# Molina Medicare Model of Care

Provider Network| Molina Healthcare | 2019

MOLINA HEALTHCARE

Your Extended Family.

# 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.

# Objectives

- 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

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

# 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 SNP Population**
   a) The ability to **define** and **analyze** our target population of dual eligible members.

2. **Care Coordination**
   a) Specifically defined staff structure and roles.
   b) Conducting Interdisciplinary Care Team (ICT) meetings.
   c) Performing Health Risk Assessments as appropriate on all dual eligible members.
   d) Creating Individualized care plans, created based on**:**
      - *Assessment results*
      - *Member preference*
      - *Interdisciplinary Care Team participation*
   e) Providing greater services and benefits to our most vulnerable members.
   f) Promoting highly effective communication activities between Molina, the member, the provider network and all other agencies involved in providing services to ensure optimized member care.

# Four Elements of Integrated Care Program (cont'd)

3. **Provider Network**
   a) Provider network with specialized expertise that supports the target population
   b) Provider utilization of Clinical practice guidelines and protocols
   c) MOC training provided for all staff and the Provider network
   d) 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 measureable goals for the following improving:
      - access to essential services
      - access to affordable care
      - coordination of care through a gatekeeper
      - seamless transitions of care across healthcare settings
      - access to preventative services
      - member health outcomes

# Element 1

## 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.

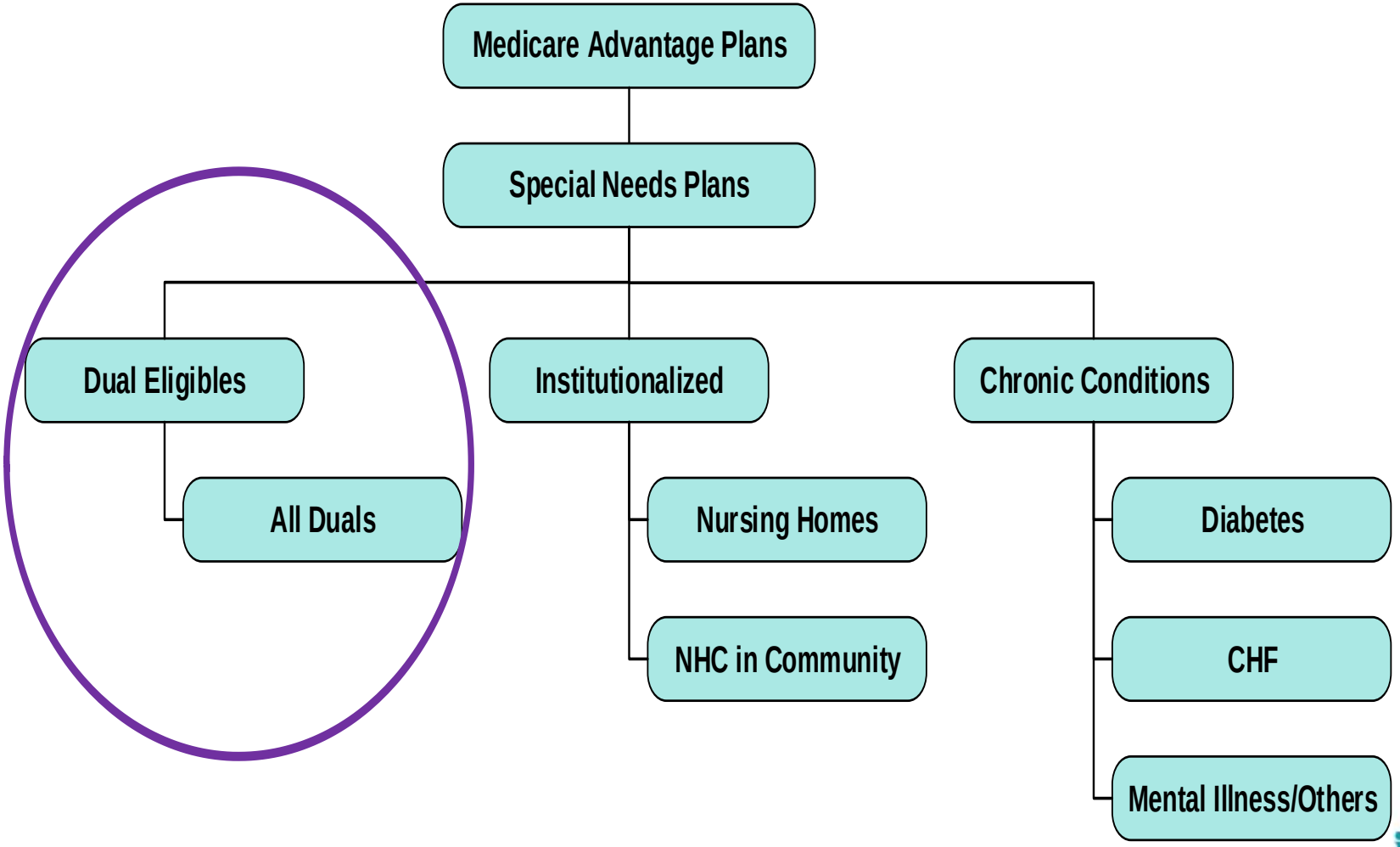
- CMS has defined three types of SNPs that serve the following types of members:
  - Dually eligible members (D-SNP)
  - Individuals with chronic conditions (C-SNP)
  - Individuals who are institutionalized or eligible for nursing home care (I-SNP)

- 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

- *Note: Also known as Molina Dual Options,*
- *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.*

# ELEMENT 2

## 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
- Care Management
- Transitions of Care
- Individualized Care Plans
- Interdisciplinary Care Team and meetings

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**.

# 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.

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)

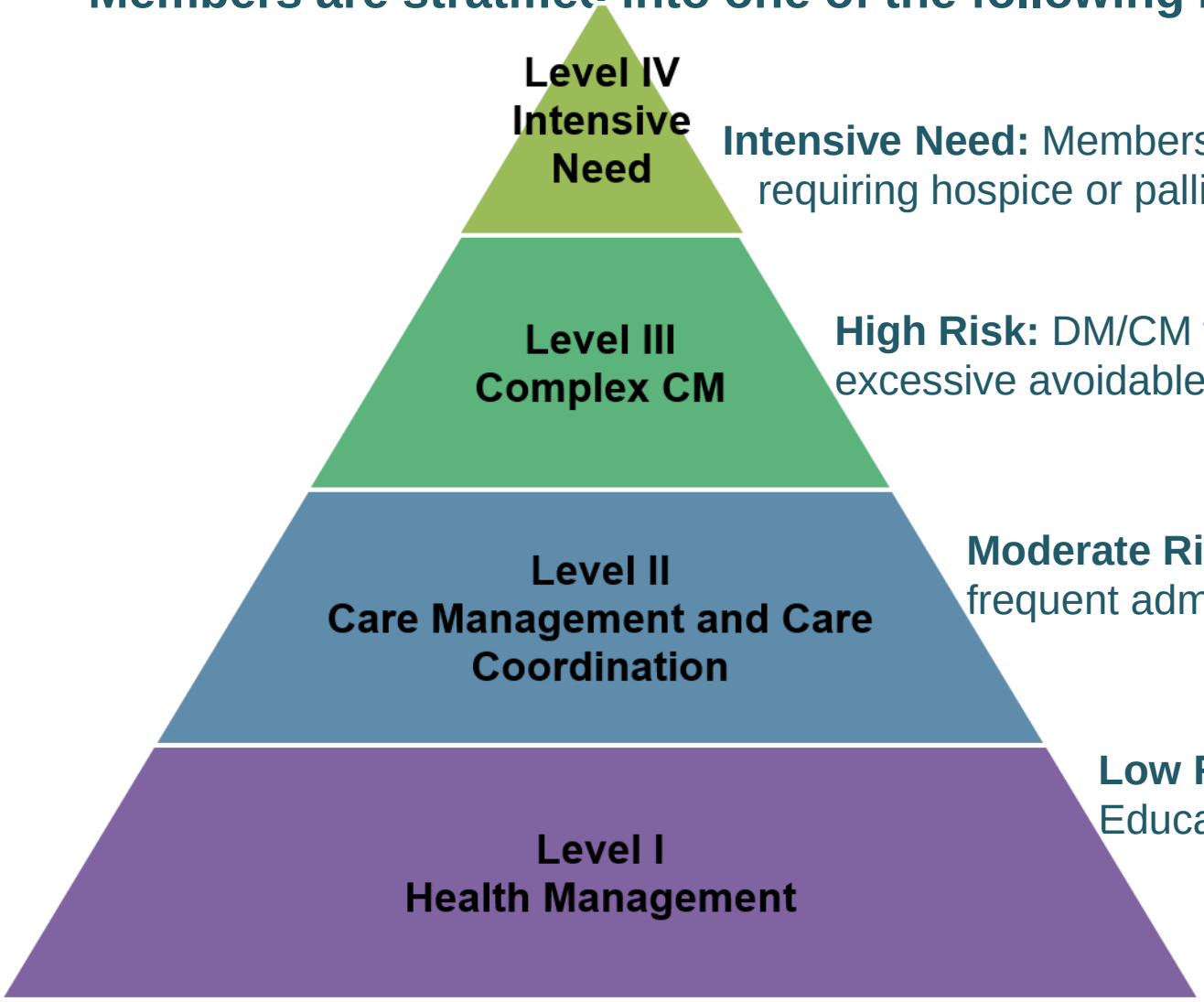
The HRA is the primary tool used for risk stratifying members. This helps efficiently identify the level of care and interventions required for the member.

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:**




**Intensive Need:** Members at end of life requiring hospice or palliative care.

**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

# Inpatient Care Coordination

**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.

# Transitions of Care

The Molina **Transitions of Care Program** is a Molina developed, patient–centered 30-day program designed to improve quality and health outcomes for members, especially those with complex care needs as they transition across settings.

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.

# Managing Transitions of Care

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.

- Outreach to member or their representative while inpatient and post discharge.

# Managing Transitions of Care (cont'd)

**Initial Member outreach may include:**

1. Assessment of member needs and understanding of treatment plan post discharge.
2. Evaluation of understanding of medication plan or changes.
3. Ensuring follow through with necessary appointments.
4. Evaluation of nutritional, functional, or social needs impacting care.

**Follow up outreach may include:**

1. Outcome of physician follow up.
2. Assessment and identification of barriers to care to avoid readmission.
3. Reassessment of progress and self-management goals.
4. Assessment for additional care management needs.
5. Referral to care management if appropriate.

# Individualized Care Plans

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.

They work with the member to develop and implement individual care plans based on member's identification of primary health concern, barriers and analysis of the assessment findings.

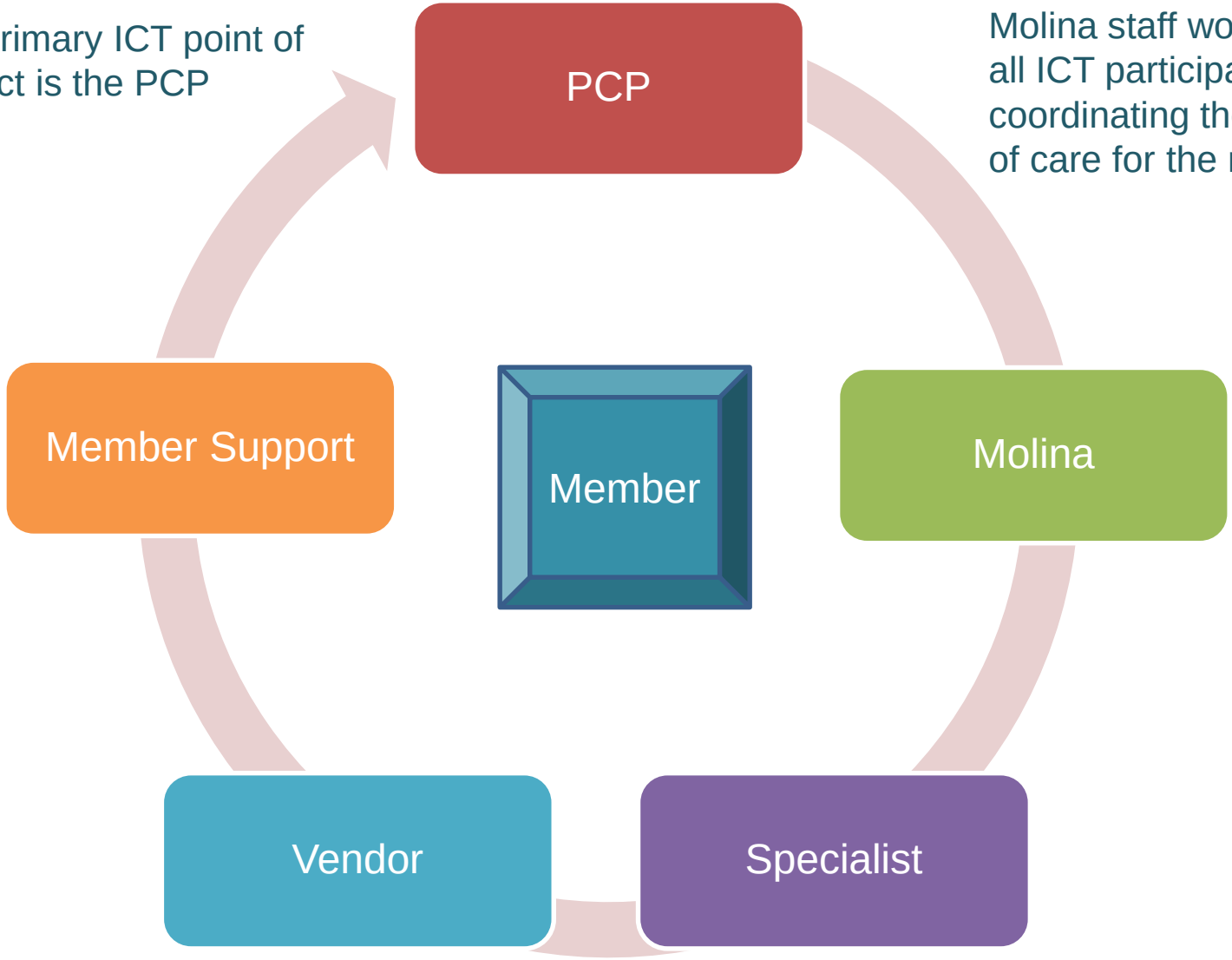
Members are encouraged to take an active role in developing their care plans. The member drives the care plan based on their needs, preferences and strengths. Input from the Interdisciplinary Care Team (ICT) is regularly sought.

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

# Interdisciplinary Care Team

The primary ICT point of contact is the PCP

Molina staff work with all ICT participants in coordinating the plan of care for the member



# Interdisciplinary Care Team (ICT)

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 internal ICT participants may include: Nurses, Social Workers, Health Educators, Coordinators, Behavioral Health Staff, Medical Directors, Pharmacists
- Member
- External ICT participants include at member's discretion may include: Family/information supports, PCP, Specialists, Service Providers, Facility Staff, Community/State resource workers

# CMS Expectations for the ICT

1. All care is per member preference.
2. Family members and caregivers included in health care decisions **as the member desires.**
3. There is continual communication between all ICT Participants regarding the member's plan of care.
4. All team meetings/communications are documented and stored within the CM documentation platform.
5. All team participants are involved and informed in the coordination of care for the member.
6. All team participants must be advised on ICT program metrics and outcomes.
7. All internal and external ICT participants are trained annually on the current Model of Care.

# Molina ICT Responsibilities

Work with each member to:

1. Develop their personal goals and interventions for improving their health outcomes.
2. Collaborate with providers and agencies in the development of the care plan.
3. Monitor implementation and barriers to compliance with the physician's plan of care.
4. Identify/anticipate problems and act as the liaison between the member and their PCP.
5. Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable.
6. Coordinate care and services between the member's Medicare and Medicaid benefit.

# Molina ICT Responsibilities (cont'd)

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

8. Educate members about the Interdisciplinary Care Team (ICT) and how to request a care team meeting.

9. Prepare members/caregivers for their provider visits – utilize personal health record or notebook.

10. Refer members to community resources as identified.

11. Notify the member's physician of planned and unplanned transitions.

12. Maintain copies of the ICP, ICT worksheets and/or transition of care notifications in the member's CM documentation platform.

# Provider ICT Responsibilities

1. Actively Communicate with:
    - Molina case managers
    - ICT participants
    - Members and caregivers
2. Accept invitations to attend member's ICT meetings whenever possible.
3. Provide feedback to Molina Case Managers on the Individualized Care Plan (ICP).
4. Assist with outreach attempts to engage members in the Case Management program.

# ELEMENT 3

## 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

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 employed and contracted personnel including delegated provider groups and independentpractice associations.

# ELEMENT 4

## QUALITY MEASUREMENT AND 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

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

- **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

- **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 the fax number provided to receive credit for this training session.

Again, thank you for partnering with Molina in this annual CMS requirement.