Molina Healthcare of California



Dual RFI Response Summary

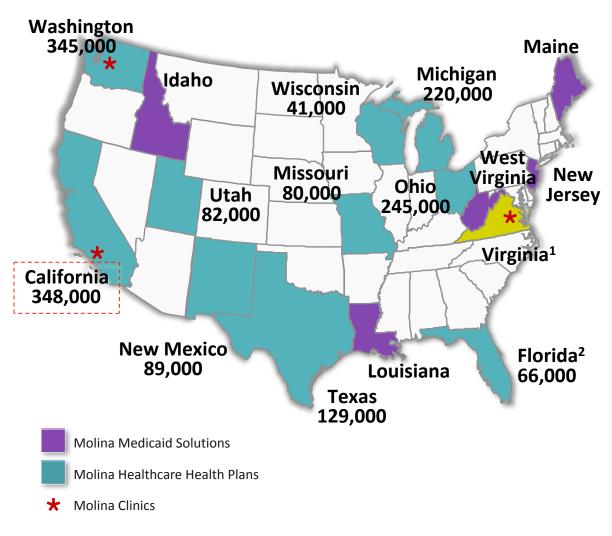
Improving Care through Integrated Medicare and Medi-Cal Delivery Models

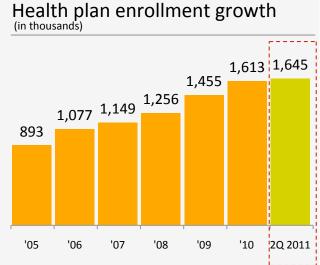
Lisa Rubino, President Stakeholder Meeting August 30, 2011



Business Footprint

Markets and members served - Q2 2011





- 9th largest Medicare SNP in Country with over 23,000 duals enrolled
- Cover over 160,000 ABD's nationwide
- 21 owned and operated clinics
- All eligible health plans accredited by NCQA



Virginia clinics provide Direct Delivery.

^{2.} Florida has a managed care program as well as a Pharmacy Rebate Program.

Dual Eligible Challenges

Duals make up 15% of the Medicaid population, but account for 40% of Medicaid spending.

Challenges	Solutions
A vulnerable population with complex medical needs: (87% of duals have 1 or more chronic conditions)	Medical Home, Health Risk Assessment, Risk Stratification, Individual Care Plan
Prevalent Mental Health co-morbidity	Multidisciplinary team for Behavioral Health support
Age, disability, financial and social issues	Coordination with Community Resources
Significant need for community and home-based services	LTC support, Coordination with IHSS, Home visits as needed
Multiple funding sources/benefits and multiple I.D. Cards	Single set of comprehensive benefits and 1 I.D. Card



Molina's Flexible Integrated Care Model- Responsive to State's Needs

Facilitates a member-centric, home and community-based care environment designed to reduce institutional care (SNF, ER, Hospital)

Level 3: Complex Case Management

- Multidisciplinary approach
- Detailed assessments and goals
- Medical, Social, Behavioral, LTC support
- ■Home visit program

Level 2: Case Management

- Multidisciplinary approach
- Disease management
- Service coordination
- Medical, Social, Behavioral, LTC support
- ■Home visit program

Level 1: Health Management

- ■Disease managementTransportation,
- Scheduling Appointments
- ■Health Education
- ■Community Resources

Care Access & Monitoring
Prior Authorization, Concurrent Reviev
Discharge Planning)

Care Transitions



State Partnerships-Proven Track Record

- Washington Medicaid Integration Partnership (WMIP)
- Designed to reduce institutional care (SNF, ER, Hospital)



Molina is the <u>only</u> health plan partnering with the state of Washington to coordinate the care for underserved SSI patients.

- Managed care for SSI or SSI-related Medicaid members
- Serves members in Snohomish County who are 21 years of age or older
- Currently serving 4,400 members as of 6/2011.
- The intent of this pilot is to improve clients' health and decrease expenditures
- Project yielding benefits since 2005



Integrated Primary Care + Behavioral Health Medical Home

Molina Staff Model Clinic for Washington WMIP Program







- Coordinated care management for people with Severe Mental Illness (SMI)
- Increased access to primary care through collocation with behavioral health provider
- Integration of physical health, mental health andchemical dependency services
- Increased patient self management and satisfaction
- Reduced hospital and ER utilization



Success should be judged on Health Outcomes, member satisfaction, and cost effectiveness:



- Prevention of institutionalization (SNF)
- HEDIS-like measuresCAHPS/HOS
- (member satisfaction) SF-12 (self
- evaluation of health status) Reduction
- of preventable Readmissions Reduction
- in avoidable ER use



What does a health plan need?



Consistent Regulatory Execution Clear standards, financing and rates, accreditation, enrollment options—
passive/voluntary/no lock-in and network requirements

Thoughtful discussions on care management & care coordination

Share in the savings as a result of better carecoordination and improved member outcomes

Transparent rate development

Use rate setting methodologies that incorporate Medicare and Medicaid funds for all covered benefits

