Molina Medicare Model of Care

This Model of Care Training is applicable to the Molina Healthcare Inc. family of brands, including Molina Healthcare, Passport Health Plan, and Senior Whole Health plans.

Provider Training | Molina Healthcare | 2023

MOLINA® HEALTHCARE

PASSPORT BY MOLINA HEALTHCARE

Senior Whole Health BY MOLINA HEALTHCARE

Purpose of the Model of Care (MOC) Training

- Understand the types of Special Needs Plans (SNP) and Dual SNP requirements.
- Description of the Model of Care (MOC) Elements:
  - MOC 1- Description of the SNP Population
  - MOC 2-Care Coordination
  - MOC 3- Provider Network
  - MOC 4- Quality Measurement and Performance
- Summary of provider responsibilities and Provider Collaboration
- Attestation process to document compliance with annual MOC training

Types of Special Needs Plans (SNP)

- **Dual Special Needs Plan** (D-SNP): a member must be eligible for both Medicare and Medicaid. Level of Medicaid coverage may be different based on the state defined requirements.
  - Available in AZ, CA, FL, ID, KY, MA, MI, NV, NY, OH, SC, TX, UT, VA, WA and WI.

- **Chronic Special Needs Plan** (C-SNP): a member must have Medicare coverage and one of the qualifying conditions as defined by CMS.
  - We offer a behavioral health C-SNP in FL.

- **Institutional/Institutional Equivalent Special Needs Plan** (I-SNP, IE-SNP): a member must, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.
  - Future development limited to TX.

For more information on the SNP types and requirements use the following link:
https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans

Dual Special Needs Plan (D-SNP)

Member must maintain eligibility for both Medicare and Medicaid.

- Full Benefit duals are eligible to receive Medicaid benefits.
- Partial benefit duals are only eligible to receive assistance with some or all Medicare premiums and cost sharing

Coordination of care and cost share requirements must be followed.

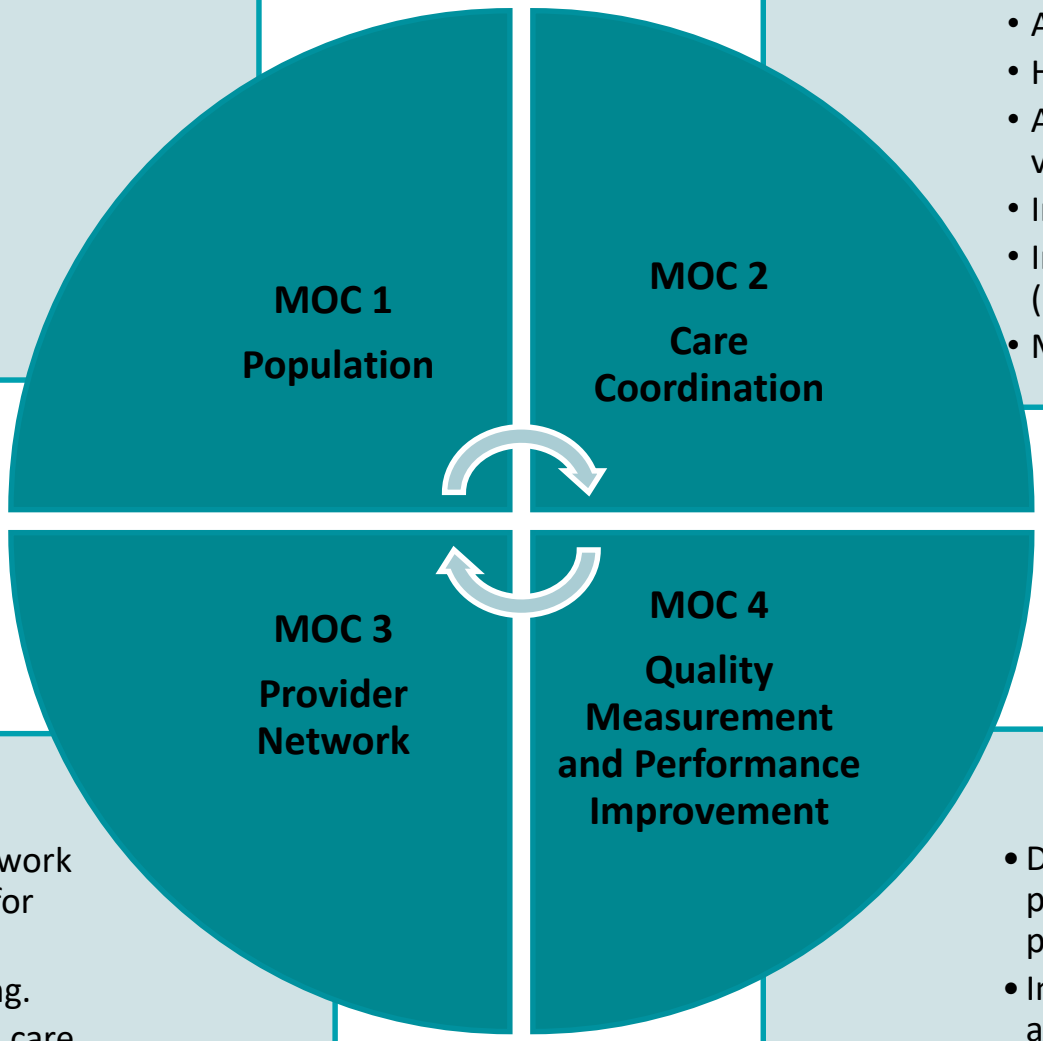
- Coordination between Medicare and Medicaid benefits required.
- Member may have another carrier for the Medicaid coverage such as behavioral health.

State Medicaid Agency Contract (SMAC)

- Contract may outline additional benefits or care coordination requirements.
- Services or benefits may be provided by agencies such as health homes.
- Appeals and grievances may be integrated.

Model of Care (MOC) Elements

- Description of the population in the SNP plan.
- Determining eligibility.
- Defines our most vulnerable members.
- Identify relationships with community partners.



- Staff structure and oversight process.
- Annual associate training.
- Health risk assessment process.
- Annual Face to Face provider visit.
- Individualized care plan (ICP).
- Interdisciplinary care team (ICT).
- Managing transitions.

- Adequate provider network with expertise to care for the SNP population.
- Annual provider training.
- Practice guidelines and care transition protocols.

- Defines our quality performance improvement plan.
- Includes how we identify, define and measure goals and health outcomes.

MOLINA® HEALTHCARE | PASSPORT BY MOLINA HEALTHCARE | Senior Whole Health BY MOLINA HEALTHCARE

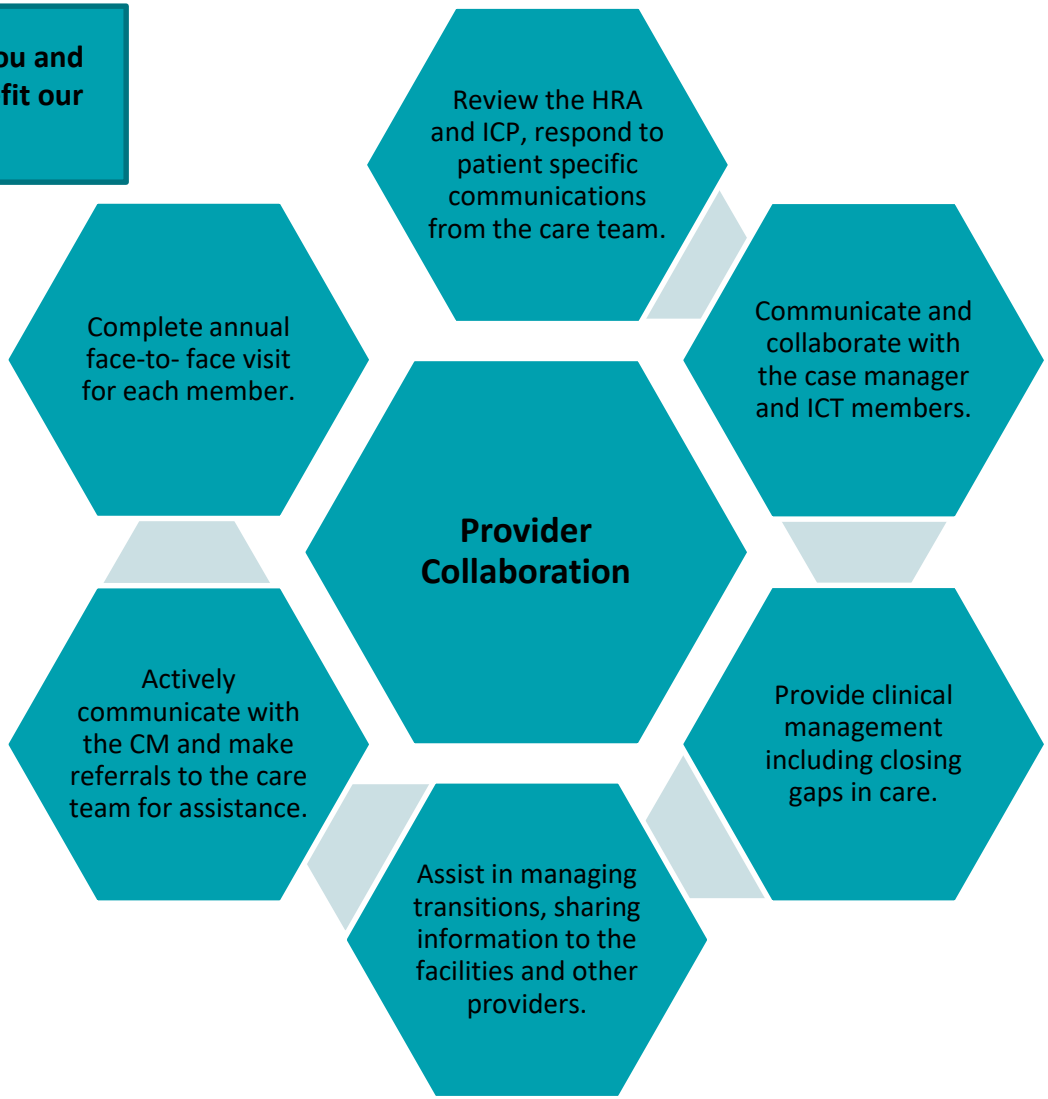
Care Coordination Processes

- **Health Risk Assessment (HRA)**
  - Completed initially within 90 days of enrollment, repeated annually and after a significant status change.
  - Identifies areas of unmet needs to address in the ICP.
  - Assesses physical, behavioral, cognitive, psychosocial, functional status and social factors impacting the member.
- **Individualized Care Plan (ICP)**
  - Includes member-specific goals and interventions based on needs identified during the assessment process.
  - The ICP is updated annually or if a significant change in status occurs and made available for the ICT.
  - Addresses coordination of care needs with providers, external agencies, community resources, and Medicaid benefits.
- **Interdisciplinary Care Team (ICT)**
  - Composition is determined based on the HRA results, identified member needs, and member preference.
  - Providers, especially the PCP are key members of the ICT and responsible for coordinating care and managing transitions.
  - Assists in development or contributes to the ICP.
  - The CM coordinates communications with members by mail, phone, provider portal, email, fax, and during formal or informal meetings.
  - New for 2023, each member must have an annual face-to-face encounter with a provider or another member of the ICT.

We embrace a person-centered, community-focused approach that assists us in identifying our member's unique needs, enabling us to connect our members with local services and resources to help support them in reaching their healthcare goals.

Provider Collaboration with the ICT

We want to partner with you and work together for the benefit our members.



MOLINA HEALTHCARE

PASSPORT BY MOLINA HEALTHCARE

Senior Whole Health BY MOLINA HEALTHCARE

MOC 4 Quality Measurement and Performance Improvement

Molina creates an annual quality improvement plan that focuses on our membership and includes identifying measurable goals and outcome objectives.

Data is collected, analyzed and evaluated throughout the year to monitor and measure the overall performance.

Each year, an evaluation is performed, and improvement actions are identified and incorporated into the next year's quality improvement plan.

MOC 4 Quality Measurement and Performance Improvement.

Additional elements in our Quality Program Include the following:

Measurable Goals and Outcomes	• Identify and clearly define measurable goals and health outcomes. • Establish methods to track impact. • Determine if goals are met. • Describe steps if goals are not met.
Measuring Patient Experience of Care	• Describe tools used to measure satisfaction. • How results of surveys are integrated into our plan. • How we address issues identified from results.
Ongoing Performance Improvement and Evaluation	• How we use results of indicators and measure to support ongoing improvement of our program. • How we use results to continually assess and evaluate quality. • Our ability for timely response to lessons learned through the evaluation. • How we share our performance improvement evaluation.

Summary of Provider Responsibilities

- Communicate and collaborate with Molina Case Managers, the ICT members, Molina members and caregivers.
- Coordinate care with Medicaid for any of the D-SNP members, which may include state agencies or other carriers.
- Encourage your patient to work with your office, keep appointments and comply with all treatment plans, participate with the care team, and complete the health risk assessment.
- Review and respond to correspondence sent by our case managers including the HRA results, the ICP and any request for information.
- Participate in applicable quality measures.
- Complete the annual MOC provider training and return the attestation.

Model of Care Training Attestation

- In order to document completion of this training, please complete and sign the attestation form for your state.
- If the training was delivered in a group setting, one attestation form (including attendance roster) should be submitted by the designated staff member with authority to sign on behalf of your provider group.

Arizona **California** **Florida** **Idaho** **Kentucky**

Michigan **Massachusetts** **Nevada** **New York** **Ohio**

South Carolina **Texas** **Utah** **Virginia** **Washington**

Wisconsin