Molina's Vision for Full Integration: April 1 and Beyond

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MOLINA® HEALTHCARE

Our mission

To provide quality health care to people receiving government assistance

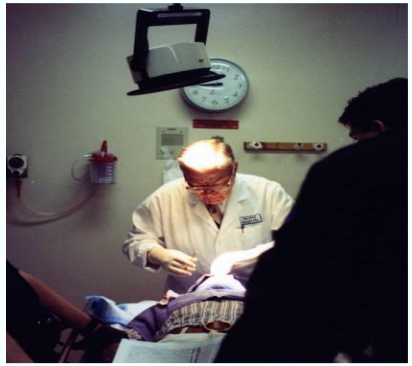
Our values

We strive to be an exemplary organization. These are our values:

We sustain our mission by being profitable.

We are one Molina.

Molina History



Founded in 1980 by Dr. C. David Molina

Single clinic

Commitment to provide quality healthcare to those most in need and least able to afford it

National company that serves over 3.5 million Medicaid beneficiaries

28 states, 2 commonwealths + Washington DC

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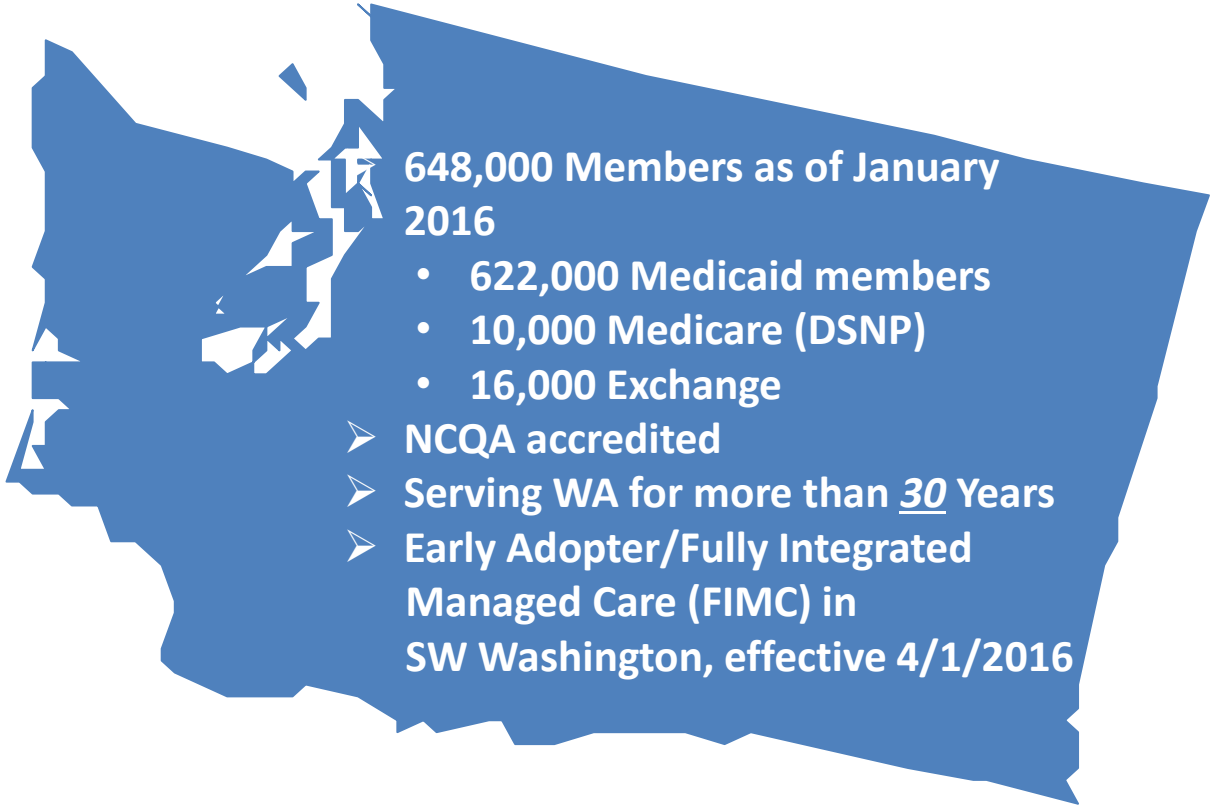
Molina in Washington



- 648,000 Members as of January 2016
  - 622,000 Medicaid members
  - 10,000 Medicare (DSNP)
  - 16,000 Exchange
- NCQA accredited
- Serving WA for more than ***30*** Years
- Early Adopter/Fully Integrated Managed Care (FIMC) in SW Washington, effective 4/1/2016

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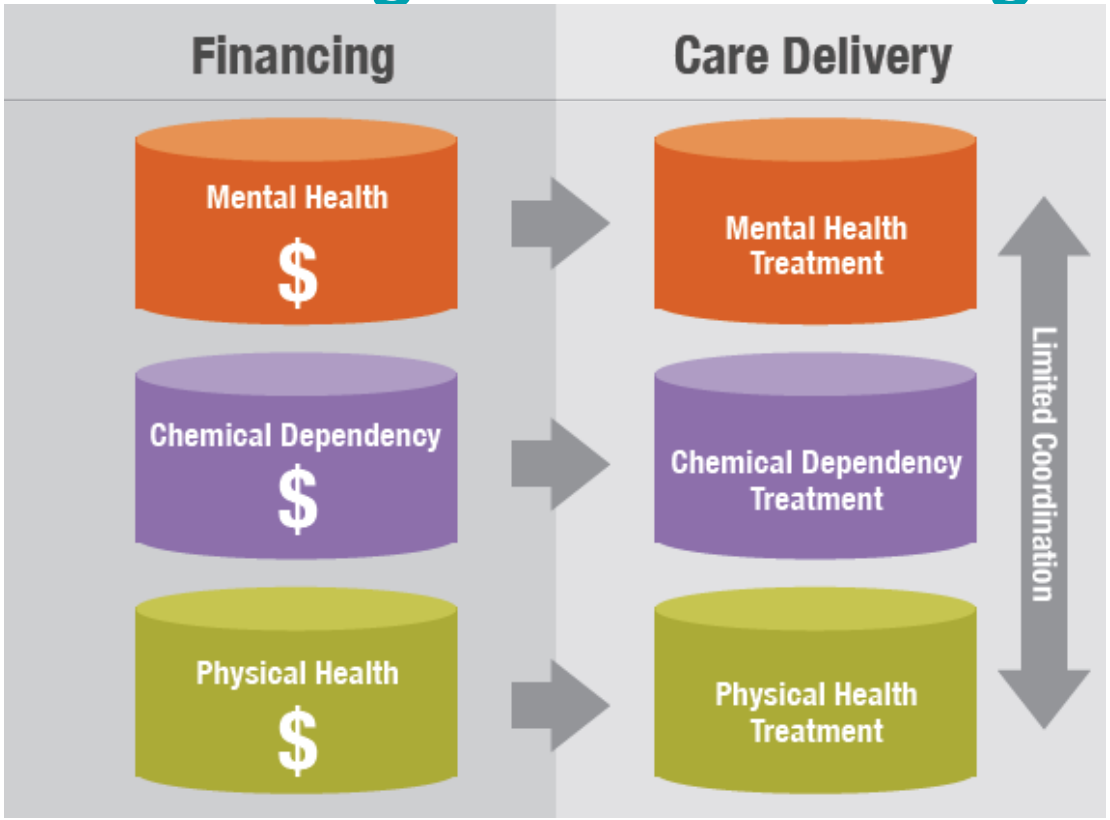
Current State – Fragmented financing and care



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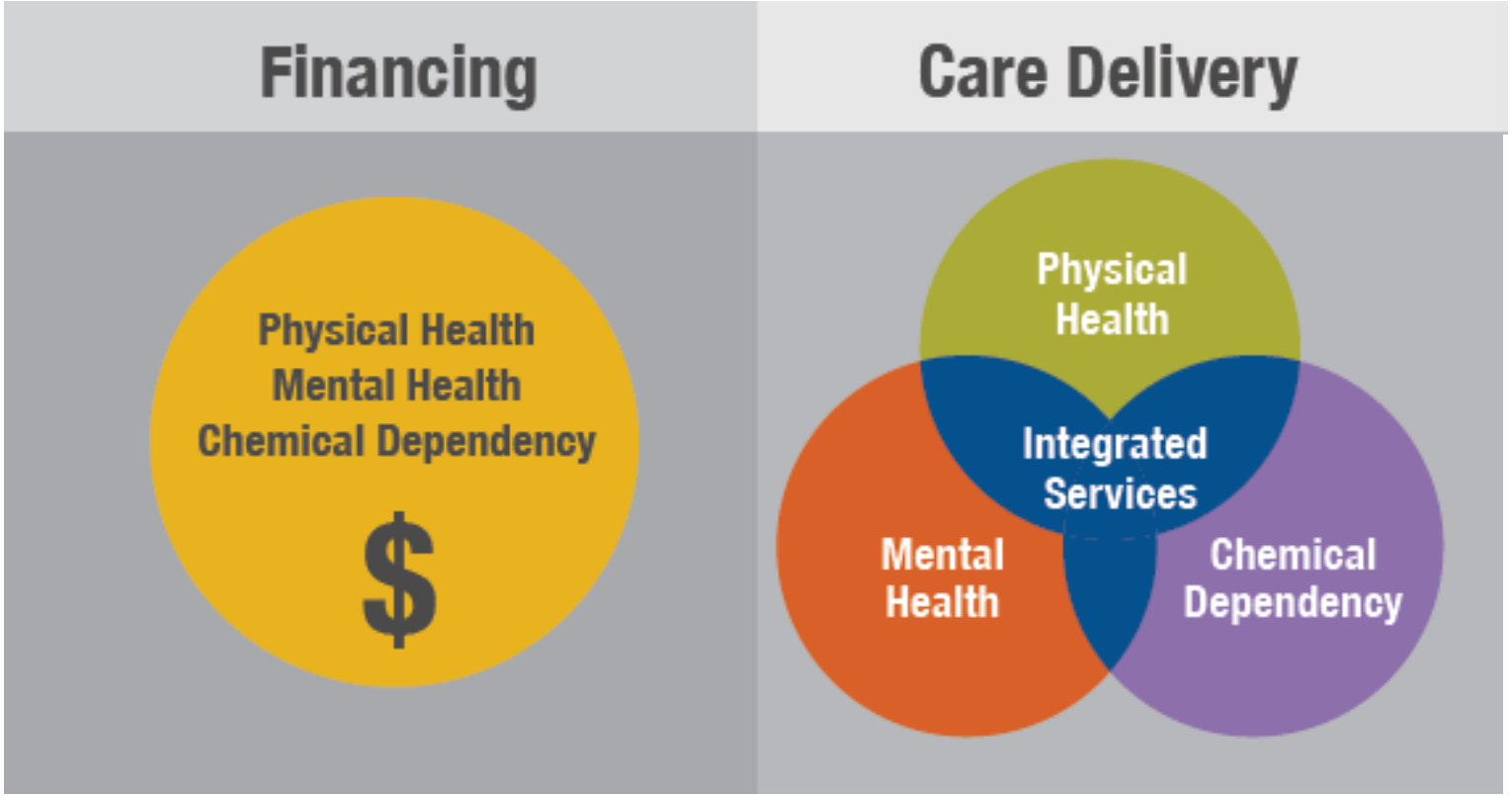
Future State – Integrated financing = Integrated care



What does better look like?

Better medical care and outcomes for people living with chronic mental illness

Better identification and treatment of behavioral health conditions in primary care

Better integration of fragmented system through care coordination – no falling through cracks

Better inclusion of Social Determinants of Health

Triple Aim

- Better health outcomes
- Lower total cost of care
- Better Patient/ Provider experience

Molina's Approach to Implementation

Apply best practices, lessons learned from previous experience	• Currently manage Medicaid BH benefits in 6 states • BH Benefit for other lines of business (Medicare, Basic Health) • Washington Medicaid Integration Partnership
Collaborate with existing and new regional partners	• 6 years partnering with providers, community organizations • Active participation in RHA/ACH • Began outreach and education in April 2015
Innovative approaches to care to increase access	• Virtual urgent care • Tele-psychiatry • Peer support services
Contracting strategies to promote improved access and integration	• Integrated care delivery, i.e. co-located services • Co-occurring (MH/CD) disorders treatment services • Community-based services including Care Coordination

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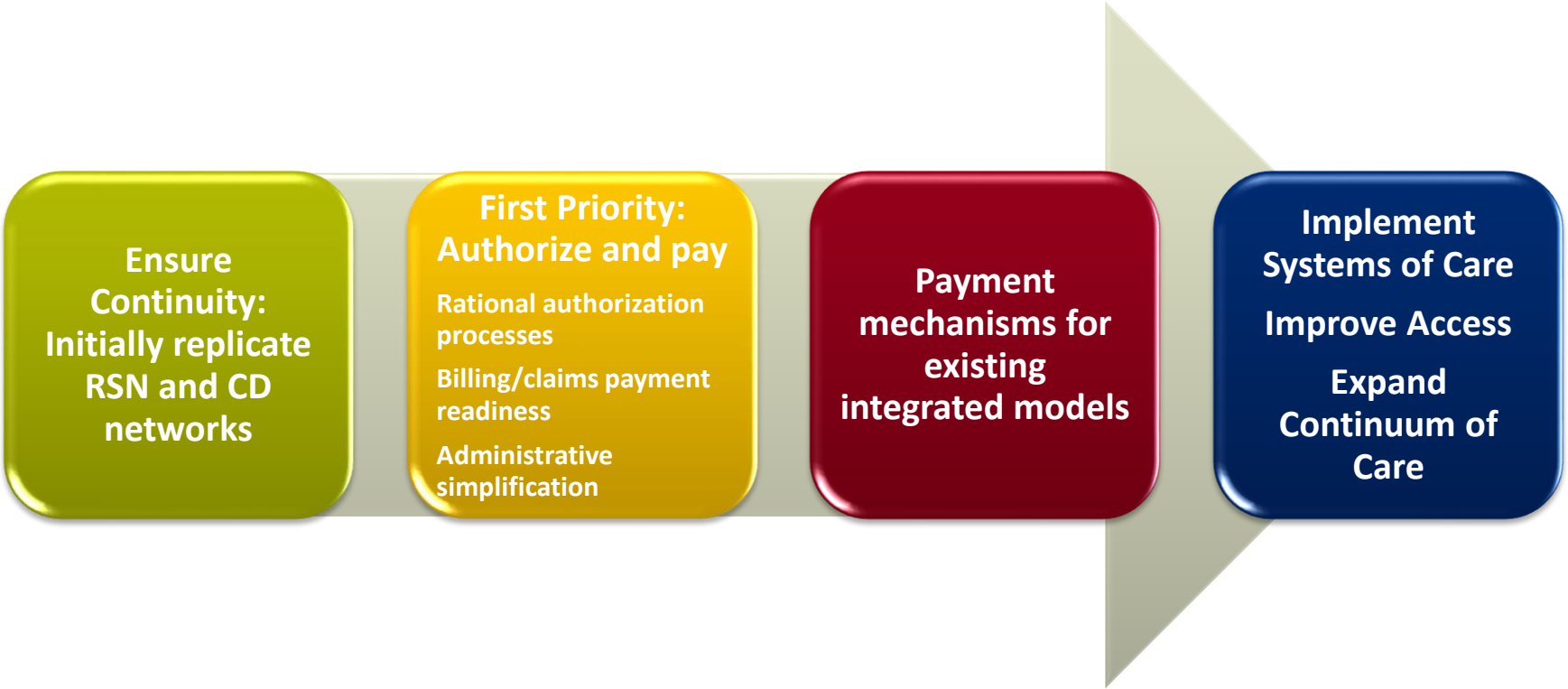
Fully Integrated Operations/Regional Design

Integrated in-house behavioral health functions	• Contracting and Provider Services • Utilization Management and Care Management • Claims payment and resolution
Behavioral Health expertise	• Employed behavioral health specialists
Member services staff	• Backed by behavioral health staff
Regional Service Center	• Located in Vancouver, WA • Local Care Coordination, Provider Services • Provider Engagement and Care Integration Teams

Behavioral Health Network



Integrated Care Delivery – "Systems of Care"

Co-location of service delivery

- Behavioral health specialists in primary care
- Primary care in behavioral health setting

Expanding "co-occurring disorders" treatment

- 40% co-occurrence rate

Facilitating primary care and behavioral health partnerships

- Referral processes
- Information exchange
- Complex case consultation/Care coordination

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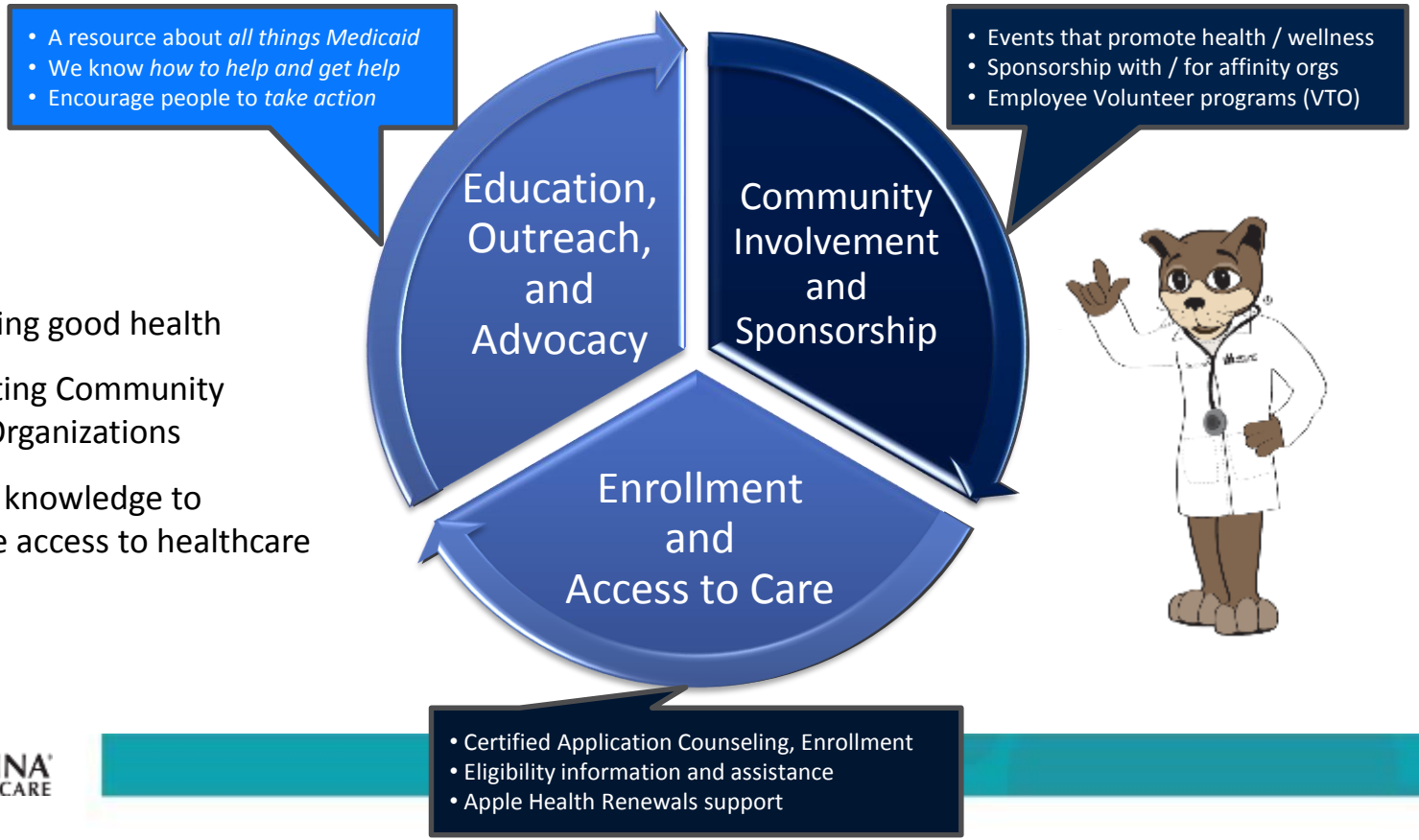
Molina's Community Engagement Team

- Promoting good health
- Supporting Community Based Organizations
- Sharing knowledge to increase access to healthcare



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Local SW WA Community Partnerships

- **Over 70 events and community meetings**
- **“Community Champions Awards” recognized Clark County residents:**
  - April Herndon, SeaMar (2013)
  - Dr. Susan Davis, Free Clinic of SWWA (2015)
  - David Bilby, Go Connect (2015)
- **Participation in regional health conferences:**
  - Integrated Care Conference
  - WA Behavioral Health
  - Latino Center for Health
- **Molina Foundation donated over 2,000 books to local schools**

FIMC and Care Management

We've always managed these members using an integrated approach

- Integrated teams – includes RNs and BH specialists (MH/CDP), BH MD
- Team-based consultation and co-management
- Single care plan incorporating all health domains

Exchange of information foundational to coordinated care

- Examples:
  - King County RSN data exchange
  - Snohomish County EMS
  - PreManage/EDIE

Community-based Care Coordination/Case Management

- Extensive Health Homes experience

Case Management Programs

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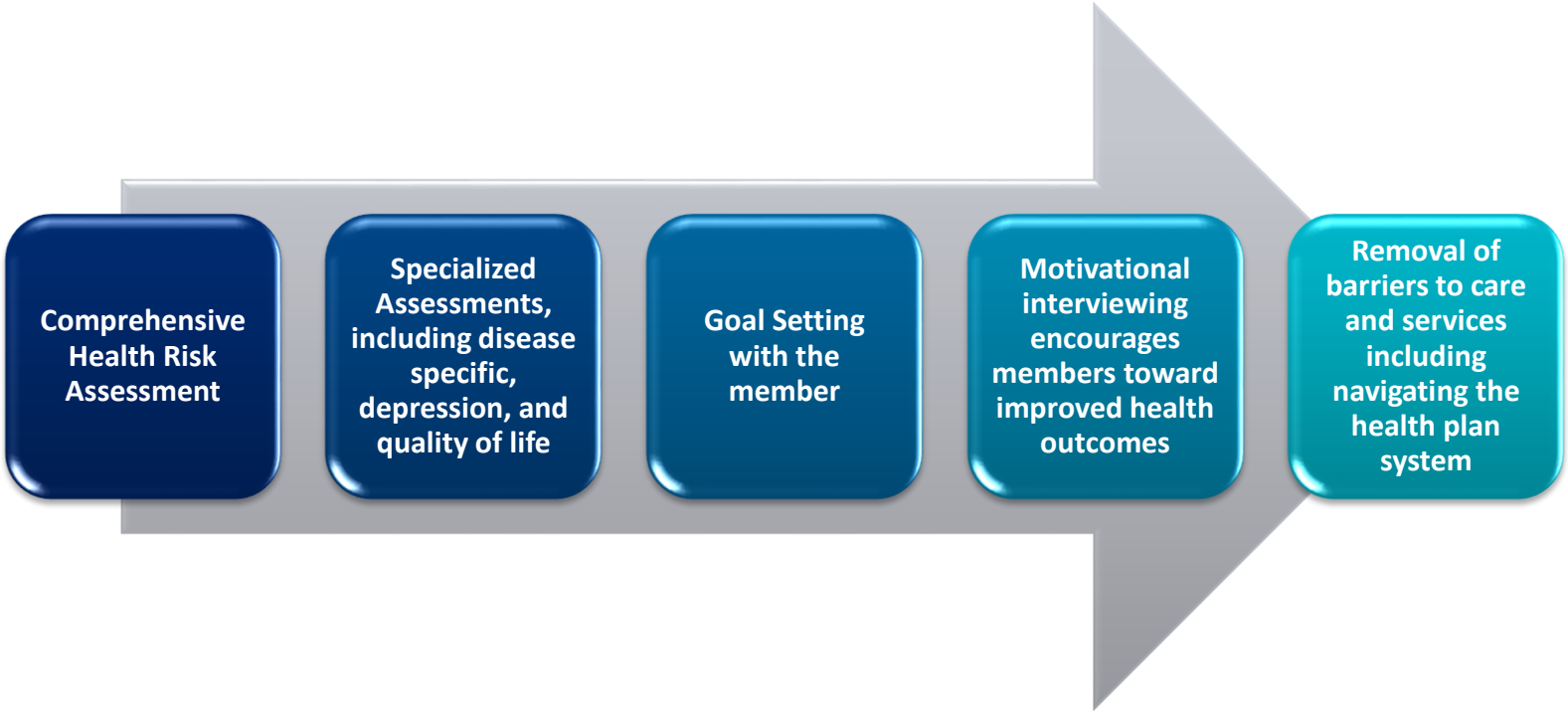
Case Management Process



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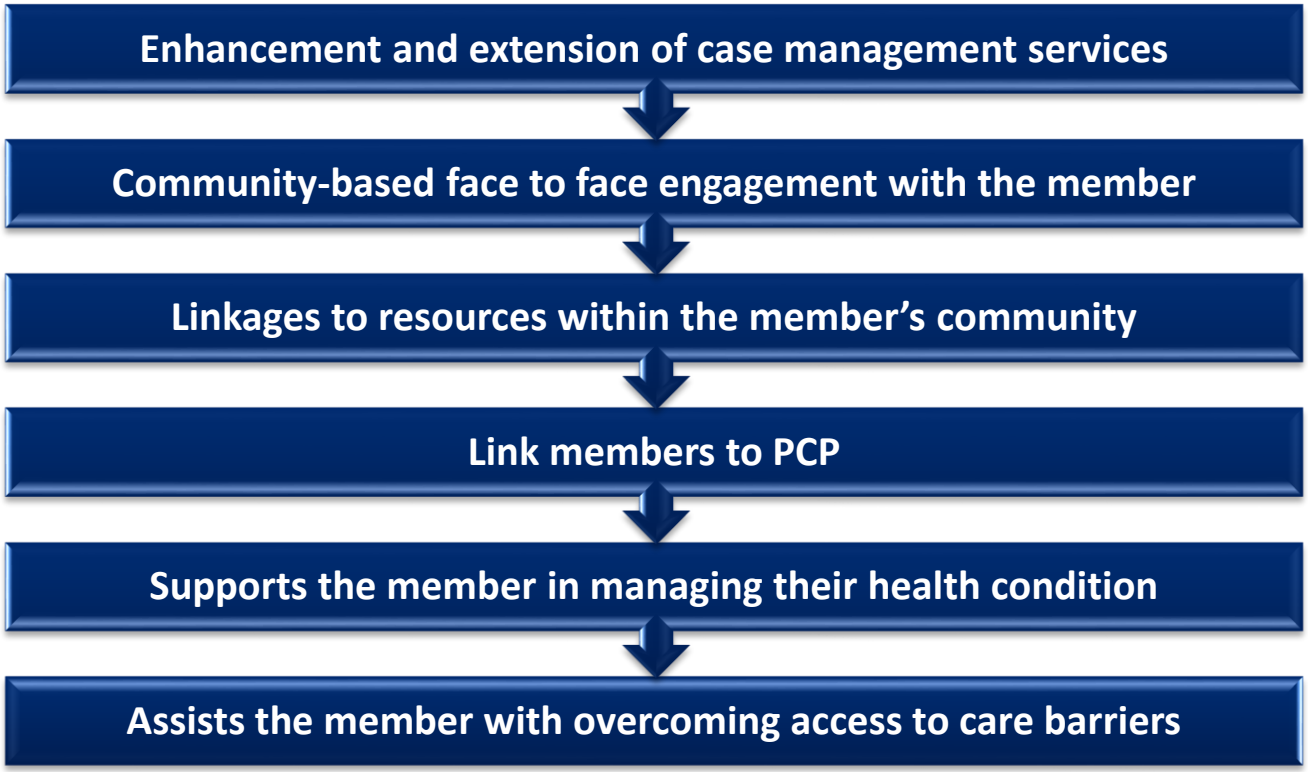
Community Connectors Program



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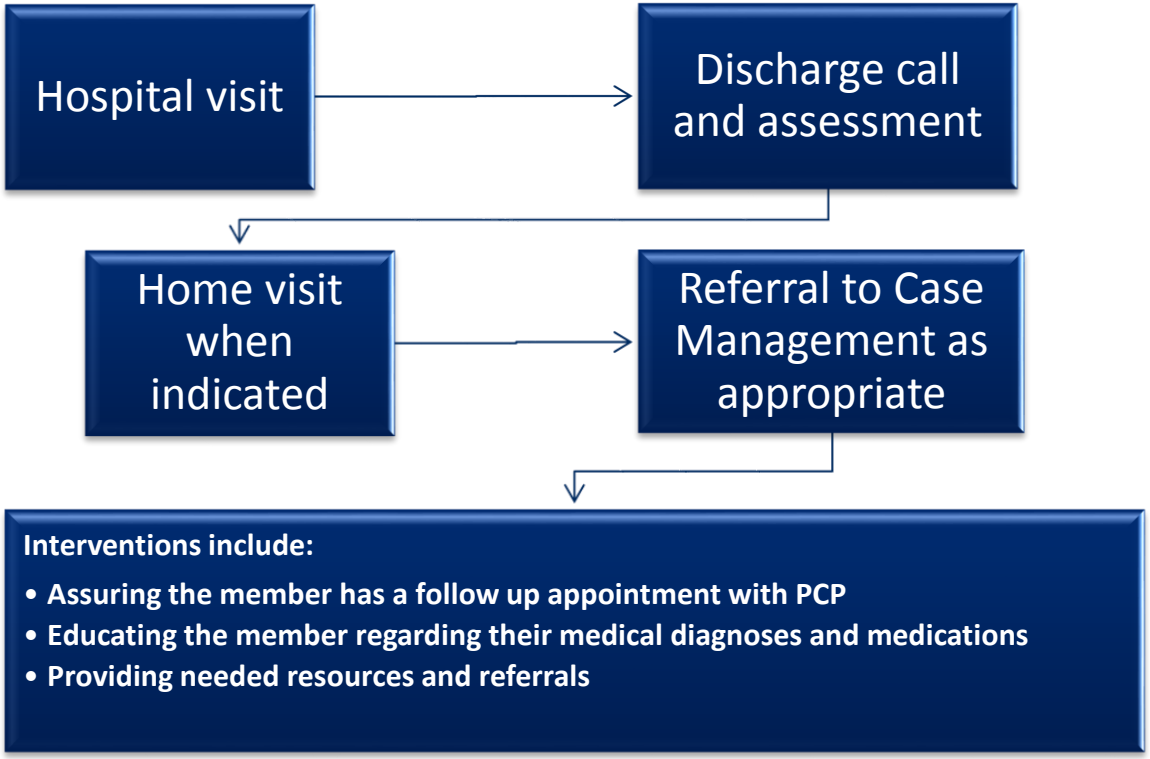
Transitions: Hospital to Home



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Health Homes Care Coordination

A Health Home is NOT a place

A Health Home IS the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically:

- Preventable hospital admissions/readmissions and avoidable emergency room visits
- Providing timely post discharge follow-up
- Improving patient outcomes by mobilizing and coordinating medical care, behavioral health and long-term care services and supports

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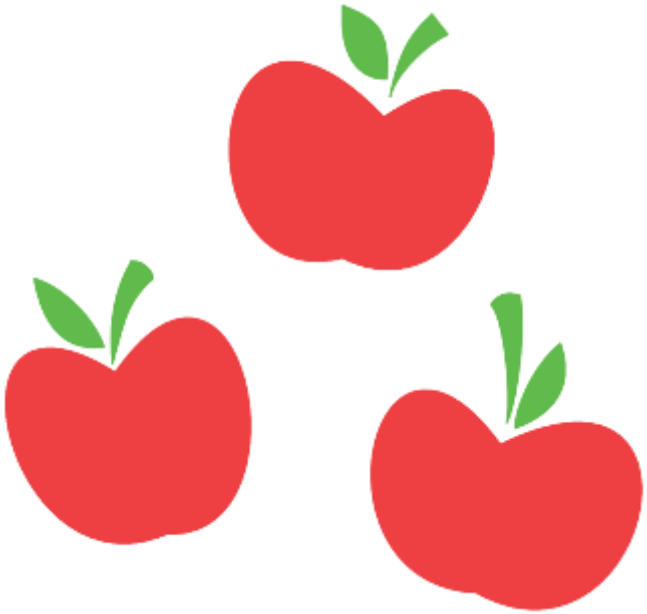
Health Promotion - Prevention Services

- Well Child Visits
- Immunizations
- Mammograms
- Colonoscopies
- Diabetic Measures



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Benefits of Case Management for Providers

- Reinforce and supplement information PCP's provide their Molina patients
- Improve medical compliance and management efforts
- Encourage patients to make healthy lifestyle changes and track health-related goals
- Remove barriers to care and refer them to needed services
- Partner with PCP's in developing and implementing case/disease management care plans
- Provide PCP's with progress updates, areas of concern, and problems identified
- Offer incentives to Molina patients to support healthy behaviors

What Does Success Look Like?

Decreases in unnecessary hospital utilization
Decreases in unnecessary hospital re-admission
Decreases in unnecessary ED use
Decreases in unnecessary EMS use

Increases in PCP visits
Increases in treatment adherence and medication reconciliation (RX)
Increases in flu vaccinations
Increased member and provider outreach and engagement
Improvement in disease-specific outcome measures
Increased compliance with HEDIS measures

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Case Management Referrals

Members can self-refer to Case Management by calling Member Services at 1-800-869-7165

Providers can request services by calling Member Services or faxing the Case Management Referral Form

Case Management referrals include:

- High utilizer of care
- Difficulty managing a chronic condition
- Psychosocial needs
- Assistance navigating health plan system
- Gaps in care

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What is new for Fully Integrated Managed Care?

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My Molina - Molina's Portable Personal Health Record

Key features include:

- HIPAA compliant, roles-based access
- Secure member portal
- Inter-disciplinary care team view
- Communication capabilities
- Access management by Molina case manager

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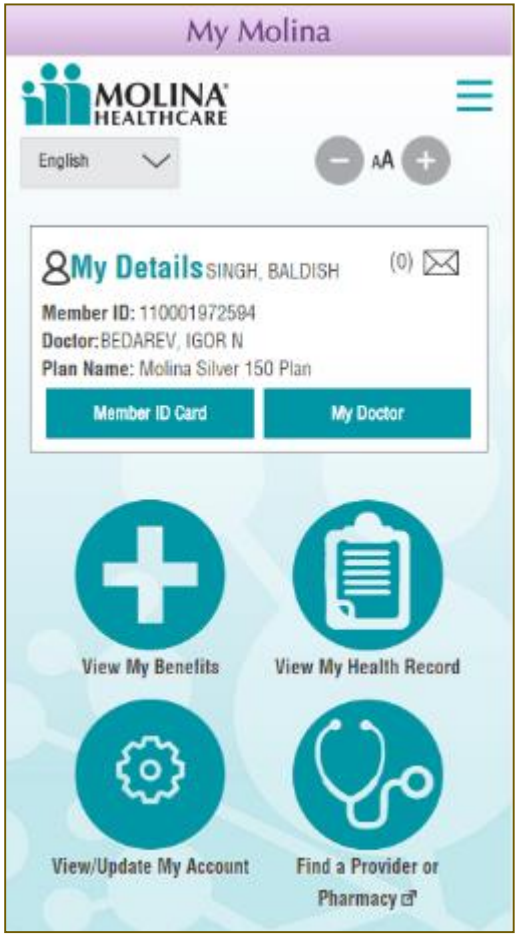

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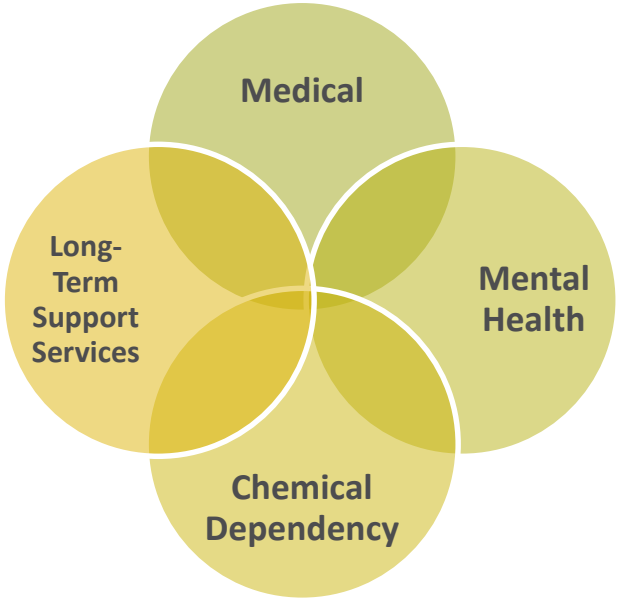
Member Home Page

Washington Medicaid Integration Partnership (WMIP)

Pilot program in Snohomish County to integrate Medicaid benefits into a single managed care plan (2006-2014)



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Successes – WMIP

Flexible Funding

- Allowed for effective investments of total health care dollars to improve quality, lower cost

Single plan

- Access to all health information improved integrated care coordination
- Single, comprehensive care plan
- Team-based approach: RN, BH Specialist, Care Specialist, CHW, Transitions

Integrated care delivery

- Flexible funding supported integrated care delivery models:
- Compass Clinic
- Embedded care management services

Improved outcomes

- Acumentra Health Evaluation of WMIP Program reported:
- Significant improvement in 7-day post-hospital follow up and Anti-Depressant Medication Management HEDIS measures
- Significant increase in outpatient visits coupled with significant decrease in ER visits

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WMIP Lessons Learned and Applied

Integration with other systems is critical

- Work closely with County leadership, crisis/first responder systems and community-based organizations
- Committed to coordination and collaboration with DSHS/BHOs

Difficult for providers to follow different authorization/billing practices

- Collaboration with CHPW and Beacon for Administrative Simplification
- Minimize changes to processes initially

Transition period for contract model changes

- Phased approach to introduction of new contracting models once initial transition is stable

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Questions?

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