Model of Care Provider Training

Quick Reference Guide

Overview

Molina Healthcare requires compliance with provider education and training programs. This includes all contracted Medicare PCPs and key high-volume specialists receiving new provider and annual basic training about our Model of Care (MOC). The Centers for Medicare & Medicaid Services (CMS) requirements are found in the Medicare Managed Care Manual, Chapter 5 – Quality Assessment, 3. SNP Provider Network; C. MOC Training for the Provider Network. Link: – https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf

What is Model of Care training?

MOC provides the basic framework under which insurers meet the needs of each of their enrollees.

The Molina Model of Care is the plan for delivering coordinated care and care management to special needs members. Insurers are responsible for conducting their own MOC training, which means you may be asked to complete multiple trainings by different health plans. CMS requires Molina to show evidence of the availability of MOC training materials communicated to providers.

This training will identify how you, as a provider of care, will support the Molina Model of Care, while understanding CMS requirements for managing those members.

In order to ensure Molina remains compliant with CMS regulatory requirements for Model of Care training, receipt of your completed Attestation Form is due to Molina by the date listed on your Attestation Form.

How can providers access Molina's MOC training?

The Model of Care Provider Training deck and associated materials can be found on Molina's website, www.MolinaHealthcare.com.

- At the top of the home page, select your State: Use the drop down arrow and click on your applicable State.
- Find the "Health Care Professionals" button: select "Medicare".
- You will be redirected to the Medicare Providers home page.
- Scroll to the middle of the web page to the "Model of Care" section.
- Model of Care Provider Training: Click on the hyperlink to access the annual training document.
- Attestation Form: From the drop down arrow, select your applicable State Attestation Form, then click "Go" to access the form. The Attestation Form is also available via link at the end of the Model of Care Provider Training.

Quick Reference Guide

Frequently Asked Questions

I have completed Model of Care Training for another insurer, does that count?

- No - You are required to complete the annual Model of Care Training for every insurer with whom you have a contract. CMS does not offer a centralized site to complete training for all insurers. CMS requires insurers, like Molina, to offer the Model of Care training and document that the care providers have completed it.

Who must complete the Model of Care training?

- All contracted primary care and key high-volume specialty providers who have been identified as directly or indirectly facilitating and/or providing Medicare Part C or D benefits for any Molina member.

How is the Model of Care training conducted?

- MOC training is available online, via web conferencing presentations, and may be scheduled as an in-person training.

Must all Attestation Forms be completed individually?

- If it is an individual provider, yes.
- If it is a group training, one Attestation Form should be submitted by the individual with authority to sign on behalf of the group, an attendance log (required) must be included.
- The Attestation Form includes instructions on how to submit your completed form to Molina.

I have not seen any Molina Medicare members this year, do I have to do the training?

- Yes, you still have to complete this training. CMS training requirements are not based on encounters or member assignment. All contracted PCPs and key high-volume specialists are required to complete this training.

If you have any additional questions, please contact your local Molina Provider Services Representative.

Molina Medicare Model of Care

Provider Training | Molina Healthcare | 2021

Course Overview

- The Model of Care (MOC) is Molina Healthcare's documentation of the Centers for Medicare and Medicaid Services (CMS) directed plan for delivering coordinated care and case management to members with both Medicare and Medicaid.

- CMS requires that appropriate Molina staff and providers receive basic training about the Molina Healthcare MOC.

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

Objectives

- Describe the Molina MOC

- List the four elements of the MOC

- Understand how member populations are identified for the MOC

- Describe the provider requirements for ICT

- Describe the provider requirements for MOC

What is a MOC?

- **Models of Care (MOC)** provides the basic framework under which the SNP will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

- The MOC is Molina's contract with CMS which Molina is audited to. The MOC formalizes how Molina will implement and manage the SNP membership.

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

MOC Requirements

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

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Four segments of the MOC

1. Description of the SNP Population

2. Care Coordination

3. SNP Provider Network

4. MOC Quality Measurement & Performance Improvement

MOC 1 and 2

1. Description of Overall SNP Population

This section **defines** and **analyzes** our target population of dual eligible members.

a) The overall description of the SNP population.

b) Description of the most vulnerable members subpopulation.

2. Care Coordination

a) Staff structure

b) Health Risk Assessment Tool

c) Individualized Care Plans (ICP)

d) Interdisciplinary Care Team (ICT)

e) Care Transitions Protocols (ToC)

MOC 3 and 4

3. **Provider Network**
   a) Specialized Expertise
   b) Use of Clinical practice guidelines and care transition protocols
   c) MOC training for Provider network

4. **MOC Quality Measurement and Performance Improvement**
   a) MOC Quality Performance Improvement Plan
   b) Measurable Goals & Health Outcomes for the MOC
   c) Measuring Patient Experience of Care (SNP Member Satisfaction)
   d) Ongoing Performance Improvement Evaluation of the MOC
   e) Dissemination of SNP Quality Performance related to the MOC

MOC 1

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.

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MOC 2 Element A: Staff Structure

Molina's MOC program has defined 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 their Molina benefits.

❖ **Clinical Staff:** Clinicians (i.e. licensed clinical social workers, nurses, psychologists, psychiatrists, mental health counselors, and medical clinicians) work together supporting the member as part of an integrated health care team.

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MOC 2 Element B: Health Risk Assessment (HRA)

Health Risk Assessment
The HRA is a standardized tool which allows for a comprehensive assessment of a member's individualized health and psychosocial needs.

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.

Frequency:
- HRA are conducted within 90 days of enrollment
- Reassessments (HRA) are conducted within 365 days of previous HRA or EED if no HRA has ever been completed
- A reassessment is also required when there is an identified change in the member's health status.

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MOC 2 Element C: Individualized Care Plans

Every member must have ONE individualized care plan (ICP) with prioritize identified needs and SMART goals. A Case Manager works with the member to develop and implement a member-centric care plan based on member's identification of primary health concern, additional conditions, barriers, assessment findings, and Case Manager's clinical judgement.

Frequency:
- ICPs are completed within 90 days of enrollment
- ICP updates are completed within 365 days of previous HRA or EED if no HRA has ever been completed
- An ICP update is also required when there is an identified change in the member's health status.

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MOC 2 Element D: Interdisciplinary Care Team (ICT)

Interdisciplinary Care Team

The ICT is a formal or informal meeting to collaborate between disciplines and coordinate care, aligning all servicing providers and core participants of the ICT that may include the Member, Primary Care Provider (PCP), and Healthcare Services (HCS) staff.

The ICT may occur through various methods such as mail, phone, email and fax, or formally. Additional participants may include but not limited to:

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

Frequency:
- ICTs are completed within 90 days of enrollment
- Annual ICT must be completed within 365 days of previous HRA or EED if no HRA has ever been completed

MOC 2 Element E: CareTransitions Protocols

Transitions of Care (TOC)

ToC is a member–centered program designed to assure continuity of care and improve quality and health outcomes for members as they move between settings to promote the coordination of medical care and support services for our members.

This focused program is provided to **all Medicare members** transitioning from an inpatient setting back into the community (their home environment) for up to 30 days.

The goal of this program is to prevent hospital readmission, ensure optimal transitioning from one care setting to another, and/or identify an unexpected change in condition requiring further assessment and intervention.

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MOC 3 –Element A: Specialized Network

In order to meet the needs of our members:

- Molina maintains a network of providers and facilities that have a special expertise in the care of SNP members.

- Molina's network is designed to provide access to medical, behavioral, and psycho-social services for the SNP 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 Network

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

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MOC 3 –Element A: Specialized Network

Collaboration with the ICT - Provider Responsibilities:

- Actively communicate with:

  o Molina Case Managers

  o Other ICT participants

  o 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 on the Individualized Care Plan (ICP)

  o Return the signed ICT attestation form to Molina after reviewing the ICP

- Refer members to care management who have an identified need

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MOC 3 – Elements B & C

Element B: Use of Clinical Practice Guidelines and Care Transition Protocols
- Molina monitors how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to the SNP population.

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

Element C: MOC Training for Provider Network
- Molina provides initial and annual Model of Care training to all employed and contracted personnel as well as contracted PCPs and key high volume specialty providers.

MOC 4 – Element A: Quality Performance Improvement Plan

Molina has a comprehensive overall quality performance improvement plan to demonstrate Molina's ability to measure and evaluate the effectiveness of the MOC program and to identify any needed changes to the program. Molina's MOC has established and defined the following goals:

- **Design and maintain programs** that improve the care and service outcomes within identified member populations, ensuring the relevance 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.

MOC 4 – Element B: Measurable Goals and Health Outcomes for the MOC

The measurable goals focus on all aspects of care and health outcomes and are integrated into the performance improvement plan through ongoing monitoring and evaluation throughout the year. The measurable goals are evaluated against benchmarks and thresholds as available. The Model of Care Quality Improvement Program Work Plan discusses all key indicators, measurable goals and benchmarks as needed. These goals address:

- Improved access to essential health services
- Improved access to affordable care
- Improved coordination of care/case management
- Improved access to preventive health services and management of chronic conditions
- Appropriate utilization of services for preventive health and chronic conditions
- Improved beneficiary health outcomes
- Improved access to behavioral health services

MOC 4 –Element C: Measuring Patient Experience of Care (Member Satisfaction)

Molina Healthcare measures patient experience using multiple surveys. The first key survey used to measure patient experience includes the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey as well as conducting the Health Outcomes Survey (HOS)

- The results of these satisfaction surveys and existing interventions are brought forward to the Leadership at the health plan, through QI Committees, NQIC, and in all areas as needed. The satisfaction survey indicators are included in the QI Program Work Plan and the QI Program Description. Specific steps for improvement are included in the Program Work Plan and a Member Experience specific work plan. Molina Healthcare also monitors member satisfaction with its services and identifies areas for improvement through a review of member grievances and appeals.
- Molina Healthcare also conducts program-specific satisfaction surveys through analysis of complaints and through member feedback. Data collection is conducted by the Quality Improvement Compliance team at Molina Healthcare, Inc. and evaluation is conducted primarily through the Healthcare Services Department. Member satisfaction with the program is measured and reported annually using analysis of member complaints and inquiries to determine opportunities to improve the program.

MOC 4 – Element D & E

Element D: Ongoing Performance Improvement Evaluation of the MOC
- Annually, work with Quality to define goals to help measure the effectiveness of the MOC.

- In first quarter of every year, Quality conducts an analysis of the previous year's MOC goal results and completes an annual MOC Evaluation.

Element E: Dissemination of SNP Quality Performance Related to the MOC
- Quarterly Measure goals and review in the local HCS and Quality Committee meetings noting any variances and implementing interventions to correct or modify including discussions in the meeting minutes.

Summary

The MOC outlines how we work together for the benefit of our members by:

- Identifying and describing the SNP Population

- Coordinating Care using an Interdisciplinary approach to the member's individual needs

- Building a specialized SNP Provider Network

- Implementing and evaluating a comprehensive quality improvement plan and objectives that support the delivery of care

Model of Care Attestation

- In order to document completion of this training, please complete and sign the Attestation form for your state.

- If this is a group training, one Attestation form should be submitted by the individual with authority to sign on behalf of the group and an attendance roster must be attached.

California   **Florida**   **Idaho**   **Michigan**

Ohio   **South Carolina**   **Texas**

Utah   **Washington**   **Wisconsin**

Thank You

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