H5810 MOLINA HEALTHCARE OF CALIFORNIA
Dual-Eligible Medicare Subset - $0 Cost Share

Model of Care Score: 93.13%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Molina Medicare operates Medicare Dual Eligible Special Needs Plans (SNP) for members who are fully eligible for Medicare and Medicaid. This population has a higher burden of multiple chronic (medical and behavioral health) illnesses than other Medicare Managed Care Plan types. The subset includes sub-populations of frail and disabled, are culturally diverse with complex or unresolved needs, requiring coordination between multiple providers, specialists and settings of care. Most members are not institutionalized but reside in the community. The average age is 56.8 years with 46 percent male and 54 percent female. The top reported conditions include but are not limited to: chest pain (cardiovascular disease), hypertension, Diabetes (with and without complications), Chronic Obstructive Pulmonary Disorder (COPD) and other respiratory and mood disorders. Twenty-two percent suffer two or more comorbidities.

Provider Network

The Molina Medicare SNP maintains a network of providers and facilities with special expertise in the care of DE SNP members and includes but is not limited to: acute care hospitals, long term acute care and skilled nursing, rehabilitation, behavioral health/substance abuse (inpatient and outpatient) facilities, surgery centers, and laboratory and radiology/imaging centers. Molina's provider network is a large community based network of medical and ancillary providers including but not limited to: primary care providers, medical specialists (all medical specialties), behavioral health providers, physical and occupational therapists and nursing professionals.

Care Management and Coordination

Molina's Health Risk Assessment (HRA) is administered to all newly enrolled members within 90 days of enrollment from one central unit to identify members "at-risk" who may benefit from Case Management and Disease Management (DM) Programs. Assessment information is documented and reported monthly using the Domain Assessment Tool (DAT). In addition, Molina conducts and annual or, as needed, more frequent re-assessments to identify members at risk for a transition. The disposition of the assessment includes a scored outcome stratification and additional information about the member's condition and needs, including transition risk. Molina using various modalities to conduct a member's assessment depending on the member needs (telephonic interview, during a face-to-face home or facility visit, through inter-active telephonic response system or written survey.

Molina's professional healthcare staff (care and case managers [CM] and social workers [SW] use results from the assessment process to develop and implement individual care plans (ICP) for

members based on analysis of HRA data. The plan of care elements may consist of member care preferences, need for utilization of medical, behavioral health and supplemental Medicare benefits, end of life needs, social or community services needs and condition specific educational needs. Care plans may also include home assessments and the provision of special services such as laboratory, spirometry and echo services for members requiring more intense management. ICP elements are structured in the form of goals (long and short term) and documentation contains identification of barriers, as appropriate, member self-management plans, tasks (for Interdisciplinary Care Team [ICT] members and member/caregivers), interventions and outcomes. Member care plans are reviewed in the event of member transitions in healthcare settings or significant changes in member health care status by professional clinical Molina staff members in conjunction with the annual comprehensive HRA review.

Individual member care plans are sent via fax, mail or email to the PCP, relevant specialists and other ICT members and their caregivers. Members, ICT members, PCPs and pertinent providers are notified of any revisions to the individualized care plans and are also made aware either verbally or in writing that they can request copies of the ICP through a request to the Member Services Department or the assigned CCM or Care Coordinator. The ICT includes the Molina Care Management Team (Authorization Coordinator, Utilization Manager, Care Manager, and Case Manager). The ICT assures that specialized services are delivered timely and effectively, directing care and monitoring access to care reports and grievance reports regarding timely access or quality of care.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.molinahealthcare.com/members/ca/en-us/Pages/home.aspx