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Dual Eligible Special Needs Plan Model of Care

Training Materials- 2010

Introduction

- CMS introduced significant changes in Special Needs Plan Models of Care for 2010
- Changes include
  - > Complete general healthcare assessments for all members initially and annually
  - > Individualized care plans for all members
  - > Interdisciplinary Care Team model
  - > Regular communication among ICT and members
  - > Model of Care training for staff and providers is required as noted in the 2009 CMS Call Letter and subsequent SNP applications
  - > Outcomes and performance measures to demonstrate the effectiveness of the Model of Care

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Molina Medicare Special Needs Plans

- In 2010 Molina Medicare operates Medicare Dual Eligible Special Needs Plans (SNP) for members who are fully eligible for both Medicare and Medicaid in 7 states (CA, FL, MI, OH, TX, UT, WA).
- In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations Molina Medicare has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP population.
- This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled members than other Medicare Managed Care Plan types.

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Health Risk Assessment

- The Molina Medicare SNP has a program to perform initial and annual Comprehensive Initial Health Risk Assessment of all SNP members.
- Molina uses a modified general care management assessment tool that is embedded in Molina's electronic care/case/disease management software platform Clinical Care Advance (a Trizetto product).
- Initial assessment information is gathered by Molina's Assessment Team of clinical professionals using telephone outreach (mail outreach is performed for members Molina is unable to contact telephonically)

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Assessments (cont)

- After assessment data is gathered into the assessment tool Molina's staff of clinical professionals reviews the information, decides if additional assessment is needed, follows stratification protocols and guides the development of an individualized care plan for the member
- Members meeting screening criteria for case management or disease management programs are referred to those programs for further assessment and care management

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Individualized Care Plan

- Molina Medicare SNP professional healthcare staff uses assessment information to develop individual care plans for members based on analysis of the data and stratification of the individual member
- Molina's care management information system, Clinical CareAdvance provides evidenced based care plans
- When feasible based on stratification, health status and availability of the member/caregiver, Molina seeks member/caregiver involvement in care plan development

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Interdisciplinary Care Team

- The Molina Medicare SNP Interdisciplinary Care Team (ICT) is the core of Molina's Care Management Program. The ICT is typically composed of the member's assigned PCP and the Molina Care Management Team (Utilization Coordinator, Licensed Clinical Social Worker, Case Manager).
- Other Molina employed healthcare professionals (medical directors, pharmacists, behavioral health specialists) and additional network providers may join the ICT on an as needed basis

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ICT Roles

- The Molina Medicare SNP member's assigned PCP and the Molina Care Management Team provides the majority of the care management in the ICT.
- PCP is a primary source of assessment information, care plan development and member interaction within the ICT.
- The Molina Care Management Team provides assessments, care plan development and individualized care goals. The Care Management Team is primarily involved during assessment periods, during transitions of care settings, during routine case management follow-up, after referral from other Molina Staff (i.e., Disease Management Program staff, Pharmacists), requests for assistance from PCPs and requests for assistance from members/caregivers and during significant changes in the member's health status.
- Transitions in care and significant changes in health status that need follow-up are detected when services requiring prior authorization are requested by the member's PCP (signaling a transition in care or complex medical condition or need).

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SNP Members/Caregivers Participation in Molina ICT

- Discussions about their health care with their PCP
- Discussions about their health care with medical specialists or ancillary providers who are participating in the member's care as directed by the member's PCP
- Discussions about their health care with facility staff who are participating in the member's care as directed by the member's PCP
- During the assessment process by Molina Staff
- Discussions about their health care with their assigned Molina Care Management Team members
- Discussions with Molina Staff in the course of disease management programs, preventive healthcare outreach and post hospital discharge outreach
- Discussion with Molina Pharmacists about complex medication issues
- Through the appeals and grievance processes
- By invitation during case conferences or regular ICT meetings
- By request of the member or caregiver to participate in regular ICT meetings

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Communication

- The Molina Medicare SNP monitors and coordinates care for members using an integrated communication system between members/caregivers, the Molina ICT, other Molina staff, providers and CMS.

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Communications structure includes the following elements:

- Molina utilizes
  - > State of the art telecommunications systems
    - capabilities for call center queues
    - call center reporting
    - computer screen sharing
    - video and audio conferencing.
- Molina maintains member and provider services call centers during CMS mandated business hours
- Nurse Advice Line available 24 hours per day, 7 days a week
- Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the member's Molina record.

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Performance and Health Outcomes Measurement

- The Molina Medicare SNP collects, analyzes, reports and acts on data evaluating the Molina SNP Model of Care.

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SNP Model of Care evaluation data sources

- Administrative (demographics, call center data)
- Authorizations
- CAHPS
- Call Tracking
- Claims
- Clinical Care Advance (Care/Case/Disease Management Program data)
- Encounters
- HEDIS
- HOS
- Medical record reviews
- Pharmacy
- Provider access survey
- Provider satisfaction survey
- Risk assessments
- Utilization
- SF12v2™ survey results
- Case Management Satisfaction survey

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Additional Information

- **To obtain a copy of these training materials or for detailed questions for the 2010 SNP Model of Care please contact your local Molina Medicare Care Management Team:**
  - California: (800) 526-8196 ext 126410
  - Florida: (866) 472-4585 ext. 177932
  - Michigan: (888) 898-7969
  - New Mexico: (888) 825-9266 ext. 177932
  - Ohio: (800) 642-4168 ext. 177932
  - Texas: (866) 449-6849 ext. 177932
  - Utah: (888) 483-0760 ext. 177932
  - Washington: (800) 745-4044 ext. 179932

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Questions and Answers

Q & A