognitive impairment, high-risk medication needs

Behavioral health



Mental health or substance use needs

SDOH



Housing instability, food insecurity, low health literacy, limited supports

Utilization



High acute utilization or extreme utilization/cost patterns

Access barriers



Difficulty navigating services or independently accessing care



Core distinction

Vulnerability is based on cumulative risk across domains, not a single condition or characteristic. Members who meet threshold criteria receive VP-specific care management services.

VP Stratification Model

1 Data sources

UAS, HRA/HRAT, claims, pharmacy, care management, demographics, and other reports.

2 Risk factors

Age, chronic conditions, cognitive/mental health, SDOH, functional limits, medication complexity, utilization (see chart).

3 Scoring

Weighted scoring and defined thresholds are applied using an automated backend process.

4 Action

Members are flagged for care management review, intervention, and ongoing monitoring.



RISK LEVEL	RISK SCORE RANGE	RISK DESCRIPTION	RECOMMENDED ACTION
 LOW Lower risk	0 – 300	Lower overall risk. Member is generally stable with minimal care needs.	 Routine monitoring Continue preventive care and regular engagement.
 MEDIUM Moderate risk	301 – 600	Moderate risk. Member may have multiple conditions or increasing needs.	 Proactive management Monitor closely, address gaps, and connect to appropriate resources.
 HIGH High risk	601+	High overall risk. Member has complex needs or frequent utilization.	 Intensive management Prioritize care coordination, frequent follow-up, and address social drivers.



VULNERABLE POPULATION – EXTRA CRITERIA



Age over 75



Limited English proficiency



Low education or low health literacy



Durable medical equipment (DME) needs



Falls with injury



Polypharmacy or high-risk medications



High utilization or cost thresholds



Complex social needs (e.g., housing, food, safety)

Members may be flagged as part of a Vulnerable Population if they meet one or more of the following criteria, which may increase risk regardless of score:



Risk scores are based on clinical, utilization, and social factors to support proactive, person-centered care.

Demographic Snapshot

87.1%

Members age 60+

59.4%

Female membership

72 / 73

Average age
Non-VP / VP

3.2%

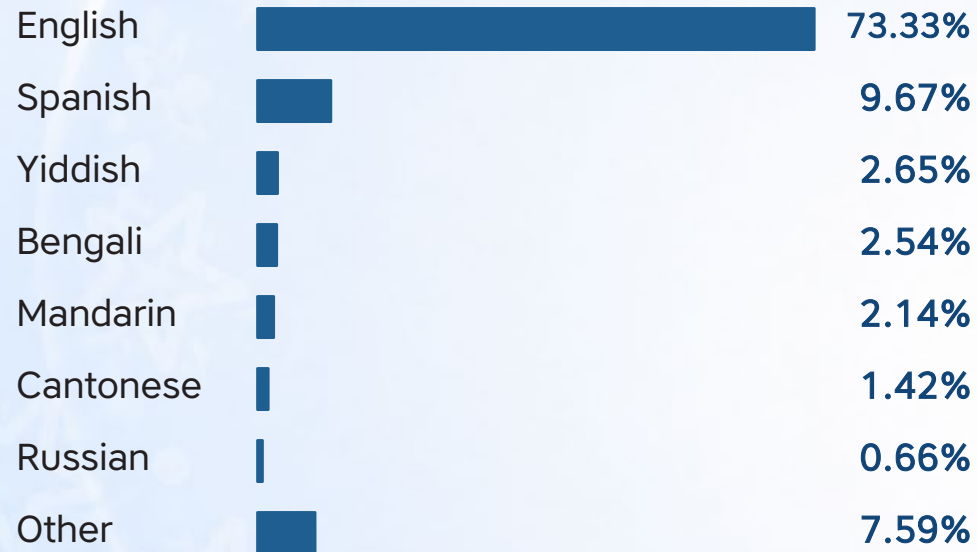
VP members
63 of 1,965



Ethnicity

Most members identify as Non-Hispanic/Latino, followed by Hispanic/Latino. Hispanic/Latino members represent 21.07% of total membership, and VP members show relatively higher proportional representation in the Hispanic/Latino subgroup.

Language, Culture, and Communication



Language access

Members with language barriers are supported through preferred-language materials, interpreter services, three-way calls, and staff language capabilities when available.



Alternative formats

Materials are provided in preferred languages and alternative formats such as braille, large print, electronic delivery, and TTY Relay services.



Care planning implication

Communication preferences and barriers inform assessment, outreach, ICP/PCSP development, caregiver engagement, and ICT participation.

Socioeconomic Status

100%

Members qualify for
Low-Income Subsidy



Education & Health Literacy

Education and health literacy are key care planning factors. 71.4% of VP members have a high school education or less, compared with 66.3% of Non-VP members. Only 9.5% of VP members have a college degree or higher, compared with 13.7% of Non-VP members.

98.4%

VP members qualify
for LIS 3
Full Extra Help /
Extreme Poverty



Training implication

Economic instability is not peripheral to care management. It affects access to medication, food, utilities, transportation, preventive care, and the ability to follow an ICP/PCSP.

92.8%

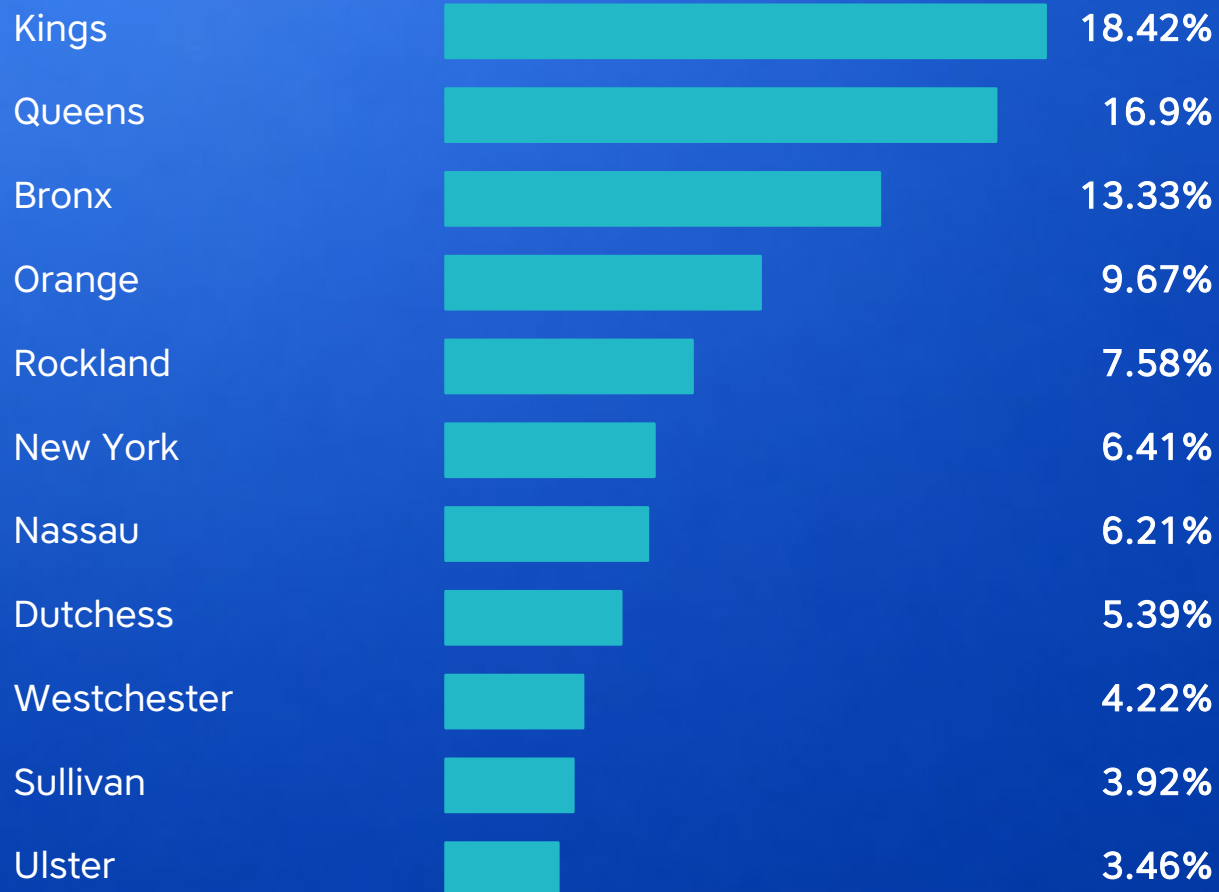
Non-VP members
qualify
for LIS 3 Full Extra Help
/ Extreme Poverty



Care manager response

HRAT and care management interactions identify socioeconomic and health literacy barriers so communication, referrals, and interventions match the member's needs.

County Distribution



Operational use

County-level concentration helps Hamaspik align network access, community partnerships, language access, in-home supports, and provider outreach to where member needs are most concentrated.



Most impacted areas

VP members are concentrated in high-membership counties including Bronx, Kings, and Queens, with additional presence across other service areas.

Health Status Overview

Clinical

Chronic conditions, comorbidities, cognitive impairment, behavioral health needs, medication complexity, and acute utilization patterns.



Functional

ADL/IADL limitations, mobility constraints, DME needs, homebound status, falls with injury, and LTSS needs.

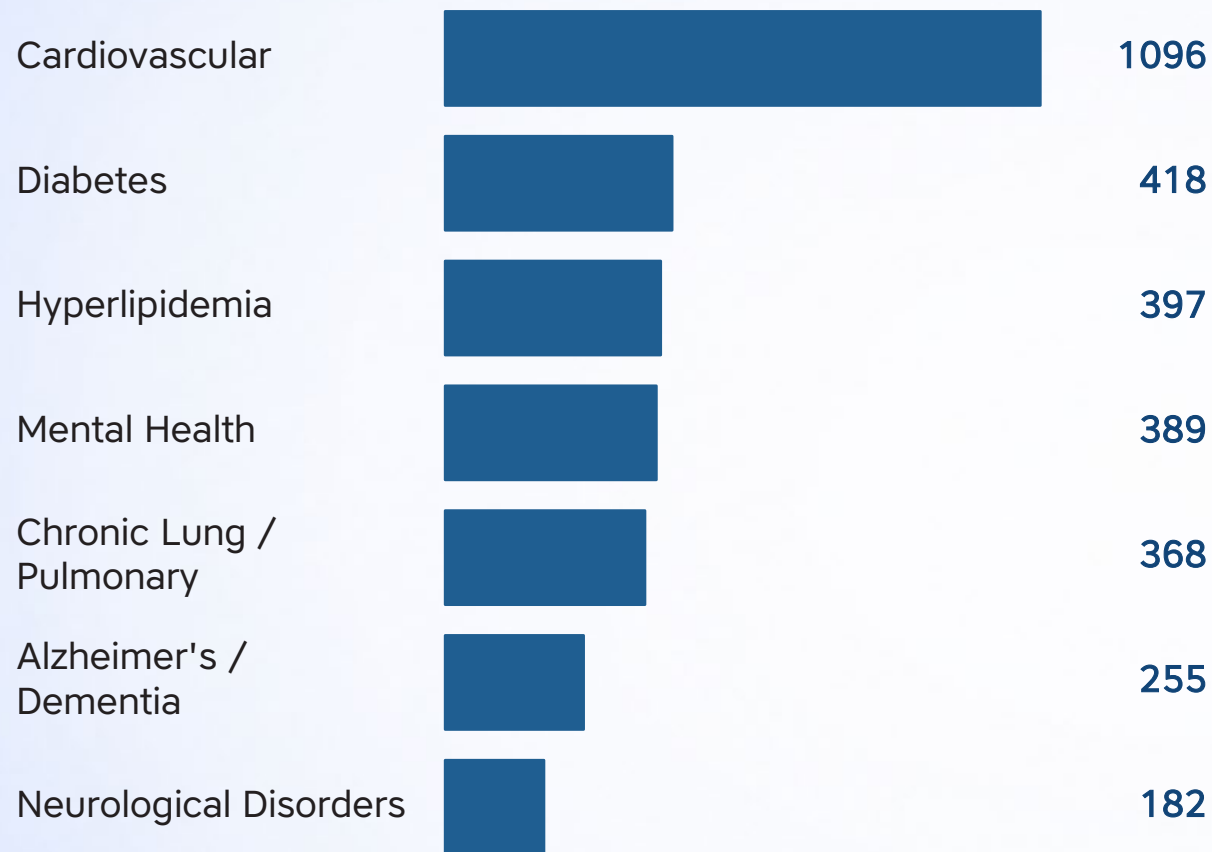


Social / environmental

Economic instability, food insecurity, transportation barriers, social isolation, housing instability, unsafe living conditions.



Chronic Conditions



What the data shows

Cardiovascular disease is the highest-burden condition. Diabetes, hyperlipidemia, mental health conditions, pulmonary disease, dementia, and neurological disorders create overlapping care management needs.



VP lens

Although VP members are a small cohort, they carry a disproportionately high burden of chronic condition assignments and require coordinated clinical, functional, behavioral, and pharmacy support.

Comorbidity Patterns

1,226



Members with 3+ chronic conditions

547



Diabetes + cardiovascular disease

23



ETOH substance abuse + mental / behavioral health conditions

Why comorbidity matters

Members with multiple conditions often need more frequent monitoring, medication reconciliation, disease education, provider coordination, and caregiver involvement.

Care management implication

The same combination of conditions can be more resource-intensive for VP members because risks stack with functional limitations, access barriers, low health literacy, or social needs.

MOC 2

Care Coordination

How the Plan organizes staff, assessments, care plans, communicates as an interdisciplinary care team, and transitions to support members.

Staff Structure



Training and compliance

HR and clinical trainers support onboarding, recurring trainings, competency assessment, and documentation.



Care management

VP/Director of Care Management, supervisors, Care Managers, TOC Care Managers, TOC Coordinators, and Care Management Coordinators drive assessment, planning, outreach, and coordination.



Utilization management

UM leadership, reviewers, coordinators, and contracted support review requests, manage authorization needs, and support continuity of services.



Clinical oversight

Chief Medical Officer provides clinical leadership across utilization review, case management, quality improvement, evidence-based practice, and care rounds.



Assessment team

Director of Assessments, UAS lead/reviewers, nurse assessors, and coordinators support UAS/HRA accuracy, timeliness, and consistency.



Pharmacy + Quality

Pharmacy and Quality support MTMP, medication adherence, Stars, preventive care, quality monitoring, and performance improvement.



Provider relations

Provider Relations and Network Development support network access, provider training, credentialing, and partner engagement.



Emergency Preparedness & Continuity

Hamaspik maintains backup staffing, hotline access, vendor service continuity, recovery review processes, and annual preparedness updates to help ensure care and support continue during emergencies or operational disruptions.

Clinical Oversight and Care Coordination Functions

Clinical guidance



CMO provides clinical leadership across UM, Care Management, Quality Improvement, policy, and practice initiatives; heads the ICT; and leads Interdisciplinary Care Rounds to ensure care plans reflect member needs, preferences, chronic conditions, goals, and SDOH.

CMO collaborates with clinical leadership and provider partners to develop, update, adhere to, and monitor evidenced-based clinical practice guidelines.

Care coordination



Care Management leads HRAs, ICP/PCSP development, member education, outreach, and case coordination.

Pharmacy consultation



Prime Therapeutics supports formulary, MTMP, medication reviews, education, and pharmacy coordination.

Utilization support



UM processes authorizations and supports care coordination through service review and medical necessity determinations.

Behavioral health



Carelon supports behavioral health services, case management, and coordinated care discussions.



Health Risk Assessment (HRA / HRAT)

1 Initial

Completed within 90 days of active enrollment.

2 Annual

Reassessment completed at least annually.

3 Significant change

Updated when condition, utilization, or risk status changes.

4 Documented

Data, attempts, refusals, and correspondence are recorded in the EHR.



Health Risk Assessment (HRA)

Personalized. Proactive. Partnered in Your Health.

It's great talking with you, Mr. Johnson. I'll help you through the assessment.

Health Risk Assessment

Overall Health	
General Health	☒
Chronic Conditions	☒
Medications	☒
Physical Activity	☐
Nutrition	☐
Mental Well-Being	☐
Social Support	☐
Safety	☐

Any concerns you'd like to discuss?

1. Outreach
Care manager reaches out and explains the HRA.

2. Complete Assessment
Member completes the Health Risk Assessment with support.

3. Review & Identify
Care manager reviews responses and identifies opportunities.

4. Create Plan
Together, we create a personalized care plan and goals.

5. Ongoing Support
We're here to help you stay healthy and supported.

Your health. Our priority. Together.

Multiple modes

HRA may be completed telephonically, virtually, by mail, in person, or through UAS NY Community Health Assessment where applicable.

Member Outreach

Hamaspik makes at least three attempts to contact members unless the member completes or declines participation before three attempts.

Care planning use

HRA results feed risk stratification, ICP/PCSP development, outreach cadence, ICT needs, and targeted interventions.

Health Risk Assessment (HRA / HRAT)

HRA Stratification

Stratification	Score threshold	Care management program	Outreach cadence
Low	<300	Episodic Care Management	No less than every 6 months
Medium	300–600	Standard Care Management	No less than every 3 months
High	>600	Intensive Care Management	No less than monthly
Transitional	N/A	Transitional Care Management	Admission through post-discharge

Face-to-Face Encounter



2 modes

In-person or visual, real-time, interactive telehealth



Annual

Face-to-face encounter requirement



Ongoing

within first 12 months of enrollment and annually thereafter



Who may complete it

Qualified staff can include ICT members, care managers, UAS assessors, care management support staff, field staff, PCPs, specialists, behavioral health providers, social workers, MLTSS staff, and other contracted plan health care providers.



What it can include

HRAT, AWW, UAS, healthcare education, care coordination, PRI, wellness visits, ICP review, Interdisciplinary Care Rounds, disease management outreach, and clinical education.

Individualized Care Plan (Person-Centered Service Plan)

ICP / PCSP element	Element Details
 Inputs	HRAT/UAS, claims, pharmacy, providers, home health, member/caregiver input, and community sources.
 OGIs	Opportunities, goals, interventions, preferences, and tailored services are documented.
 Required content	Goals and preferences; covered services; scope, amount, and frequency; formal and informal supports; setting; risk factors; SDOH; unmet needs; backup plan; and responsible care manager.
 Review & update	Updated after health assessments and reassessed during outreach, transitions, and changes in status.
 Share / disseminate	Provided to the member or representative and available to authorized ICT members and stakeholders.
 Outreach cadence	Low: no less than every 6 months. Medium: no less than every 3 months. High: no less than monthly. Transitional: admission through post-discharge.

Interdisciplinary Care Team (ICT)



Member + caregiver voice

Members, caregivers, and appointed/designated representatives are integral participants; preferences, goals, and lived experience inform care planning.



Internal team

CMO, CM leadership, Care Managers, Nurse Assessors, care coordination/support staff, UM, pharmacy, behavioral health, and quality roles as applicable.



External team

PCP, specialists, behavioral health providers, pharmacists, rehabilitation therapists, LTSS providers, home health, and community-based organizations as needed.

How membership is determined

ICT membership is driven by HRAT/UAS findings, the ICP/PCSP, clinical, functional, behavioral, psychosocial needs, the member's confirmed representatives, and the services required to manage care holistically and safely.

How communication works

Information exchange occurs through EHR documentation, ICP distribution, ICR notes, outreach, referrals, case conferences, secure communication, and provider/caregiver engagement. The ICP is distributed to the Member, their designated representative(s), their PCP, and additional ICT/stakeholders.

Outcome Evaluation

The ICT reviews member status, ICP/PCSP progress, utilization trends, gaps in care, and changing needs to determine whether care management strategies, services, provider involvement, or outreach should be adjusted.

Transitions of Care

1 Admission

TOC team documents notification, notifies appropriate parties, and coordinates with UM and facility.

2 During stay

Clinical updates, authorization needs, service interruptions, and discharge planning are coordinated.

3 Discharge

Services are resumed or adjusted; new DME, CHHA, or supports are coordinated as needed.

4 Post-discharge

Outreach, medication reconciliation, provider follow-up, and community supports mitigate readmission risk.

Additional TOC expectations: TOC applies to all enrollees and includes planned/unplanned transitions, RHIO or facility-triggered notifications, homecare service hold/resumption, member/caregiver point-of-contact communication, and teach-back to confirm understanding.

48 hrs

Admission / SNF notification to DOH or MLTC when applicable

2 days

PCP notification of admissions, transfers, and discharges

72 hrs

Post-discharge outreach attempt after notification

30 days

TOC support after discharge



MOC 3

Provider Network

Provider expertise, care transition protocols, and training that connect the MOC to care delivery.

Provider Roles & Responsibilities



- ✓ **Communicate** with D-SNP care managers, ICT members, members, and caregivers



- ✓ **Collaborate** with our organization on the individualized care plan (ICP/PCSP)



- ✓ **Participate** in the ICT and care rounds



- ✓ **Review and respond** to member-specific communication



- ✓ **Maintain** relevant care plan information in the medical record



- ✓ **Encourage** member completion of the HRA/HRAT



- ✓ **Notify** care management of admissions, discharges, and transitions of care



- ✓ **Send** medical records as needed



- ✓ **Code** claims appropriately



- ✓ **Complete** medication reconciliation post-discharge



Support timely follow-up visits after discharge.

Ensure member follow-up appointments are completed within 14 days of discharge.



Provider MOC training is completed at onboarding and at least once throughout MOC Approval period.

Provider Manual

The Provider Manual is your go-to reference for understanding plan policies, processes, and your role in delivering high-quality, coordinated care to our members.



Reference source

The Provider Manual supports provider alignment with plan expectations, benefit information, authorization processes, claims/coding expectations, and care coordination responsibilities.



MOC connection

The manual reinforces the same operating model as the training: collaborate on the ICP/PCSP, communicate with the ICT, support transitions, close gaps, and document timely.



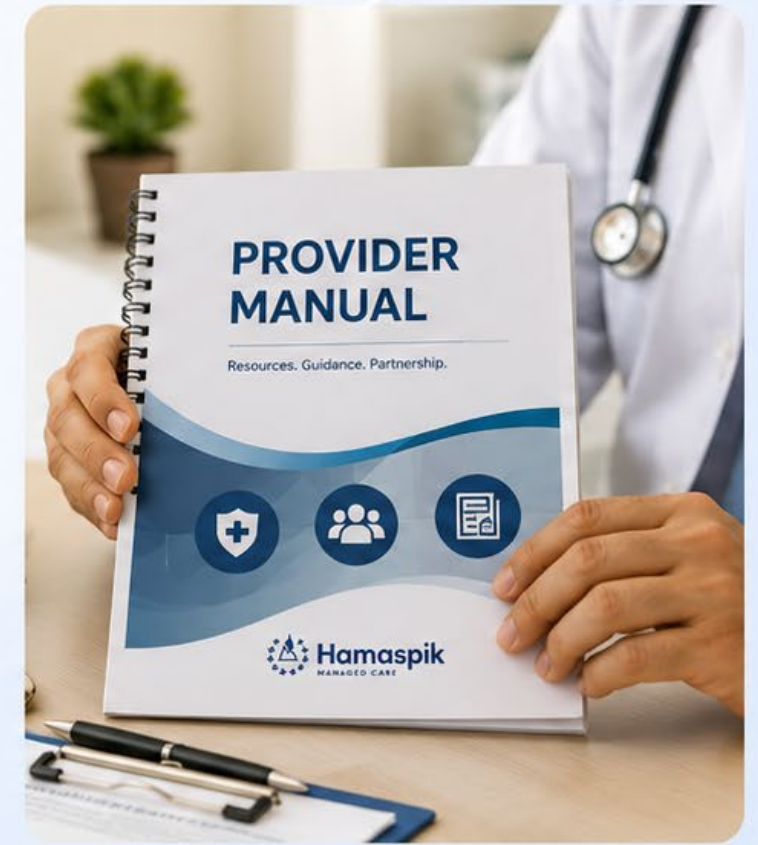
When to use it

Providers should reference the manual when confirming workflows, documentation requirements, benefit expectations, or updates that affect member care.



Training evidence

Provider education and manual updates should remain trackable, auditable, and aligned with the annual MOC training cycle.



Provider Network: Specialized Expertise

Hamaspik builds and maintains a provider network with the specialized expertise needed to address the complex needs of our SNP members.



Network purpose

The provider network must support the full range of member needs across primary care, specialty care, behavioral health, rehabilitation, pharmacy, LTSS, and community-based services.



Credentialing and qualifications

Network providers participating in the ICT are credentialed and verified for appropriate licensure, certifications, education, training, and work history as applicable.



VP support

In-home providers and community providers help address mobility and access barriers, especially for vulnerable members requiring preventive and primary care services.



Out-of-network continuity

For newly enrolled members, Hamaspik may collaborate with out-of-network providers to maintain existing services during transition periods.

Clinical Practice Guidelines & Care Transition Protocols



Clinical Practice Guidelines

Evidence-based practice and clinical practice guidelines support consistent care for common chronic conditions, utilization review, care management, and provider alignment.



Care Transition Protocols

Protocols are used for planned and unplanned transitions, including pre-transition activities, during-transition communication, and post-transition follow-up.



Provider role

Providers help identify changes in condition, share clinical information, coordinate with the TOC/CM teams, complete qualifying encounters, and participate in care planning when appropriate.



Documentation role

Clinical notes, claims, discharge summaries, progress notes, medication updates, and care recommendations support verification and continuity across settings.

Provider Quick Reference Guide

Fast access to key timeframes, contacts, and support.



Prior Authorization Timeframes



Elective Services

14 days prior to the scheduled service, when possible.



Urgent Services

Before the service.
If prior contact is not possible, within 1 business day.



Emergent Services

Notification within 1 business day of emergent services.



Support & Routing



Referrals

Contact Care Management for assistance with referrals and prior authorization.



Care Coordination

Call Care Management for locating members, program support, and coordination of care.



Laboratory / Service Routing

Use participating labs and facilities.
For non-participating services, contact Care Management.



Key Service Lines / Contacts

SERVICE	HOURS OF OPERATION	CONTACT / HOW TO REACH US
 Member Services / Eligibility Verification	Oct 1 – Mar 31: 8:00 am – 8:00 pm 7 days per week	Tel: 1-888-HAMASPIK 1-888-426-2774 Select "Provider" then option 1 TTY users should call 711
	Apr 1 – Sep 30: 8:00 am – 8:00 pm Mon – Fri	
 Care Management	Mon – Fri: 9:00 am – 5:00 pm	Tel: 1-888-HAMASPIK 1-888-426-2774 Select "Provider" then option 1 Fax: 1-845-503-1911
 Behavioral Health Services	24 hours / 7 days a week	Tel: 1-866-201-1401
 Pharmacy Services Prime	24 hours / 7 days a week	Tel: 1-800-424-4437
 Claims	Mon – Fri: 9:00 am – 5:00 pm	Tel: 1-888-HAMASPIK 1-888-426-2774 Select "Provider" then option 2
	Mail Paper Claims to: Hamaspik Medicare Select Attn: Claims 58 Route 59, Suite 1 Monsey, NY 10952	Electronic Submissions / Clearinghouse Tel: 1-866-371-9066 Hamaspik payer ID #47738
 Provider Relations	Mon – Fri: 9:00 am – 5:00 pm	Tel: 1-888-HAMASPIK 1-888-426-2774 Select "Provider" then option 4 Email: providerrelations@hamaspikchoice.org



MOC 4

Quality Measurement and Performance Improvement

How Hamaspik uses data, goals, member experience, and evaluation to continuously improve the MOC.

MOC Quality Outcomes & Measures

Measuring What Matters. Improving What Counts.

OUTCOME MEASURES



HEDIS Data

Performance on evidence-based measures that drive better health outcomes.



Gaps in Care

Identify and close gaps to improve member health and outcomes.



Member Risk Stratification

Identify high-risk members to prioritize outreach and interventions.



Sentinel Events & Quality of Care Issues

Monitor and address events that impact member safety and care quality.



Preventive Care & Immunization Utilization

Increase uptake of recommended screenings, vaccines, and preventive services.

PROCESS MEASURES



HRA Completion Rate

Capture comprehensive member data to support whole-person care.



Care Plan Completion Rate

Ensure timely, personalized care plans for every member.



Transitional Care Management

Support members through transitions to reduce readmissions and improve outcomes.



Call Center Measures

Track hold times, dropped calls, and member experience for responsive service.



Clinical Practice Guideline Compliance

Promote evidence-based care through guideline adherence.



UTILIZATION MEASURES (PROVIDER IMPACT)



Annual Wellness Visits



ER Visits / Hospital Admissions / Readmissions



Length of Stay



SNF Admissions



Medication Adherence



Behavioral Health Services



Out-of-Network Utilization



Medical Loss Ratio (MLR)



Better data. Better processes. Better outcomes.

Stronger providers. Healthier members.

MOC Quality Measurement & Performance Improvement

Performance improvement plan

Quality structures evaluate member needs, outcomes, barriers, care coordination effectiveness, and opportunities to improve workflows.

Measurable goals

Data supports goals related to outcomes, utilization, care coordination, preventive care, medication adherence, access, and member experience.

Patient experience

Member satisfaction, communication access, care manager contact, provider access, and service continuity inform improvement opportunities.

Ongoing evaluation

Findings from HRAs, ICPs, claims, utilization, care management notes, readmissions, ED utilization, adherence, and preventive care are reviewed and trended. QIC reviews quality data quarterly; selected operational metrics are monitored monthly/as needed.

Dissemination

Quality performance related to the MOC should be shared with appropriate committees, leaders, departments, providers, and stakeholders to drive action.



Your Role in Making the MOC Work



Know the member

Use clinical visits, history, caregiver input, and available care information to understand the member's medical, functional, and social needs.



Document care clearly

Record assessments, care plans, follow-up actions, medication reconciliation, referrals, transitions, and clinically relevant communication in the medical record.



Coordinate with the care team

Collaborate with care managers, specialists, hospitals, behavioral health providers, caregivers, and other partners involved in the member's care.



Close the loop

Follow up on referrals, discharge needs, testing, treatment plans, and identified barriers so members receive timely, coordinated care.



Respond to changes

Escalate urgent clinical, safety, access, or social concerns and communicate significant status changes that may affect the care plan.



Support quality outcomes

Promote preventive care, adherence, follow-up appointments, and evidence-based care that improves quality, compliance, and member outcomes.

The MOC succeeds when providers turn member needs into coordinated, documented action.



Any Questions?

Thank you for supporting coordinated, member-centered care.

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