



2011 Special Needs Plan (SNP) Model of Care

Provider Training

Molina Medicare 2011

Course Overview

- The Centers for Medicare and Medicaid (CMS) requires all contracted medical providers to receive basic training about the Special Needs Plans (SNP) Model of Care.
- The SNP Model of Care is the plan for delivering coordinated care and case management to Molina's Special Needs Plan members.
- This course will describe how Molina Medicare and its contracted providers can work together to successfully deliver the SNP Model of Care.

Learning Objectives

After the training, attendees will be able to:

1. Describe the basic components of the Molina Medicare SNP Model of Care.
2. Explain how Molina Medicare case management programs work and how contracted providers will work with the programs and function as a member of the interdisciplinary care team.
3. Describe the essential role of contracted providers in delivering the SNP Model of Care

What are Special Needs Plans?

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs.

- There are three types of SNPs that serve the following types of members:
 - Dually eligible members (D-SNP)
 - Individuals with chronic conditions (C-SNP)
 - Individuals who are institutionalized or eligible for nursing home care (I-SNP)

What is the SNP Model of Care?

The SNP Model of Care is the CMS plan for delivering case management and services for Medicare Advantage members with special needs. It sets guidelines for:

- Assessment and case management of members
- Communication among members, caregivers, and providers
- Use of an Interdisciplinary Team (ICT) of health professionals
- Integration of the primary care physician (PCP) as a key member of the ICT
- Measurement of individual and program outcomes

Molina Medicare SNP Model of Care

Molina Medicare is contracted with CMS as a D-SNP for dual eligible members

Every SNP member is evaluated annually with a comprehensive Health Risk Assessment

Members are then triaged to the appropriate Molina Medicare case management program

An Interdisciplinary Team develops an Individualized Care Plan (ICP) with input from providers, members and their caregivers/families as appropriate

Molina Medicare SNP Model of Care

Members receive monitoring, service referrals, and condition specific education

Case managers and PCPs work closely together to implement and evaluate the member's Individualized Care Plan (ICP)

Molina Medicare will disseminate evidence-based clinical guidelines and will conduct studies:

- to measure benefits to member and Molina Medicare
- to monitor quality of care
- to evaluate the effectiveness of the Model of Care

SNP Programs

Inpatient Case Management

- Coordinates with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level
- Works with the facility and member or member's representative to develop a discharge plan
- Notifies the PCP, IPA, or member's usual practitioner of planned and unplanned admissions.
- Notifies PCP, IPA, or members usual practitioner of the discharge date and discharge plan of care.

Care Transitions

The Care Transitions (CT) Program is a Molina developed, patient-centered program designed to improve quality and contain costs for members with complex care needs as they transition across settings.

During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions.

Molina Care Transition staff ensure that members have appropriate follow-up care after a hospitalization to prevent hospital re-admissions

Care Transitions (cont'd)

Care Transition interventions may include but not limited to:

1. Face to face or telephonic contact with the member or their representative in the hospital, prior to discharge, to discuss the DC plan
2. In home visit or phone call within 1-2 days post discharge to evaluate member's:
 1. Understanding of their discharge plan,
 2. Understanding of their medication plan,
 3. Follow up appointments have been made
 4. Home situation supports the discharge plan.

Care Transitions (cont'd)

Member's with targeted diagnosis and complex care issues will be followed by the Care Transitions team for 4-6 weeks for 1:1 training on self management skills

If additional support is needed beyond the 4-6 weeks timeframe a referral is made to Molina Case Management

Case Management

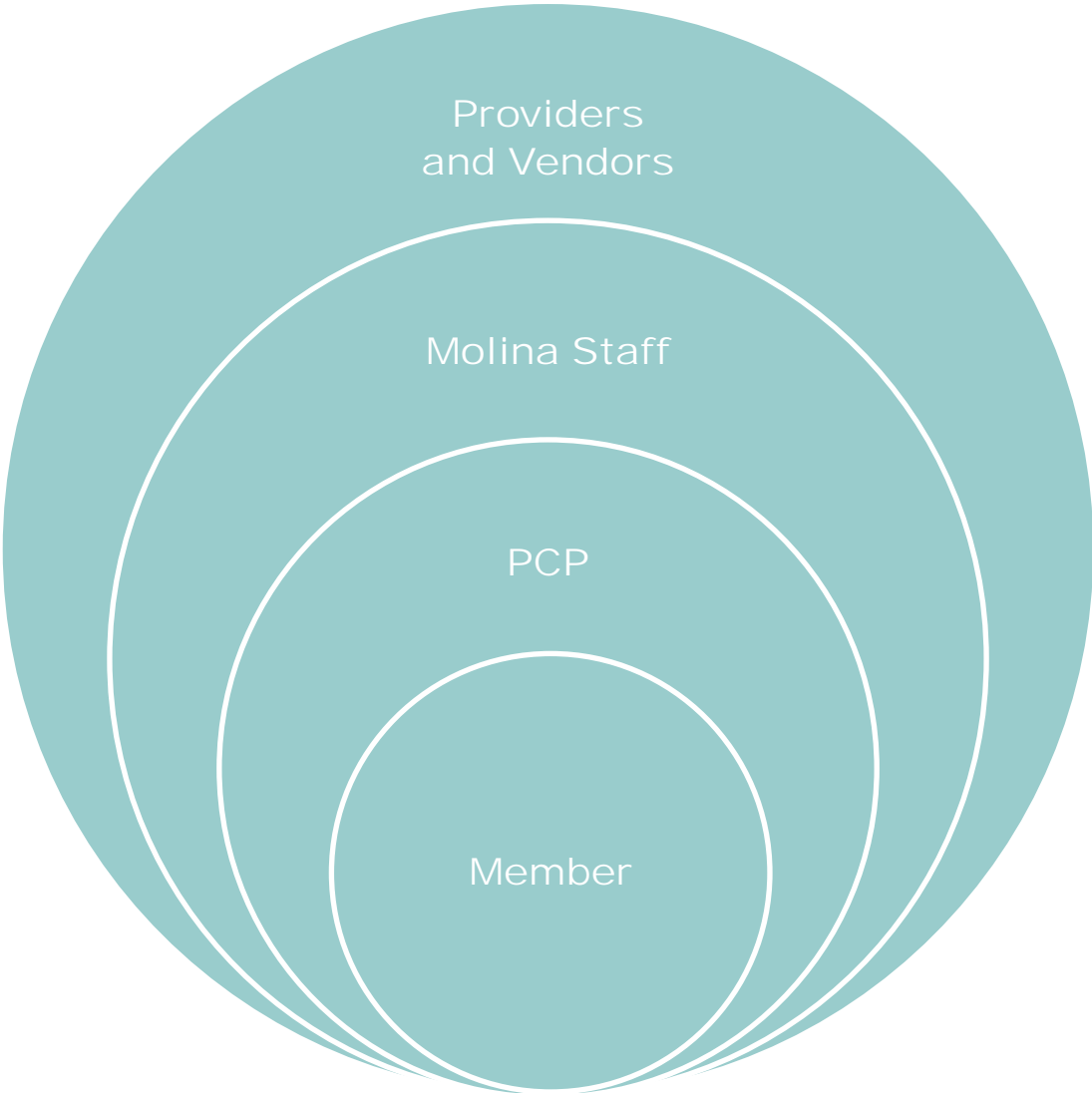
Molina Case Managers coordinate the member's care with **all** practitioners and vendors involved in the member's care. (The Interdisciplinary Care Team ICT)

Molina Case Managers work with the member to promote knowledge and self-management of their condition.

Molina interdisciplinary staff may include:

- Nurses
- Social Workers
- Health Educators
- Coordinators
- Behavioral Health Staff
- Physicians
- Pharmacists

Interdisciplinary Care Team (ICT)



What Can Molina Medicare Do for You?

- ✓ Work with the member to develop personal goals and interventions for improving their health
- ✓ Monitor the member's implementation and compliance with your plan of care
- ✓ Identify problems/anticipate crises
- ✓ Coordinate care and services between the member's Medicare and Medicaid benefit
- ✓ Educate members about their health conditions and medications
- ✓ Prepare members/caregivers for their provider visits
- ✓
- ✓ Refer members to community resources
- ✓ Notify you of planned and unplanned transitions

What Can You Do For Molina?

- ✓ Communicate with:
 - ✓ Molina case managers
 - ✓ Members of the Interdisciplinary Care Team (ICT),
 - ✓ Members and caregivers

- ✓ Understand that providers are key members of the ICT

- ✓ Collaborate with Molina Case Managers on the Individualized Care Plan (ICP)

- ✓ Review and respond to patient–specific communication

- ✓ Maintain ICP, ICT worksheets and transition of care notifications in the member’s medical record

- ✓ Participate in Interdisciplinary Care Team Meetings

Summary

Molina Medicare values our partnership with our providers

Molina Medicare SNP Model of Care offers the opportunity for us to work together for the benefit of our member, your patient with

- Enhance communication between you and Molina
- Focus on the member's special needs
- Comprehensive coordination with all care partners
- Support for the member's plan of care
- Reinforcement of the member's connection with their medical home.

Molina Contacts For the SNP Model of Care

Plan	Fax	Medicare Member Services & Pharmacy	Behavioral Health	Transportation
California	866-472-0596	800-665-0898	877-436-3604	866-475-5423
Florida	866-472-9509	866-553-9494	866-553-9494	866-475-5423
Michigan	800-594-7404	800-665-3072	800-541-3647	866-475-5423
New Mexico	888-802-5711	866-440-0127	888-825-9266	866-475-5423
Ohio	866-449-6843	866-472-4584	800-642-4168	866-475-5423
Texas	866-420-3639	866-440-0012	800-576-9666	866-475-5423
Utah	866-504-7262	888-665-1328	888-483-0760	866-475-5423
Utah Healthy Advantage	866-472-9481	877-644-0344	866-472-9479	877-564-0577
Washington	800-767-7188	800-665-1029	800-745-4044	866-475-5423