Molina Healthcare Inc.
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 Inc. | 2022

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Training Objectives- Model of Care (MOC)

The following objectives will be covered during this training:

- Description of the different types of Special Needs Plans (SNP)
  - Dual SNP, Chronic Condition SNP, Institutional/Institutional Equivalent SNP
- 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
- Attestation process to document compliance with annual MOC training

Types of Special Needs Plans (SNP)

We have all the follow SNP plan types in our markets (varies by state):

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

For more information on the SNP types and requirements use the following link:

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

Dual Special Needs Plan (D-SNP)

D-SNP information and eligibility requirements:

- We have multiple D-SNP plans across our markets.
- Members in a D-SNP must maintain eligibility in both Medicare and Medicaid and live in the applicable state service area.
  - Full Benefit duals are eligible for Medicaid benefits
  - Partial benefit duals are only eligible to receive assistance with some or all Medicare premiums and cost sharing.
- Coordination and cost share requirements must be followed by providers.
- Member may have coverage of both Medicare and Medicaid with Molina or coverage with different organizations.
- Each D-SNP plan must have a State Medicaid Agency Contract (SMAC) which may define additional state required benefits or requirements.

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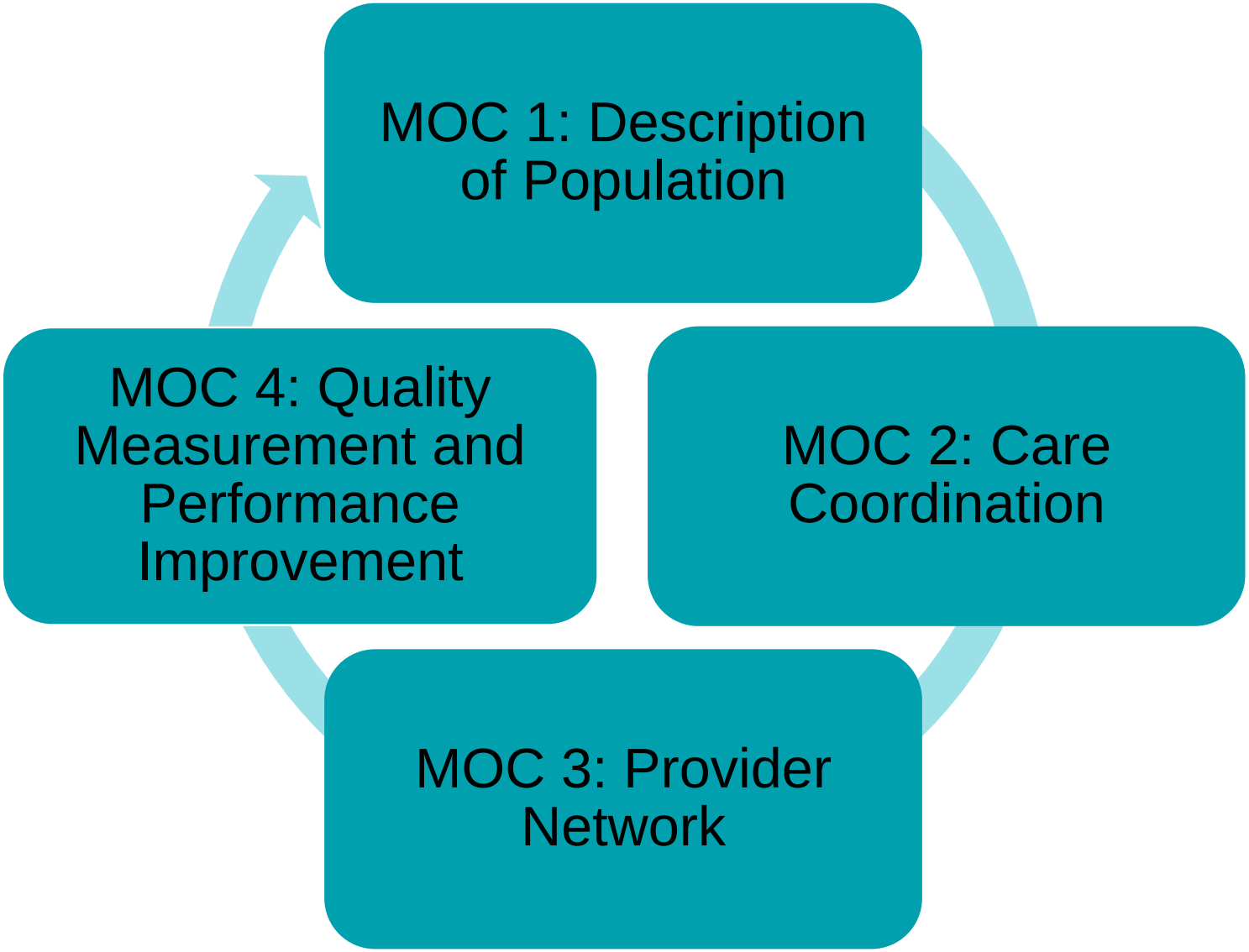
Model of Care (MOC) Elements



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MOC 1: Description of the SNP Population

Requirements in MOC 1 include the following:

- Description and analysis of the population in our SNP market.
- Eligibility Requirements and how we verify a member qualifies for the type of SNP.
- Define our most vulnerable sub-set of members, those that may require more coordination and interventions to maintain health status.
- Describe the relationship with community partners and how we work with them to provide care to our members.

In our assessment, we determine the most prevalent medical, behavioral, and social factors impacting our members.

MOC 2- Care Coordination

Elements within MOC 2 include the following:

- Define our staff structure and oversight process.
  - Administrative and Clinical Teams.
- Annual MOC training for our internal team and contractors.
- Health risk assessment (HRA) process.
- Development of an Individualized Care Plan (ICP).
- Development of the Interdisciplinary Care Team (ICT).
- Transitions of Care (TOC) management.

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.

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Health Risk Assessment (HRA)

HRA is Completed:

- Within 90 days of enrollment
- Annually (within 365 days of the previous HRA)
- When a significant change in health status occurs

HRA Assesses the Following Areas:

- Physical/Medical
- Behavioral Health
- Psychosocial
- Cognitive
- Functional

HRA Drives Results in:

- Individualized Care Plan (ICP)
- Referrals to programs or community resources
- Identifies needs for care coordination and any urgent issues.
- Membership of the ICT

Individualized Care Plan (ICP)

- Includes member-specific goals and interventions based on needs identified during the assessment process.
- If a member is unable to reach to complete an assessment, an ICP is created using historical information and interventions applicable for the population.
- The ICP is ever evolving and updated at least annually and/or if a significant change in status occurs
- The ICP is available to the ICT including the member and providers.

Interdisciplinary Care Team (ICT):

- Membership is based on assessment results, identified needs, complexity or risk level, and member request.
- Providers, especially the PCP are key members of the ICT and responsible for coordinating care and managing transitions.
- We may collaborate with ICT members by mail, phone, provider portal, email, fax or formal or informal meetings.
- Formal ICT meetings will be coordinated by the case manager.
- Actions from the ICT may include any of the following:

Communicating treatment and management options	Collaborating with providers	Advocating, educating and communicating with member	Completing assessments
Develops and/or contributes to the ICP	Coordinate care between disciplines	Reviews HRA results and ICP	Arranges community resources

How Our Providers Collaborate with the ICT

- Actively Communicate with :
  - Molina Case Managers
  - Other ICT Members
  - Members and their representatives
- Accept invitations to attend formal ICT meetings or provide feedback to the CM to present to the team.
- Review and provide feedback on the ICP
  - If received, return the signed ICT attestation form after reviewing the ICP.
- Refer members to our case management team when you identify a need we can assist with.
  - Contact us by calling the number on the member's identification card or in correspondence received from our care team or through the provider portal where applicable.

Care Transitions

- SNP members have many providers and experience multiple transitions in care.
- A member of our care team may be contacting you and your patient during transitions to validate needs are met, services are coordinated, prescriptions are filled, and medications are being taken as prescribed.
- Care transition protocols are published in the provider manual.
- Members may also be directed to contact member services for assistance.

Our providers are key to successful coordination of care during transitions.

MOC 3 Provider Network

Elements within MOC 3 include the following:

- We must show we have an adequate and specialized provider network that maintains licensure and competency to address the needs of our SNP population including:
  - Evidence of provider expertise.
  - Updating provider information.
  - How the PCP and providers collaborate with the ICT.
- Demonstrate we have clinical practice guidelines (CPG) and care transition protocols for our providers to use, how we monitor compliance, how the CPG may be modified for the population and how we maintain continuity of care using care transition protocols.
- Annual MOC training is required for our provider network. We have processes in place to track completion and what actions are taken if training is not completed.
  - We offer the training on the Molina Healthcare website.

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 measures to support the 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.

Measurable Goals and Health Outcomes

The measurable goals focus on all aspects of care and health outcomes including but not limited to, the following:

- Improving access to essential healthcare services.
- Improved access to affordable services.
- Improvement made in coordination of care and delivery of services.
- Appropriate utilization of services for preventive health and chronic conditions.
- Improved member health outcomes.

Our goals have benchmarks, data sources for measurement, specific timeframes, and how we will determine if we have achieved the goal.

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.

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

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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 **Florida** **Kentucky**

California **Idaho** **Ohio**

Michigan **Massachusetts** **New York**

Utah **South Carolina** **Texas**

Washington **Wisconsin** **Virginia**

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