2014 Model of Care

Provider Training

Molina Medicare 2014

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Course Overview

- The Model of Care (MOC) is Molina Healthcare's documentation of the CMS directed plan for delivering coordinated care and case management to enrollees with both Medicare and Medicaid

- The Centers for Medicare and Medicaid (CMS) require all Molina staff and contracted medical providers receive basic training about the Molina Healthcare duals program Model of Care (MOC).

- This course will describe how Molina Healthcare and its contracted providers work together to successfully deliver the duals MOC program.

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Learning Objectives

After the training, attendees will be able to:

1. Describe the basic components of the Molina Model of Care (MOC).

2. Explain how Molina Healthcare Services (Health Management/Case Management) coordinates care for dual eligible members

3. Describe the essential role of providers in the implementation of the MOC program

4. Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).

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What Members Fall under the MOC?

Molina services two programs of dual eligible members.

Medicare D-SNP

Medicare and Medicaid Program (MMP)

D-SNP

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of enrollees with special health care needs.

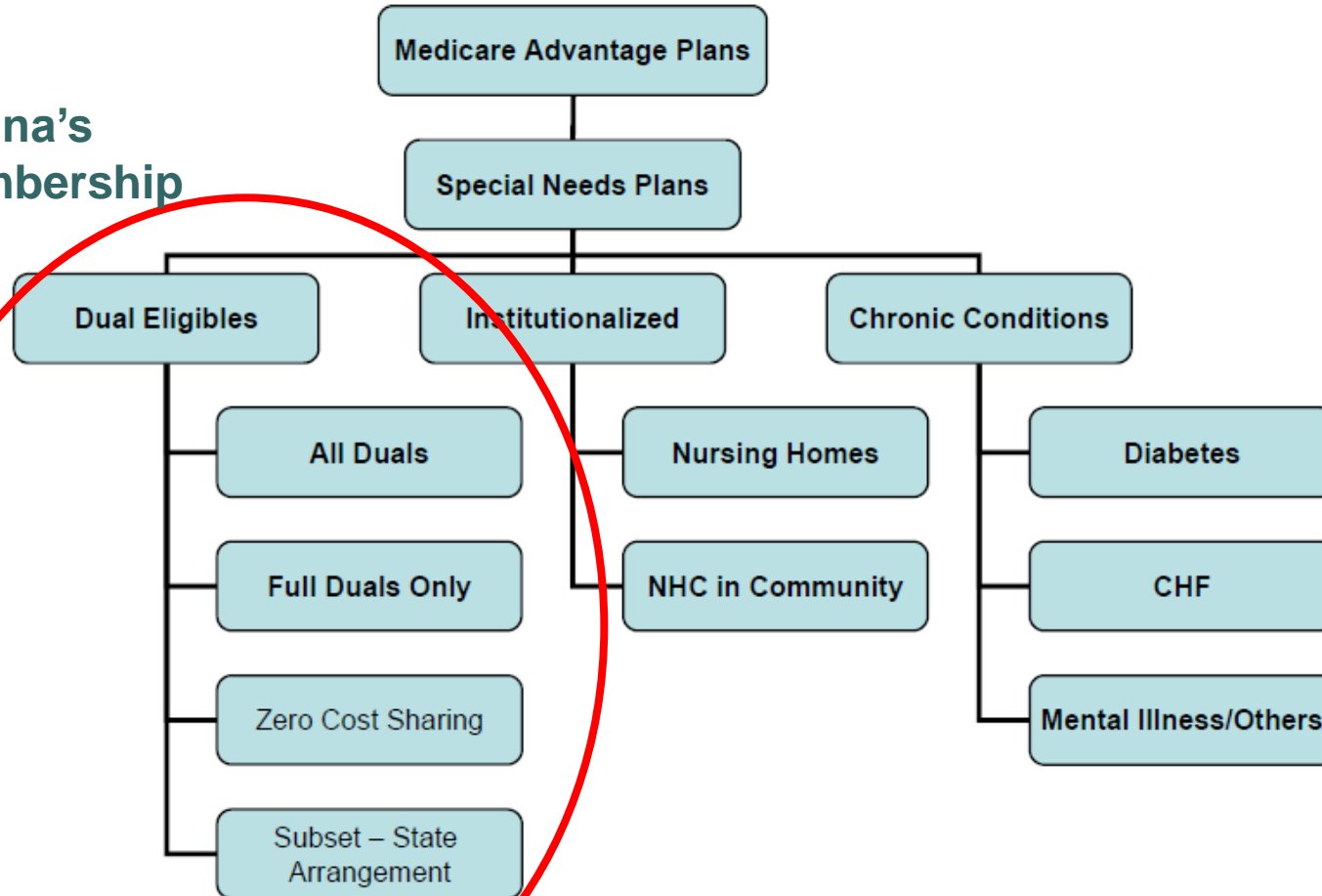CMS has defined three types of SNPs that serve the following types of enrollees:

- Dually eligible enrollees (D-SNP)
- Individuals with chronic conditions (C-SNP)
- Individuals who are institutionalized or eligible for nursing home care (I-SNP)

Health plans may contract with CMS for one or more programs.

Molina currently contracts for D-SNP only

Types of Medicare SNPs

Molina's Membership

Medicare Advantage Plans

Special Needs Plans

- Dual Eligibles
  - All Duals
  - Full Duals Only
  - Zero Cost Sharing
  - Subset – State Arrangement
- Institutionalized
  - Nursing Homes
  - NHC in Community
- Chronic Conditions
  - Diabetes
  - CHF
  - Mental Illness/Others

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D-SNP: *Verifying Coverage*

For **D-SNP** enrollees, Medicare is **always the primary** insurance and Medicaid is secondary.

D-SNP enrollees **may have both** Molina Medicare and Molina Medicaid, **but not always.** Therefore, it is extremely important to verify coverage prior to servicing the member.

*You may see members with Molina Medicare and their Medicaid under another health plan or traditional Fee-for-Service (**FFS**) Medicaid or vice versa.*

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MMP

(Note: Also known as Molina Dual Options)

New 3 way program between CMS, Medicaid and Molina as defined in **Section 2602 of the Affordable Care Act**

Purpose: Improve quality, reduce costs, and improve the member experience.
- ✓ Ensure dually eligible individuals have full **access** to the services to which they are entitled.
- ✓ Improve the **coordination** between the federal government requirements and state requirements.
- ✓ Develop **innovative** care coordination and integration models.
- ✓ Eliminate financial **misalignments** that lead to poor quality and cost shifting.

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MMP: *The Difference*

*(Note: Also known as **Molina Dual Options**)*

For MMP enrollees, the Medicare and Medicaid benefits are rolled up as one benefit with Molina coordinating services and payment.

MMP enrollees have full Medicare **AND** Medicaid benefits.

Benefits for both D-SNP and MMP are the same.

The only difference is the payment methodology, *something that should be invisible both to the member and providers.*

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Model of Care: *Defined*

Molina Model of Care:	The plan for delivering our integrated care management program to members with special needs.

CMS sets guidelines for:

- ✓ Enrollee and family centered health care

- ✓ Assessment and case management of enrollees

- ✓ Communication among enrollees, caregivers, and providers

- ✓ Use of an Interdisciplinary Care Team (ICT) comprised of health professionals delivering services to the member

- ✓ Integration with the primary care physician (PCP) as a key participant of the ICT

- ✓ Measurement and reporting of both individual AND program outcomes

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Four Elements Define the Integrated Care Program

1. **Description of SNP Population**

   a) The ability to **define** and **analyze** our target population

2. **Care Coordination**

   a) Specifically defined staff structure and roles

   b) Conducting Interdisciplinary Care Team (ICT) meetings

   c) Regularly performing Health Risk Assessments on all enrollees

   d) Individualized care plans, created based on**:**

      ▪ *Assessment results*

      ▪ *Member preference*

      ▪ *Interdisciplinary Care Team participation*

   e) Greater services and benefits to the most vulnerable members

   f) Communication activities between Molina, the member, the provider network and all other agencies involved in member's care

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Four Elements Define the Integrated Care Program

3. **Provider Network**

   a) Provider network with specialized expertise, using Clinical practice guidelines and protocols

   b) MOC training provided for all staff and the Provider network

   c) Communication activities between Molina, the member, the provider network and all agencies involved in member's care

4. **Quality Measurement and Performance Improvement**

   a) Performance and health-outcomes measurements for evaluating the effectiveness of the MOC program.

   b) Set measureable goals for the following:

      a) Improving access to essential services
      b) Improving access to affordable care
      c) Improving coordination of care through a gatekeeper
      d) Improving seamless transitions of care across healthcare settings
      e) Improving access to preventative services
      f) Improving member health outcomes

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Model of Care – Program Process

Health Risk Assessment:

Every dual member is evaluated with a comprehensive

Health Risk Assessment (HRA) upon enrollment, and at

minimum annually, or more frequently with any significant

change in condition or transition of care.

Member Triage:

Members are then triaged to the appropriate Molina case

management program for follow up.

Individualized Care Plan (ICP):

An Individualized Care Plan (**ICP**) is developed based on

input from all parties involved in the member's care, such as

the member, caregivers and families approved by the

member.

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Model of Care – Program Process

Care Coordination:

Members receive monitoring, service referrals, and condition specific education.

ICT Participation:

Working closely together, the ICT members prepare, implement and evaluate the Individualized Care Plan (ICP) with the member and the member's family.

Monitoring and Evaluating the MOC:

Molina will disseminate evidence-based clinical guidelines and conduct studies:

- ✓ to measure benefits to member
- ✓ to monitor quality of care
- ✓ to evaluate the effectiveness of the **MOC**

Model of Care – Program Examination

Member-Based Program Review and Evaluation:

- Molina creates and/or participates in member advisory boards/councils that include enrollees/members, physicians, ancillary providers, vendors, community and state agencies to evaluate the MOC and suggest solutions for improving the program.

- Molina shares the results of the advisory boards and any program metrics or analysis with the provider network.

Core Program Components of Molina's Model of Care

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Inpatient Care

Inpatient Care Coordination Clinical staff

- Coordinate with facilities to assist enrollees/members in the hospital or in a skilled nursing facility to access care at the appropriate level

- Work with the facility and enrollee/member or the enrollee/member's representative to develop a discharge plan

- Notifies the PCP, IPA (Independent Provider Association), Medical Home or enrollee/member's usual practitioner of planned and unplanned admissions. *(Measured)*

- Notifies PCP, IPA, Medical Home or enrollee/member's usual practitioner of the discharge date and discharge plan of care. *(Measured)*

Care Transitions

The Molina **Healthcare Transition Program** is a Molina developed, patient–centered 4 – 6 week program designed to improve quality and health outcomes for members with complex care needs as they transition across settings.

This is focused program based on specific disease diagnosis with specific follow up protocols.

Molina Healthcare Services (HCS) staff manage transitions of care to ensure that members have appropriate follow-up care after a facility stay to prevent hospital re-admissions *(Measured)*

During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions.

Managing Transitions of Care (cont'd)

Managing Transitions of Care interventions for all discharged duals members may include but not limited to:

1. Face to face or telephonic contact with the enrollee or their representative in the facility prior to discharge to discuss the discharge plan

2. In home visit or phone call within 1-2 days post discharge to evaluate member's: *(Measured)*

   a. Understanding of their discharge plan,
   b. Understanding of their medication plan,
   c. Follow up appointments have been made
   d. Home situation supports the discharge plan.
   e. Follow-up on days 7 and 14 post discharge

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Managing Transitions of Care(cont'd)

Members with targeted diagnosis and complex care issues will be followed by the Molina Healthcare Transitions team for 4-6 weeks for 1:1 training on self management skills *(Measured)*

If additional support is needed beyond the 4-6 weeks timeframe a referral is made to appropriate level for Molina Case Management follow up*(Measured)*
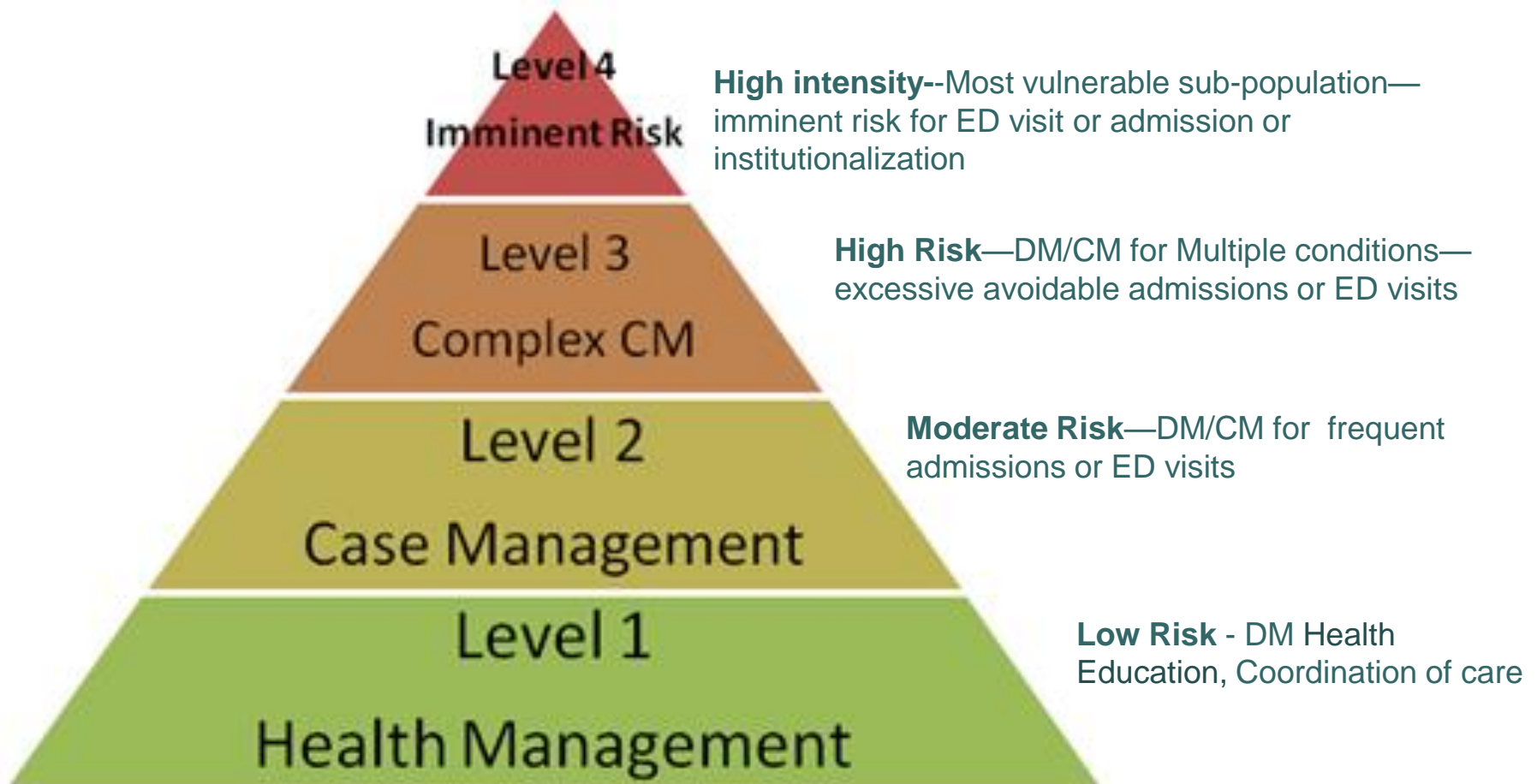
Case Management

Molina Case Managers coordinate the enrollee/member's care with the Interdisciplinary Care Team (ICT) which includes appropriately involved Molina staff, the member and their family/caregiver, external practitioners and vendors involved in the enrollee's/member's care **based on the member's preference** of who they wish to attend.*(Measured)*

Molina Case Managers work with the member to encourage self-management of their condition as well as communicate the member's progress toward these goals to the other members of the ICT.

Molina is responsible to maintain a single, integrated care plan that requires reaching out to external ICT members to coordinate many separate plans of care into one that is made available to all providers **based on member's preference.***(Measured)*

Case Management Levels

High intensity--Most vulnerable sub-population—imminent risk for ED visit or admission or institutionalization

High Risk—DM/CM for Multiple conditions—excessive avoidable admissions or ED visits

Moderate Risk—DM/CM for frequent admissions or ED visits

Low Risk - DM Health Education, Coordination of care

Interdisciplinary Care Team (ICT)

Molina's program is member centric with the PCP being the primary ICT point of contact.

Molina staff work with all members of the ICT in coordinating the plan of care for the enrollee

PCP	Molina
Member	
Specialist	Vendor
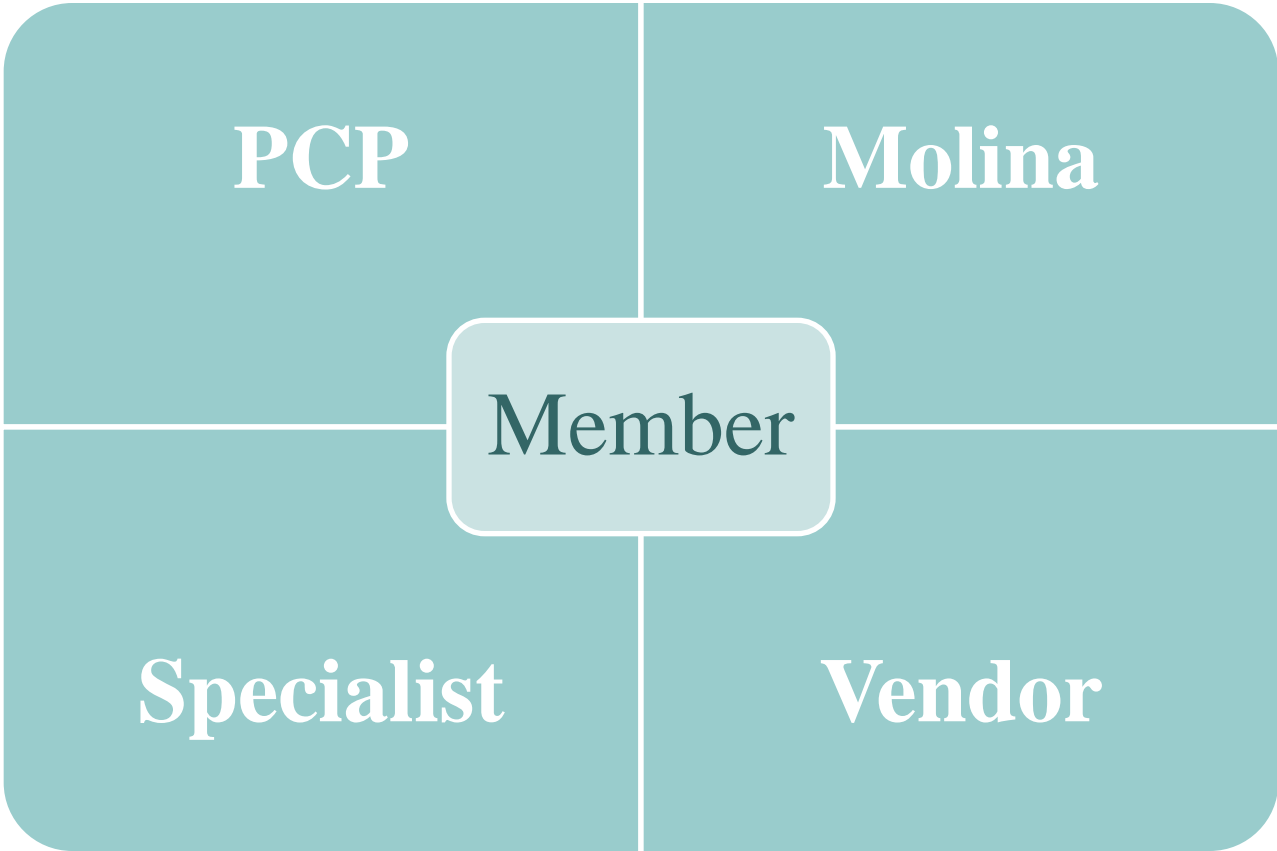
Interdisciplinary Care Team (ICT)

Additional Molina internal ICT members may include:

- Nurses
- Social Workers
- Health Educators
- Coordinators
- Behavioral Health Staff
- Medical Directors
- Pharmacists

External ICT members may include **at the enrollee's discretion:**

- Family/Informal supports
- PCP
- Specialists
- Ancillary vendors
- Facility staff
- Community/State resource workers

Molina ICT Member Responsibilities

Work with each member to:

1. Develop their personal goals and interventions for improving their health outcomes

2. Monitor implementation and barriers to compliance with the physician's plan of care

3. Identify/anticipate problems and act as the liaison between the member and their PCP

4. Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable

5. Coordinate care and services between the member's Medicare and Medicaid benefit

Molina ICT Member Responsibilities (cont'd)

6. Educate members about their health conditions and medications and empower them to make good healthcare decisions

7. Prepare members/caregivers for their provider visits – utilize personal health record

8. Refer members to community resources as identified

9. Notify the member's physician of planned and unplanned transitions *(Measured)*

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Provider ICT Responsibilities

1. Actively Communicate with:

   a) Molina case managers
   b) Members of the Interdisciplinary Care Team (ICT),
   c) Members and caregivers

2. Accept invitations to attend member's ICT meetings whenever possible.

3. Collaborate with Molina Case Managers on the Individualized Care Plan (ICP)

4. Maintain copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received *(Audited)*

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CMS Expectations for the ICT

1. All care is per member preference.

2. Family members and caregivers are included in health care decisions **as the member desires**

3. There is continual communication between all members of the ICT regarding the member's plan of care.

4. All team meetings/communications are documented and stored.

5. All team members are involved and informed in the coordination of care for the member.

6. All team members must be advised on ICT program metrics and outcomes

7. All internal and external ICT members are trained annually on the current Model of Care.

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Summary

Molina Healthcare values our partnership with our physicians and providers

The Model of Care requires all of us to work together for the benefit of our members by:

- Enhanced communication between members, physicians, providers and Molina

- Interdisciplinary approach to the member's special needs

- Comprehensive coordination with all care partners

- Support for the member's preferences in the plan of care

- Reinforcement of the member's connection with their medical home.

Molina Contacts For Duals Model of Care

Plan	Fax	Medicare enrollee Services & Pharmacy	Behavioral Health	Transportation
California	866-472-0596	800-665-0898	800-818-7235 619-528-4600 (San Diego)	866-475-5423
Florida	866-472-9509	866-553-9494	866-553-9494	866-475-5423
Illinois	866-617-4971	855-966-5462	888-275-8750	866-475-5423
Michigan	800-594-7404	800-665-3072	800-541-3647	866-475-5423
New Mexico	888-802-5711	866-440-0127	888-825-9266	866-475-5423
Ohio	866-449-6843	866-472-4584	800-642-4168	866-475-5423
Texas	866-420-3639	866-440-0012	800-576-9666	866-475-5423
Utah	866-504-7262	888-665-1328	888-483-0760	866-475-5423
Utah – Healthy Advantage	866-472-9481	877-644-0344	866-472-9479	877-564-0577
Washington	800-767-7188	800-665-1029	800-745-4044	866-475-5423

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