

**H9082 Molina Healthcare of New Mexico, Inc.  
Dual Eligible (All Dual) Special Needs Plan**

**Model of Care Score: 86.67%**

**3-Year Approval**

**January 1, 2015 – December 31, 2017**

---

**Target Population**

Molina Healthcare of New Mexico, Inc. (Molina) Dual Special Needs Plan (D-SNP) enrolls members who are entitled to Medicare and Medicaid benefits and reside in one of the plan's service areas in New Mexico.

Molina's total membership includes 37,386 individuals of which 131 live in New Mexico. Among Molina's D-SNP population, there is a smaller percentage of White members and higher percentages of Black or African-American, Asian, American Indian or Alaskan Native and Native Hawaiian or other Pacific Islander members. English is the preferred spoken language among members.

The most prevalent medical conditions among D-SNP members are diabetes (3 percent), ischemic heart disease (22 percent), chronic obstructive pulmonary disease (19 percent) and congestive heart failure (12 percent). Other conditions such as stroke/transient ischemic attack, depression, Alzheimer's and acute myocardial infarction impact about one percent of Molina's membership. Less than one percent of members have been diagnosed with breast cancer or colorectal cancer. Forty-three percent of members are age 65 or older, and account for 27 percent of the behavioral health diagnoses. Conversely, 57 percent of members who are under the age of 65 are responsible for 73 percent of the behavioral health diagnoses among the entire population.

**Provider Network**

Molina's network is designed to provide access to medical and behavioral care for the Molina D-SNP. The network's facilities include: acute care hospitals, long-term acute care facilities, skilled nursing, rehabilitation and urgent care facilities, emergency departments, outpatient surgery centers, inpatient/outpatient rehabilitation centers, inpatient/outpatient mental health/substance abuse facilities, outpatient surgery centers, laboratory facilities, radiology imaging centers, renal dialysis center, emergency departments and diabetes education centers. In addition to primary care providers (PCP), medical specialists and ancillary providers, Molina's has an extensive network of mental health clinicians/providers.

**Care Coordination and Management**

Within 30 to 90 days of enrollment, Molina staff initiate an outreach call or home visit to the member to complete an initial health risk assessment (HRA). Based on the HRA results, the member may undergo

secondary assessments using evidence-based tools which may include in-person functional assessments of activities of daily living and instrumental activities of daily living, skin assessment, falls assessment, dementia screening, mental health screening, substance use screening, environmental safety assessment and disease management. Molina uses standardized screenings to screen for depression. Re-assessments occur annually, or more frequently depending on risk stratification, significant changes in the member's health status or a transition event.

The case manager (CM) works with the member and/or caregiver, the PCP and the interdisciplinary care team (ICT) to determine the individualized care plan (ICP). ICP content is based on assessments conducted with the member, a review of utilization history, discussions with the member, their caregiver and treating providers, member's goals, identification of barriers and clinical acuity. The ICP is updated annually, at a minimum, and at every member contact or in the event of a significant change in their health status. Elements of the ICP may include: member's care preferences/needs for service utilization, supplemental Medicare benefits, end-of-life care, social or community services and condition-specific education. It may also contain behavioral health components, including the results of the primary and secondary assessments and the disease/health management services needed for the behavioral health conditions.

The ICT is designed to address all aspects of a member's healthcare with input from the member and/or caregiver. The ICT is typically composed of the member's assigned PCP or primary specialty physician, Molina's integrated care management team (medical, behavioral health, and pharmacy clinicians), home and community based services staff as well as other ancillary providers as appropriate based on the members/enrollee's needs identified in the HRA.

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: [www.molinahealthcare.com](http://www.molinahealthcare.com).