Molina Medicare Model of Care

This Model of Care training is applicable to the Molina Healthcare Inc. family of brands, including Molina Healthcare, Passport, Central Health Medicare Plan, My Choice Wisconsin and Senior Whole Health plans.

Provider Training | Molina Healthcare | 2025

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Molina KY 2382_APP (1/16/2025)

Purpose of the Model of Care (MOC) training

- Understand requirements of Dual Special Needs Plans (D-SNPs) and Chronic Condition Special Needs Plans (C-SNPs)
- Describe MOC elements:
  1. Description of the SNP population
  2. Care coordination
  3. Provider network
  4. Quality measurement and performance

- Summarize provider responsibilities and provider collaboration
- Document compliance with annual MOC training through attestation process

Special Needs Plan (SNP) markets

D-SNP markets
• Arizona • California • Idaho • Kentucky • Massachusetts • Michigan • Mississippi • Nebraska • Nevada • New Mexico • New York • Ohio • South Carolina • Texas • Utah • Virginia • Washington

C-SNP market
• California • **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 dual members are eligible to receive Medicaid benefits.
- Partial-benefit dual members 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 is required.
- A member may have another carrier for their Medicaid coverage, such as behavioral health.

State Medicaid Agency Contract (SMAC)

- The 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.

Chronic Special Needs Plan (C-SNP)

To enroll in a C-SNP, a member must have:

- Medicare coverage
- A confirmed diagnosis of the qualifying condition(s) as defined by CMS and offered by the plan

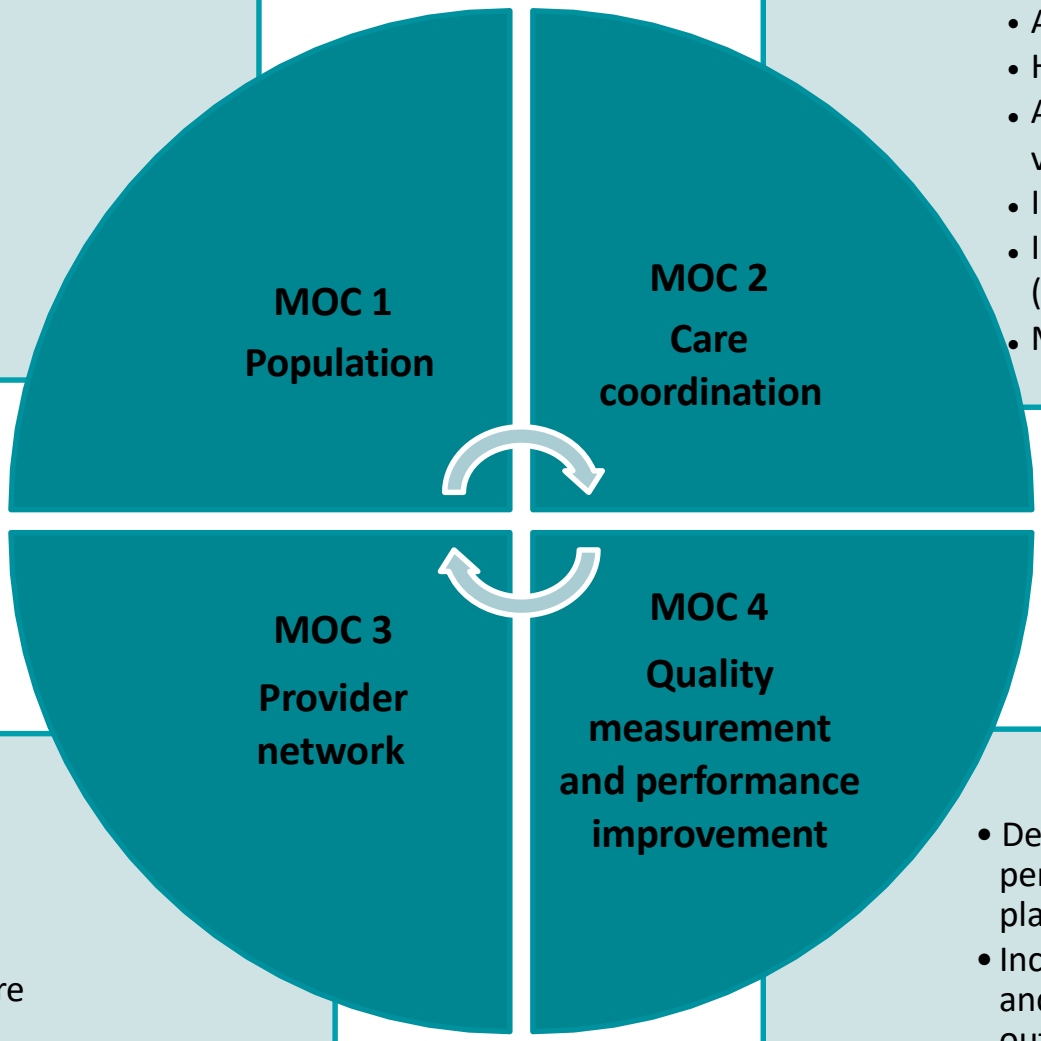
We offer the following C-SNP types in California:

- Diabetes
- Congestive heart failure
- Cardiovascular disease, limited to:
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Chronic venous thromboembolic disorder

Please complete and return any correspondence you may receive asking to confirm the qualifying condition.

Model of Care (MOC) elements

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



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

- 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

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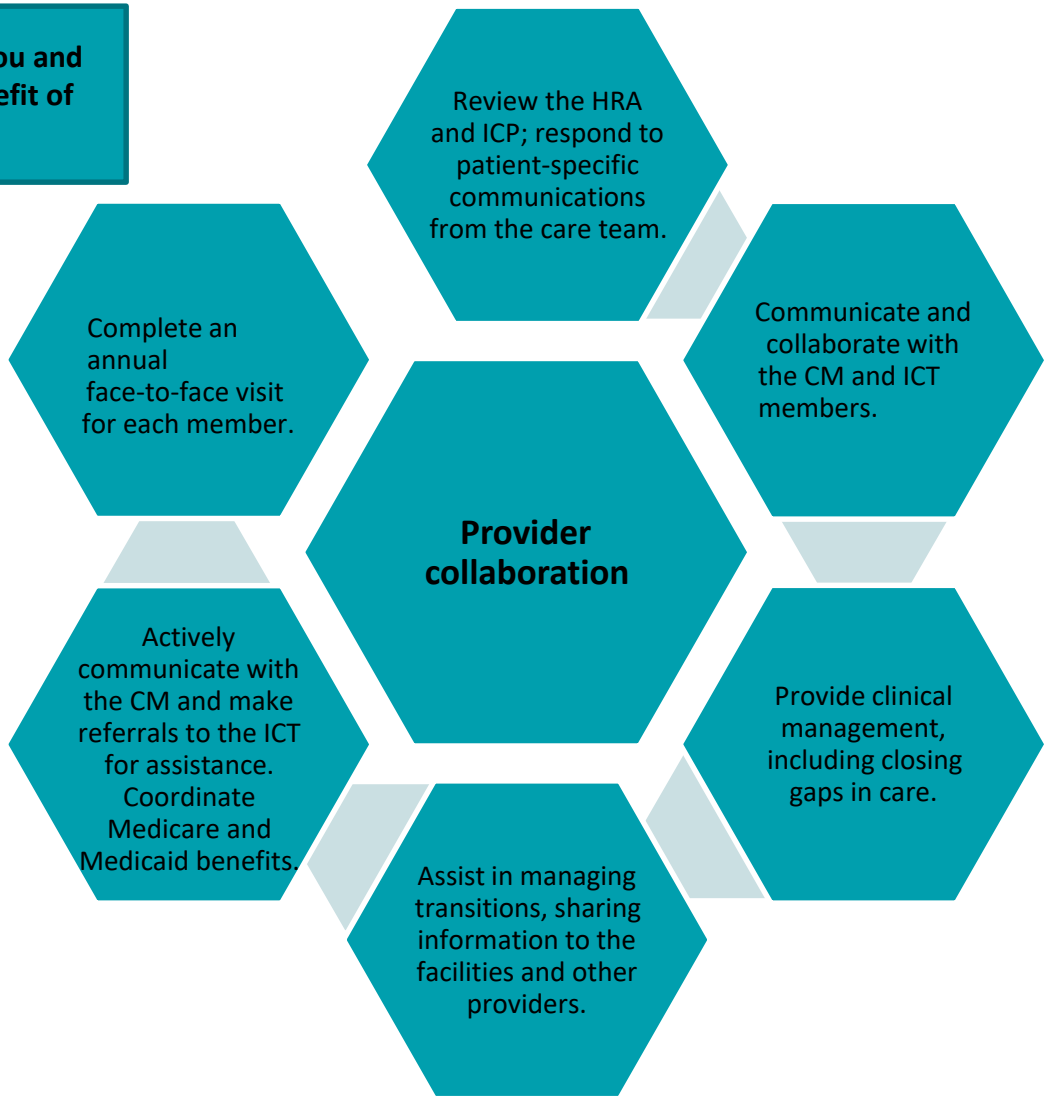
Care coordination processes

- **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 be addressed in the ICP
  - Assesses physical, behavioral, cognitive, psychosocial and 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
  - 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)**
  - All SNP members have an ICT to provide and coordinate care; composition is determined based on member needs and member preference
  - Providers, especially PCP, are key members of ICT and are responsible for coordinating care and managing transitions
  - May review or contribute to ICP
  - Case manager (CM) coordinates communications with ICT by mail, phone, provider portal, email or fax
  - Each member must have an annual face-to-face encounter with a provider or other ICT member

We embrace a person-centered, community-focused approach that assists us in identifying our members' 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 of our members.



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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.

Quality measurement and performance improvement

Additional elements in our 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 to take if goals are not met.
Measuring patient experience of care	• Describe tools used to measure satisfaction. • Establish how survey results are integrated into our plan. • Determine how we address issues identified from the results.
Ongoing performance improvement and evaluation	• Use the results of indicators and measures to support the ongoing improvement of our program. • Use results to continually assess and evaluate quality. • Identify our ability to respond in a timely manner to the lessons learned through the evaluation. • Share our performance improvement evaluation.

Summary of provider responsibilities

- Communicate and collaborate with our case managers, ICT members, Molina members and caregivers.
- Coordinate care with Medicaid for D-SNP members, which may include services provided by other carriers and state agencies such as Long-Term Services and Supports (LTSS) partners, behavioral health services only administrators, and home- and community-based providers.
- Access important member information on the provider portal, including their assessment results, ICP and members of their care team.
- Encourage your patient to work with your office, keep appointments, comply with all treatment plans, participate with the care team and complete the health risk assessment (HRA).
- Participate in quality measures and close care gaps.
- Review and respond to correspondence sent by our case managers. Sign and return the ICP attestation if requested.
- Review annual provider training and complete attestation.

Model of Care training attestation

- 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 Idaho Kentucky Massachusetts

Michigan Mississippi Nebraska New Mexico Nevada

New York Ohio South Carolina Texas Utah Virginia

Washington

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