



Molina Medicare Model of Care

Healthcare Services | Molina Healthcare | 2016



Molina's Mission

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

In order to achieve our mission, it is essential that team members have a clear understanding of Molina's Model of Care and how it impacts the Care Management Process for members who are covered by both Medicaid and Medicare (dual-eligible members).



Molina's Values

Molina strives to be an exemplary organization:

- We care about the people we serve and advocate on their behalf
- We provide quality service and remove barriers to health services
- We are health care innovators and embrace change quickly
- We respect each other and value ethical business practices
- We are careful in the management of our financial resources and serve as prudent stewards of the public's funds

In order to achieve our mission, all of our team members need to be able to demonstrate the behaviors that bring our values to life. This training will assist you in doing this.



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 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 network providers work together to successfully deliver the duals MOC program.

Objectives

- Describe the Molina Model of Care
- List the four categories of the MOC
- List which members the MOC applies to
- List at least four MOC Best Practices

What is a “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 beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.
- **Molina Model of Care:** The plan for delivering our integrated care management program to members with special needs as outlined by the CMS MOC.

<http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-Model-Of-Care-Summaries.html>

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

What is a “Model of Care”?

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

Description of the
SNP Population

Care Coordination

SNP Provider
Network

MOC Quality
Measurement &
Performance
Improvement

Four Elements of 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 to promote highly effective collaborations to support optimized member care

Four Elements of Integrated Care Program

3. Provider Network

- A) Provider network with specialized expertise that supports the target population
- B) Provider utilization of 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-outcome measurements for evaluating the effectiveness of the MOC program.
- B) Set measurable 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

Element 1

Description of the SNP Population

What members fall under the Model of Care?

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)

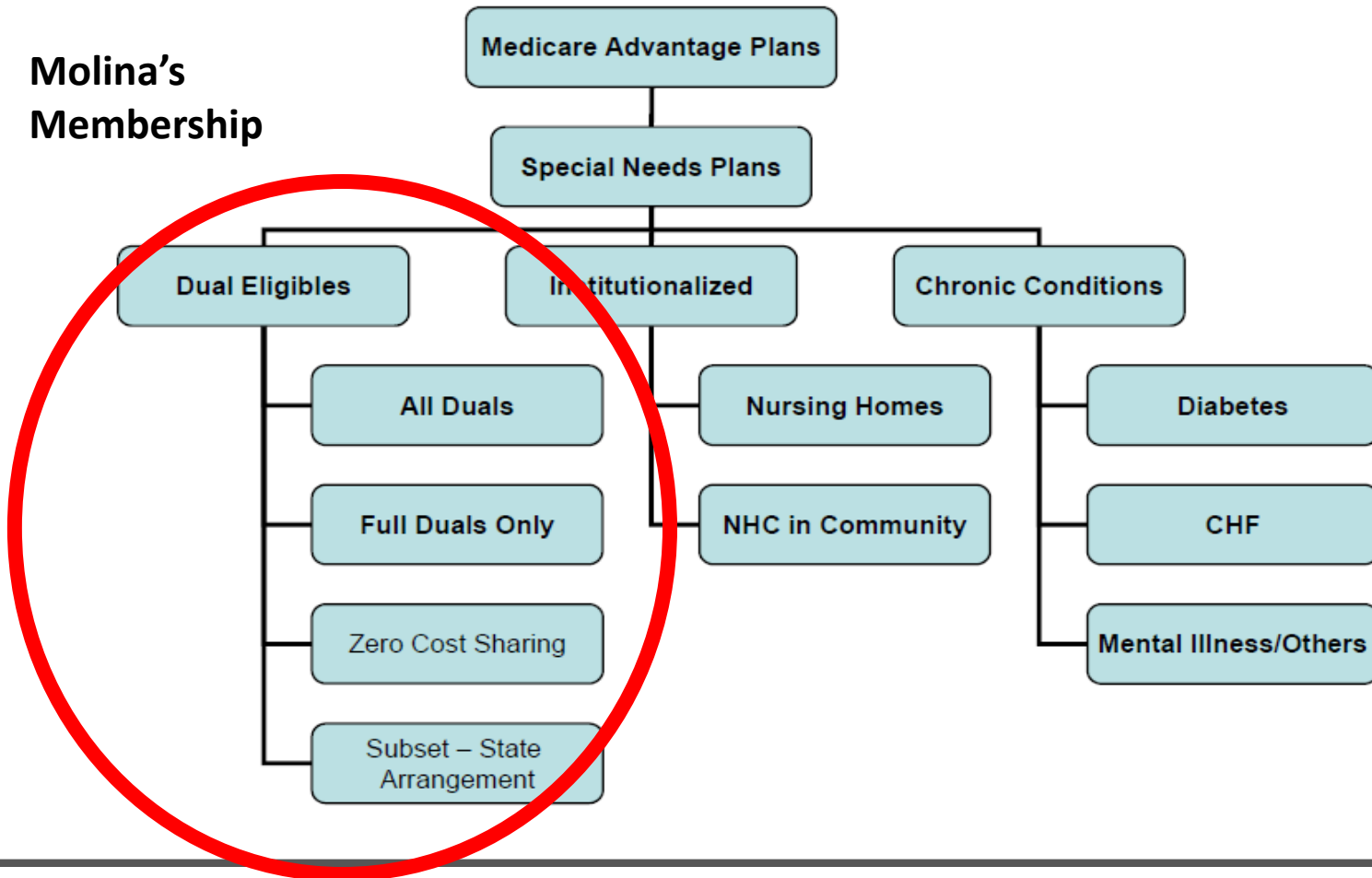
Health plans may contract with CMS for one or more programs.

Molina currently contracts for D-SNP only

Types of D-SNPs

Types of Medicare SNPs

Molina's
Membership



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 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.

MMP vs SNP

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.

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

Analyzing the Population

On an annual basis, Molina performs a population General Needs Assessment to identify the characteristics and needs of the 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.

Element 2

Care Coordination

Defined Staff Structure

Molina Medicare D-SNP and MMP have developed staff structure and roles to meet the needs of dual eligible plan members/enrollees.

Staff Roles include but are not limited to:

- ❖ **Administrative Staff:** Member/Enrollee Services Team that serves as a member's/enrollee's initial point of contact for Molina D-SNP and MMP and main source of information about utilizing the Molina benefits. This team includes; Customer Service Staff, Appeals and Grievances Staff, Member/Enrollee Accounting Team, and Claims Team
- ❖ **Clinical Staff:** This team emphasizes behavioral 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/enrollee as part of an integrated team.

Defined Staff Structure

- ❖ Administrative and Clinical Oversight Staff:
 - The Quality Improvement Team monitors and evaluates MOC activities to help improve the Molina D- SNP and MMP programs.
 - The Credentialing department is responsible for ensuring physicians are fully credentialed.
 - The Human Resources team is responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.
 - The Provider Services is responsible for network availability/access, provider training, and evaluation to ensure valuable member experiences.
 - The Medical Director Team has oversight of the development, training and integrity of Molina D-SNP and MMP Healthcare Services and Quality Improvement programs. The team serves as a resource for Integrated Case Management Teams and providers regarding member/enrollee's 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

Tools

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



Goals

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

Case 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 and vendors, anyone involved in the enrollee's/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.**

Assessments

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.

The HRA includes questions that address with members the following domains:

- Medical
- Behavioral Health
- Substance Use
- Cognitive
- Functional
- Long Term Services/Support needs

- *Health Risk Assessment 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 .*

Member Triage

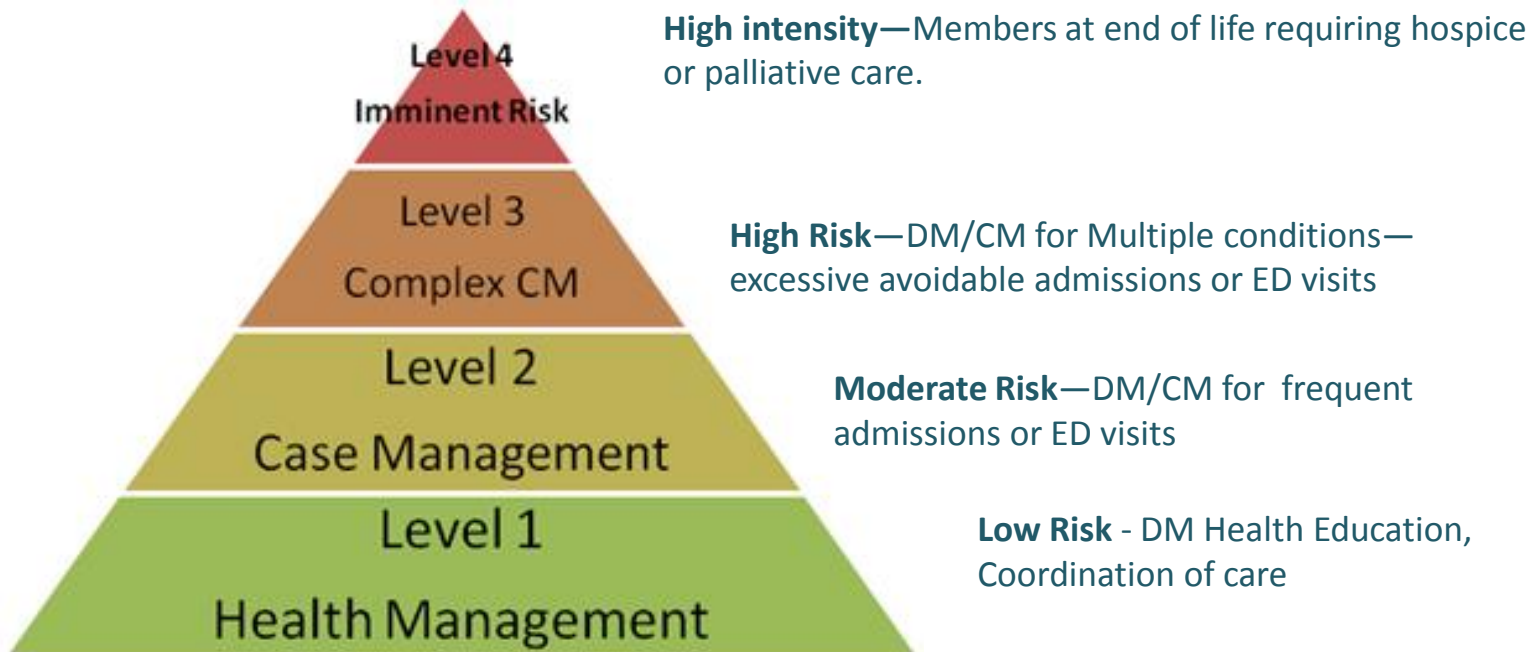
The HRA is the primary tool used for **risk stratifying** members. This helps efficiently identify the level of care interventions required for the member.

Other methods of Risk Stratification

- Pre-enrollment, members may be assigned a preliminary risk level based on the Chronic Disability Predictive System (CDPS) if utilization data is 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 will re-stratify members as they move through the Case Management program and become more self-sufficient in managing their conditions.

Model of Care – Member Triage

Members are stratified into one of the following risk levels:



Care Management

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, 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 enrollee/member's usual practitioner of the discharge date and discharge plan of care.

Transitions of Care

The Molina **Transitions of Care 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 focused program is based on specific disease diagnoses 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. Molina's Transition of Care Program is working to bridge these gaps and deliver more comprehensive, coordinated and cost effective care.

Managing Transitions of Care (cont'd)

Managing Transitions of Care interventions for all discharged dual 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. First Post Discharge visit or phone call within 1-2 business days post discharge to evaluate member's: *(Measured)*
 - a. Understanding of their discharge and treatment plan
 - b. Understanding of their medication plan
 - c. Following through with necessary appointments
 - d. Nutritional, functional, or social needs impacting care.

Managing Transitions of Care (cont'd)

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

3. Second Post Discharge Contact (Face to Face or Telephonic within 7 business days)
 - a. Verify scheduled physician follow up
 - b. Physician updated on PHR and reviewed medications
 - c. Assess short and Long Term Support Services and make referrals as needed
 - d. Assess barriers and progress

4. Third Post Discharge Contact (Face to Face or Telephonic within 14 business days)
 - a. All of above criteria is being monitored and met in section 3
 - b. Reassess progress and self-management goals
 - c. Assess for additional care management needs
 - d. Refer to case management if appropriate

Individualized Care Plans

Molina Case Managers (nurse and social worker case managers) use information from the assessment process to develop and implement individual care plans with the member/enrollee in a timely manner based on member's/enrollee's identification of primary health concern, analysis of the data, and stratification of the individual member/enrollee into risk levels.

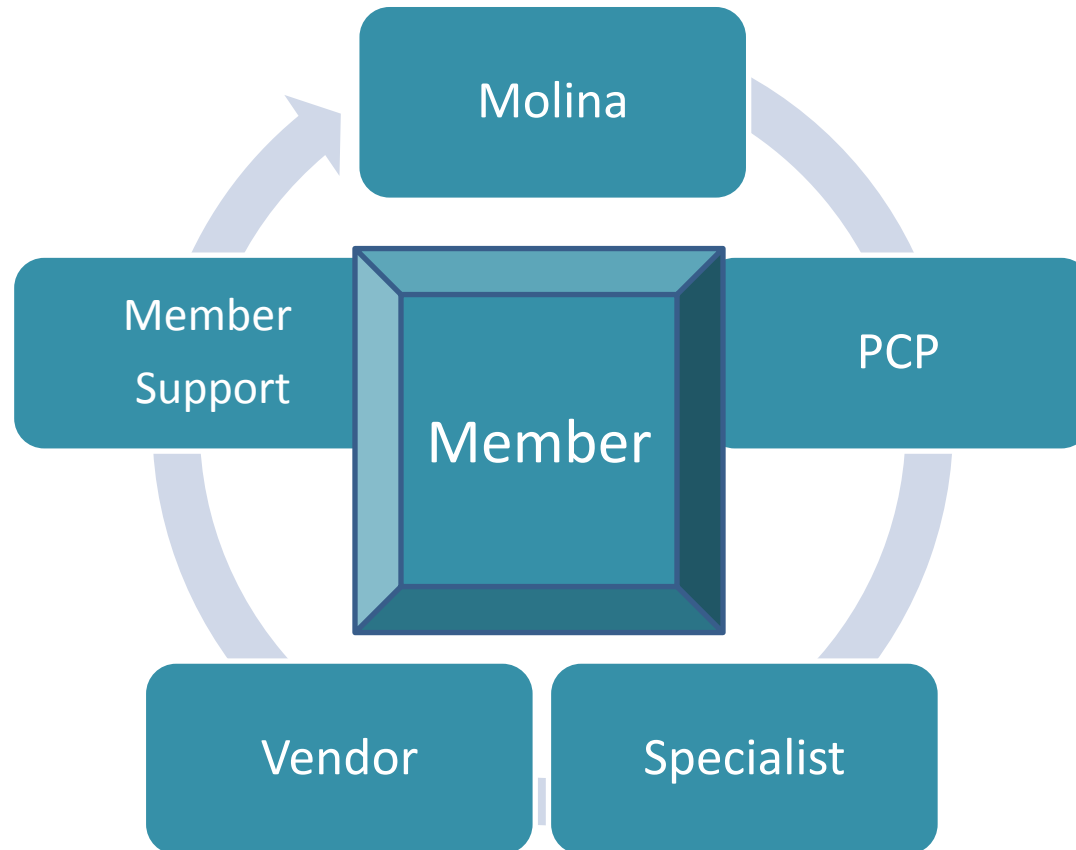
Members/enrollees are encouraged to take an active role in developing their care plans, and input from the ICT is regularly sought. The member/enrollee has the primary decision-making role in identifying his or her needs, preferences and strengths, and a shared decision-making role in determining the services and supports that are most effective and helpful.

Member/enrollee care plans are reviewed and may be updated with every member/enrollee contact but at least annually by professional clinical Molina staff in conjunction with member/enrollee annual Comprehensive Health Risk Assessments.

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



Interdisciplinary Care Team (ICT)

Molina internal ICT members may include:

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

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

- Member/Representative
- Family/Informal supports
- PCP
- Specialists
- Ancillary vendors (e.g. DME, Home Health Care, etc.)
- Facility staff
- Community/State resource workers

Molina ICT 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 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*)

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*)

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.

Element 3

Provider Network

Provider Network

- The Molina D-SNP and MMP maintain a network of providers and facilities that has a special expertise in the care of Dual Eligible members/enrollees.
- Molina's network is designed to provide access to medical and behavioral care for the Molina D-SNP and MMP 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 D-SNP and MMP Network.
- Molina provides initial and annual Model of Care training to all employed and contracted personnel including delegated provider groups and independent practice associations.

Quality Measurement and 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.

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

Quality Measurement and Performance Improvement

Molina's Model of Care 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 D-SNP and MMP Beneficiaries:

- Design and maintain programs that improve the care and service outcomes within identified member/enrollee 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/enrollee safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Beneficiaries. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.

Quality Measurement and Performance Improvement

- Ensure program relevance through understanding of member/enrollee demographics and epidemiological data and provide services and interventions that address the diverse cultural, ethnic, racial and linguistic needs of our member/enrollees.
- 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 beneficiaries 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 and Performance Improvement

- 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/enrollee, the State, the Health Plan, and the service delivery system.

Summary

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
- Comprehensive quality improvement plan and objectives that support the delivery of care.

Questions

