Molina Medicare Model of Care

Provider Network| Molina Healthcare | 2020

By: MHI Training Team

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 members with both Medicare and Medicaid.

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

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

Learning Objectives

Upon completion of the training, participants will be able to:

- Describe the Molina Model of Care
- List the four categories of the MOC
- List which members the MOC applies to
- Describe provider responsibilities for ICT
- Describe provider responsibilities for MOC activities

What is “Model of Care”?

Models of Care (MOCs) are considered by CMS to be a vital quality improvement tool and integral component for ensuring that the unique needs of each member enrolled in a dual program (Medicare and Medicaid eligible) are identified and addressed.

Molina Model of Care: A document describing our plan for delivering integrated care management to members with special needs as outlined by CMS MOC Guidelines

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

Model of Care: *Defined*

The plan for delivering our integrated care management program to members with special needs.

CMS sets guidelines for:

- Member and family centered health care
- Assessment and care management of members
- Communication among members, 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

MOC Comprised of 4 Categories

The MOC is comprised of the following clinical and non-clinical categories:

1. Description of the Dual Population
2. Care Coordination
3. Provider Network
4. MOC Quality Measurement & Performance Improvement

Four Elements of Integrated Care Program

1. **Description of Population**
   - The ability to **define** and **analyze** our target population of dual eligible members.

2. **Care Coordination**
   - Specifically defined staff structure and roles, including oversight functions.
   - Performing Health Risk Assessments upon initial enrollment, annually, and with every change in health status.
   - Creating Individualized Care Plans (ICP) based on assessment results, member preference, review of historical data, Case Manager/HCS staff clinical judgement, and Interdisciplinary Care Team (ICT) participation.
   - ICT composition with role responsibilities, and communication plan to exchange information to improve the health status of the dual eligible beneficiaries.
   - Maintain continuity of care by using transition of care protocols

Four Elements of Integrated Care Program(cont'd)

3. **Provider Network**
   - Establish a provider network with specialized expertise that supports the target population
   - Monitor provider utilization of Clinical practice guidelines and protocols
   - Ensure and track that MOC training is provided for all staff and all contracted PCPs and key high volume specialty providers
   - Establish communication activities between Molina, the member, the provider network and all agencies involved in member's care

4. **Quality Measurement and Performance Improvement**
   - Establish performance and health-outcome measurements for evaluating the effectiveness of the MOC program.
   - Identifying and defining measurable goals and health outcomes to improve the health care needs of the dual population.

DESCRIPTION OF THE DUAL POPULATION

What members fall under the Model of Care?

Molina services two programs of dual eligible members:

- Medicare D-SNP
  - **FIDE-SNP** is a subset of the Dual Eligible Special Needs Plans (D-SNPs) created by the Affordable Care Act in 2010
    - This is a HMO D-SNP Plan (i.e., MMOP) but this Plan provides fully integrated Medicare AND Medicaid services.
- Medicare and Medicaid Program (MMP)
  - Medicare Medicaid Coordinated Program (MMCP)

D-SNP

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

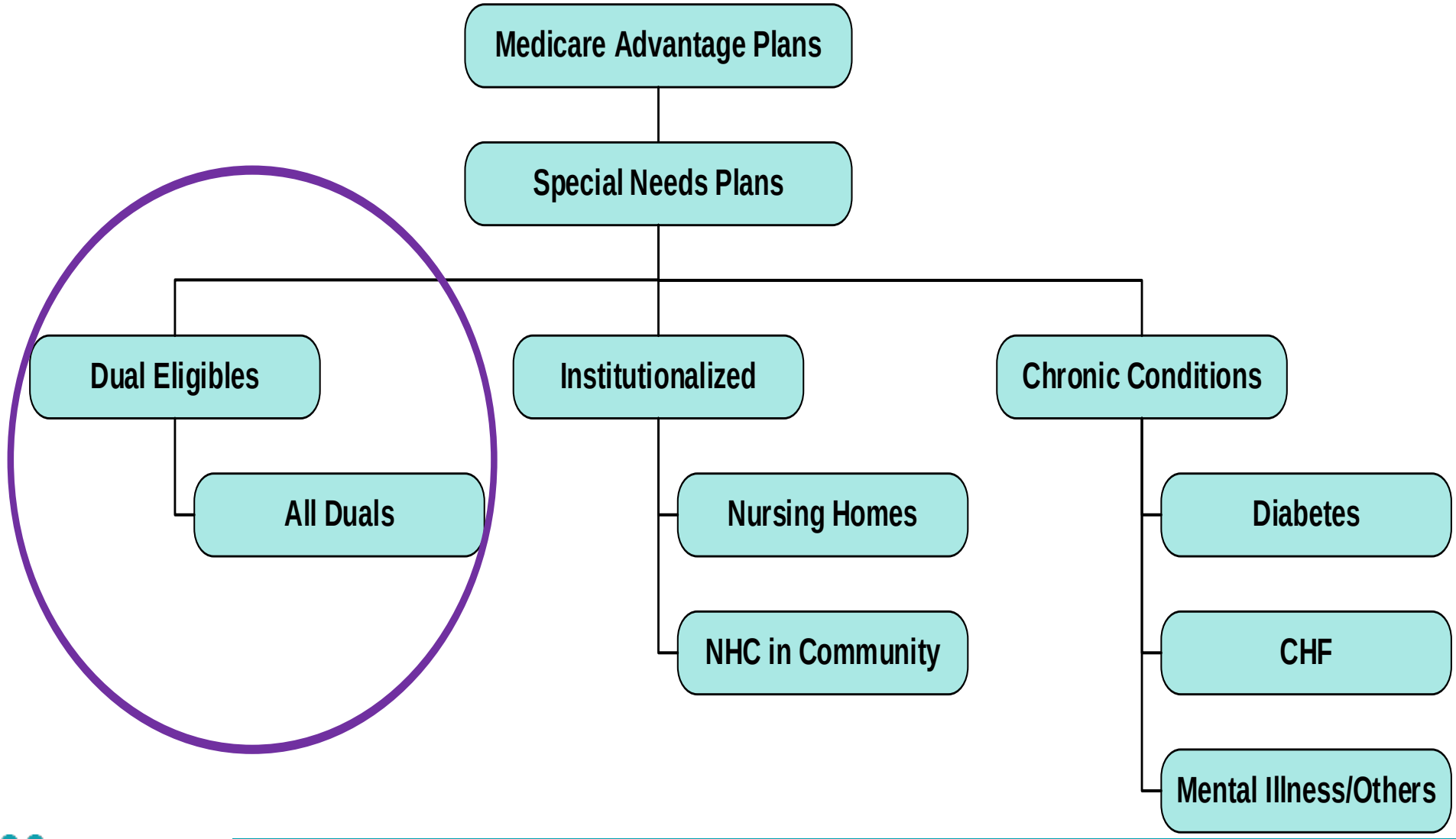
- CMS has defined three types of SNPs that serve the following types of members:
  - Dually eligible members (D-SNP)
  - Individuals with chronic conditions (C-SNP)
  - Individuals who are institutionalized or eligible for nursing home care (I-SNP)

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

Molina currently contracts for D-SNP only

Medicare SNPs

Molina's Membership and types of SNPs



MMP

Also known as Molina Dual Options or Medicare-Medicaid Coordinated Plan (MMCP) for Idaho

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** by coordinating service delivery.
- Ensure dually eligible individuals have **full access** to the services to which they are entitled through comprehensive assessment, case management and provider referrals.
- Improve the **coordination** between the federal government requirements and state requirements to improve provider and member experience.
- Develop **innovative** care coordination and integration models.
- Eliminate financial **misalignments** that lead to poor quality and cost shifting.

Analyzing the Population

- On an annual basis, Molina performs a population Needs Assessment to identify the characteristics and needs of the dual eligible member population.

- A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the Duals population is developed for each health plan's geographic service area.

- This analysis is used by Molina to determine which processes and resources may require updating to address specific population needs.

Example: Analysis shows a higher concentration of members with cardiovascular disease in a specific area, Molina would work to make sure the provider network adequately supports this increase.

CARE COORDINATION

Defined Staff Structure

Molina's MOC program has developed staff structure and roles to meet the needs of dual eligible plan members.

Staff Roles include but are not limited to:

- **Administrative Staff**: Member Services Team that serves as a member's initial point of contact and main source of information about utilizing the Molina benefits. This team includes; Appeals and Grievances Staff, Member Accounting Team, and Claims Team.

- **Clinical Staff:** This team emphasizes health clinicians (i.e. licensed clinical social workers, nurses, psychologists, psychiatrists and mental health counselors etc.), medical clinicians, and paraprofessionals (Community Connectors) all working together in the service of the member as part of an integrated team.

Administrative and Clinical Oversight Staff

- **Quality Improvement Team:** monitors and evaluates MOC activities to help improve the MOC program.
- **Credentialing department:** responsible for ensuring physicians are fully credentialed.
- **Human Resources team:** responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.
- **Provider Services:** responsible for network availability/access, provider training, and evaluation to ensure valuable member experiences.
- **The Medical Director Team** has oversight of development, training and integrity of Molina's MOC program and is a resource for Integrated Case Management Teams and providers regarding member health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

Core Program Components

Molina utilizes identified tools to improve the quality of care our members receive.

The tools include:

- Health Risk Assessments
- Member Triage
- Individualized Care Plans
- Interdisciplinary Care Team
- Transitions of Care

By utilizing these tools we strive to achieve the following goals:

- Coordination of Care
- Continuity of Care
- Seamless Transition of Care
- Access to least restrictive setting

Care Management

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

Molina Case Managers strive to do the right thing for members by encouraging self-management of their condition, as well as communicating 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**.

Health Risk Assessment (HRA)

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.

Frequency:

- HRA are conducted within 90 days of enrollment
- Reassessments are conducted at least every 12 months or sooner if there has been a change in the member's health status.

The HRA includes questions that address with members the following domains: Medical, Behavioral Health, Substance User, Cognitive, Functional, Long Term Services/Support needs, Social Determinants.

Health Risk Assessment (HRA) cont.

The HRA is the primary tool used for risk stratifying members. This helps efficiently identify the level of care and interventions required for the member.

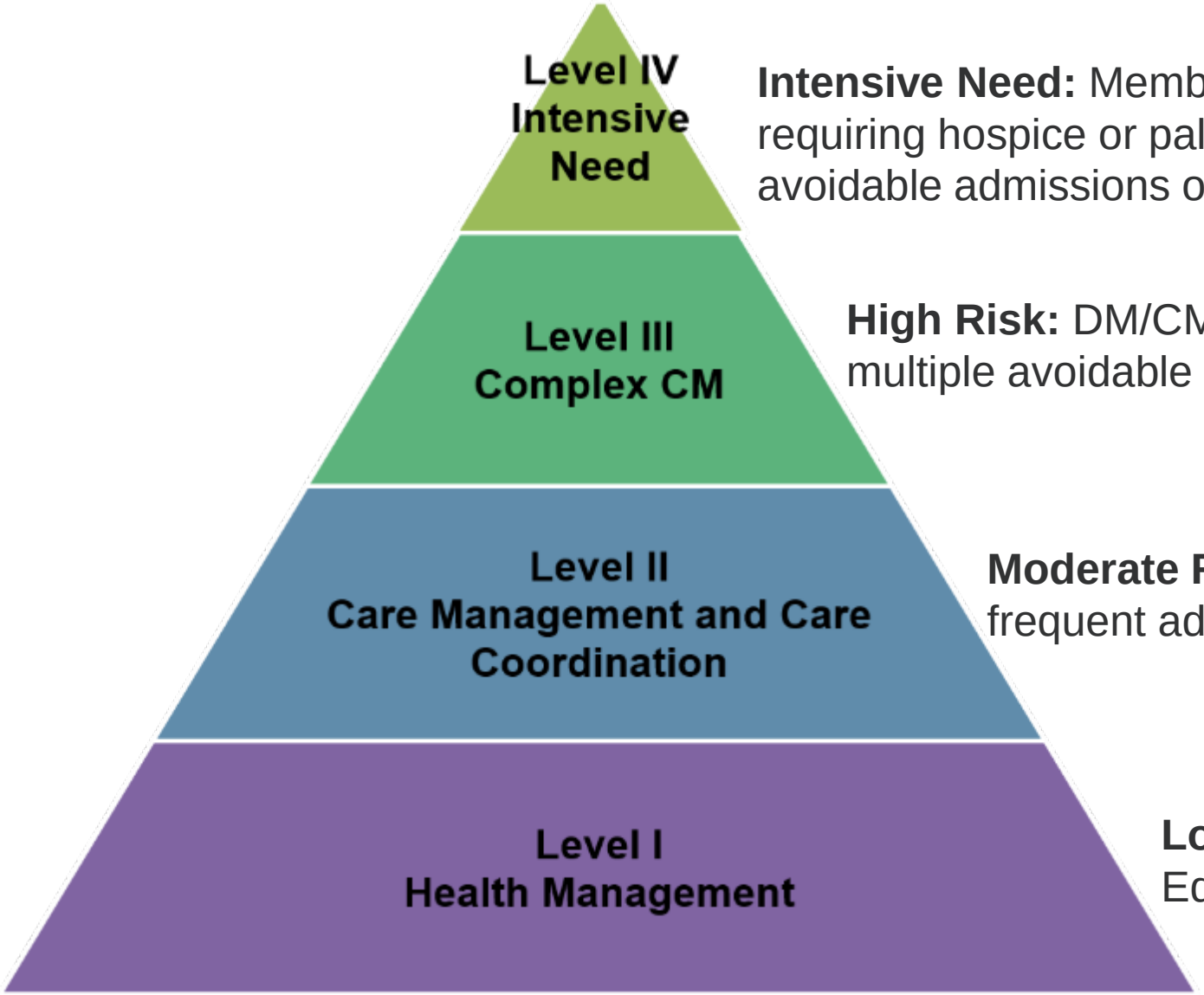
The results of the HRA are discussed with the member, when engaged, to jointly develop the member's Individualized Care Plan (ICP) and prioritize identified needs and member goals. Molina Case Managers (nurses, social workers, health educators, behavioral health clinicians) use information from the assessment process for stratification of the individual member into a risk level that determines the acuity of interventions.

Other methods of Risk Stratification:

- Pre-enrollment: members may be assigned a preliminary risk level based on utilization data supplied by the state or CMS.
- Members may be re-leveled during Monthly-Quarterly sweeps of utilization and encounter data through a Predictive Modeling application.
- Case Manager may classify members into programmatic risk levels during member engagement throughout the continuum of care.

Model of Care – Member Triage

Members are stratified into one of the following risk levels:



Intensive Need: Members at end of life requiring hospice or palliative care; excessive avoidable admissions or ED visits.

High Risk: DM/CM for multiple conditions — multiple avoidable admissions or ED visits

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

Low Risk - DM Health Education, coordination of care

Individualized Care Plans

The results of the HRA are discussed with the member, when engaged, to jointly develop the member's Individualized Care Plan (ICP) and prioritize identified needs and member goals. The Case Manager's work with the member to develop and implement member-centric care plans based on member's identification of primary health concern, additional conditions, barriers, assessment findings, and Case Manager's clinical judgement.

Member care plans are reviewed and may be updated with every member contact. The ICP update is completed at least annually by Molina clinical staff in conjunction with the member's annual comprehensive Health Risk Assessment.

Individualized Care Plans cont.

When engaged, the member's agreement with the ICP is documented. As core members of the Interdisciplinary Care Team (ICT), all ICPs that are developed or have a significant update must be sent to the Primary Care Provider (PCP) and the member to allow for additional feedback.

As the Primary Care Provider (PCP), the PCP is a critical member of the Interdisciplinary Care Team. When a new Individualized Care Plan (ICP) is created or has a significant update, a copy of the ICP will be sent along with an ICT attestation form. The PCP is asked to review the ICP. As a member of the ICT, the PCPs signature is required and without other changes, indicates agreement to the care plan.

Interdisciplinary Care Team (ICT)

The core participants of the ICT include the Member, Primary Care Provider (PCP), and Healthcare Services (HCS) staff (e.g. Case Manager, Health Manager).

The HCS staff may collaborate with members of the ICT informally through methods such as mail, phone, email and fax or formally through a formal meeting of the ICT. When a formal meeting of the ICT is needed, the HCS staff will provide invitations either verbally or in writing to the PCP and other participants on a case by case basis depending on member's condition/health status, HRA results and preference.

Additional participants may include:

- Molina Behavioral Health staff
- Molina Clinical Pharmacist
- Molina Medical Director
- Specialty Providers
- Home Health Providers
- Molina Community Connectors
- Member's Family

Interdisciplinary Care Team (ICT) cont.

The ICT is built around the member's preferences and decisions are made collaboratively and with respect to the member's right to self-direct care. Family members and caregiver participation is encouraged and promoted, with the member's permission.

Molina HCS staff will ensure:

- Ongoing communication between ICT participants regarding the member's plan of care
- All ICT participants are involved and informed in the coordination of the member's care
- All ICT participants are advised of the ICT program metrics and outcomes
- All internal and external ICT participants are trained annually on the current Model of Care

Provider ICT Responsibilities

- Actively communicate with:
    - Molina Case Managers
    - ICT participants
    - Members and their representatives
- Accept invitations to attend formal meetings of the ICT to discuss member's care and needs whenever possible
- Review and provide feedback to Molina Case Managers on the Individualized Care Plan (ICP)
    - Return the signed ICT attestation form to Molina after reviewing the ICP
- Assist with outreach attempts to engage members in the Care Management Program

Transitions of Care

The Molina **Transitions of Care (TOC) Program** is a Molina developed, patient–centered program designed to improve quality and health outcomes for members, especially those with complex care needs.

During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions. Molina's Transitions of Care Program works to bridge these gaps and deliver more comprehensive, coordinated, and cost effective care.

This focused program is provided to **all Medicare members** with facility admissions. The level of interventions may be based on certain conditions or other identified risks for readmission with specific follow-up protocols.

Molina Healthcare Services (HCS) manage transitions of care to ensure that members have appropriate follow-up care after an inpatient stay, to prevent avoidable hospital re-admissions, and promote the health and wellness of our members.

Transition of Care (ToC) cont.

Inpatient Care Coordination Clinical Staff:

- Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level
- Work with the facility and member or the member's representative, the case manager and ICT members to develop a discharge plan
- Notify the PCP, IPA (Independent Provider Association), Medical Home or member's usual practitioner of planned and unplanned admissions.
- Notify PCP, IPA, Medical Home or member's usual practitioner of the discharge date and discharge plan of care.

Managing Transitions of Care (ToC) cont.

The TOC program supports our members as they transition from an inpatient level of care back to the community for up to 30 days post discharge.

Member support may include:

- Outreach while in the facility to introduce the program and provide contact information
- Assessment and identification of barriers to care to prevent an avoidable re-admission
- Assessment of needs and provide an understanding of treatment and discharge plan
- Ensuring member is scheduled, and follows through with necessary post discharge appointments
- Evaluate nutritional, functional, or social needs impacting care

PROVIDER NETWORK

Provider Network

The Molina MOC program maintains a network of providers and facilities that has a special expertise in the care of Dual Eligible members.

Molina's network is designed to provide access to medical, behavioral, and psycho-social services for the dual population.

Molina determines provider and facility licensure and competence through the credentialing process. Molina has a rigorous credentialing process for all providers and facilities that must be passed in order to join the Molina Medicare Network.

Molina requires providers to participate/collaborate with the ICT and contribute to a member's ICP to provide necessary specialized services.

Provider Network Cont.

Molina monitors how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to the duals population.

Molina monitors how providers maintain continuity of care using care transition protocols.

Molina provides initial and annual Model of Care training to all contracted PCPs and key high volume specialty providers. All contracted providers have access to the online MOC training materials located on the Molina provider website.

QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT

Quality Measurement & Performance Improvement

Molina employs a comprehensive overall quality performance improvement plan across all of Molina's departments and functions in collaboration with its provider network.

The Quality Improvement plan ensures Molina's ability to measure and evaluate the effectiveness of the MOC program and to identify any needed changes to the program.

Molina implements a multitude of programs and activities that ensure our Special Needs members receive appropriate and timely health care and services (from Molina and our network of providers) based on their unique needs.

Quality Measurement/ Performance Improvement cont.

Molina's MOC has established and defined the following goals, in alignment with the Quality Improvement Program and the Quality Performance Improvement Plan, and objectives that support the delivery of care to Molina Medicare members:

- **Design and maintain programs** that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- **Define**, **demonstrate, and communicate the organization-wide commitment** to and involvement in achieving improvement in the quality of care, member safety and service.
- **Improve the quality, appropriateness, availability, accessibility**, coordination and continuity of the health care and service provided to members through ongoing and systematic monitoring, interventions and evaluation to improve Molina's MOC program's structure, process, and outcomes.

Quality Measurement/ Performance Improvement (cont)

- **Ensure program relevance** through understanding of member demographics and epidemiological data and provide services and interventions that address the diverse cultural, ethnic, racial and linguistic needs of our member.
- **Coordinate state and federal benefits** and access to care across care settings, improve continuity of care, and use a person-centered approach.
- **Maximize the ability of dual eligible members** to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
- **Increase the availability and access** to home- and community-based alternatives.
- **Preserve and enhance the ability** for consumers to self-direct their care and receive high quality care.

Quality Measurement/ Performance Improvement cont'd

- **Optimize the use** of Medicare, Medicaid, and other State/County resources.
- **Provide whole-person integrated care** management and care coordination.
- **Reduce institutional** (skilled and unskilled nursing facility, state hospital,) placements.
- **Improve collaboration** among the spectrum of participating agencies and individuals in support of a whole-person approach to care coordination and care management.
- **Improve shared accountability** for decision making and achieving outcomes by the member, the State, the Health Plan, and the service delivery system.

Summary

The CMS MOC guidelines requires all of us to work together for the benefit of our members by:

- Enhancing communication between members, physicians, providers and Molina.
- Interdisciplinary approach to the member's individualized needs.
- Comprehensive coordination with all care partners.
- Supporting the member's preferences in the plan of care.
- Comprehensive quality improvement plan and objectives that support the delivery of care.

Thank You

Thank you for your participation in this annual MOC training. We appreciate your willingness to collaborate with Molina.

Please complete the attestation form and return to Molina Healthcare.

If you have any questions please contact the Provider Service Department.