Molina Healthcare of Texas, H7678
Dual-Eligible (Subset – Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 96.25 percent
3-Year Approval **January 1, 2014 to December 31, 2016**

Target Population Summary

Molina operates Dual Eligible Special Needs Plans that encompass all categories of Medicaid eligibility in seven states. Females comprise 57.49 percent of this population and males 42.51 percent. Sixty-six percent of the plan's members have a high school education or less. Over 18 percent of Molina's members are Black with Hispanic/Latinos and American Indian/Alaska Natives comprising 26.2 percent and 6 percent of the membership respectively.

Approximately 46 percent of Molina's members have one or more of the National Quality Forum's Top 10 Medicare high-impact conditions. Its members include sub-populations of frail, disabled, culturally diverse individuals with complex or unresolved needs. Over 41 percent of those identified as risk level II and III have one or more needs for caregivers, financial assistance, homelessness or support in the form of a walker or wheelchair. The plan's members also include those who are institutionalized and those who are mobile within the community.

Provider Network Summary

Molina maintains a network of providers and facilities with special expertise to care for SNP members. It includes: hospitals, urgent care, long term care, skilled nursing, rehabilitation and mental health/substance abuse facilities, laboratories, radiology/imaging, and dialysis and diabetes education centers. The plan also has a large network of: primary care practitioners (PCPs); specialists in orthopedics, neurology, physical medicine and rehabilitation, cardiology, psychiatry and clinical psychology; along with clinical social workers, certified substance abuse specialists, physical therapists, occupational therapists, speech/language pathology, chiropractic, podiatry and nursing professionals.

Molina provides specialized services such as in-home and outpatient psychotherapy, crime victim services, elder abuse prevention and intervention.

Care Management and Coordination Summary

A centralized team of professional and support staff initiates an outreach call or home visit to conduct an initial health risk assessment (HRA) within 30-90 days of the member's enrollment. Based on results of the HRA, a member may undergo secondary assessments using evidence-

based tools. These may include in-person functional assessments of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), skin assessment, falls assessment, dementia screening, mental health screening, substance use screening, environmental safety assessment and disease management (e.g., asthma, COPD, diabetes, ESRD, HIV). Molina uses standardized screenings (SF-12 and PHQ-9) to screen for depression. The plan uses assessments, claims, predictive modeling, member self-report, provider and community organization referrals to stratify members by risk. Annual re-assessments occur within 365 days of the last assessment.

The case manager works with the member, his/her family (with permission), the PCP and the interdisciplinary care team (ICT) to determine the care plan. Elements within it may consist of member care preferences and needs for: service utilization, supplemental Medicare benefits, end of life, social or community services and condition specific education. Care plans may also include home assessments and the provision of laboratory, spirometry, and echo services for individuals requiring more intense management. Care plan elements take the form of prioritized goals (long and short term) and documentation contains the identification of barriers, member self-management plans, tasks (for the ICT and member/caregivers), interventions and outcomes.

Molina's staff review and update care plans with every member contact, for significant changes in their health status and at least annually.

The ICT is composed of the PCP and the Molina Integrated Case Management Team (medical and behavioral health clinicians). Additional ICT members may be added on a case-by-case basis depending on a member's conditions and health status.

The PCP will be a primary source of assessment information, care plan development and member interaction within the ICT. The Integrated Case Management Team will be primarily involved during: assessment periods, care plan follow-up; transitions of care; routine case management follow-up, requests for assistance from PCPs; requests for assistance from members/caregivers; during significant changes in the member's health status; and after referral from other Molina staff.

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/