Commission on Healthcare and Hospital Funding
David Pollack, Regional Vice President, Molina Healthcare
July 24, 2015
Agenda

• Introduction to Molina Healthcare
• Quality
• Healthcare Outreach
• Network Adequacy and Access
• Financial Performance and Managed Care Value
• Subscriber Story
Molina Healthcare

Established in 1980 by Dr. C. David Molina

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

Fortune 500 company that services over 3 million beneficiaries

11 states and Commonwealth of Puerto Rico
What makes us unique

We are a multistate healthcare organization with broad capabilities focused exclusively on government-sponsored healthcare programs for low income individuals and families.

Managed Care
Health Plans

Risk-based health plan outsourcing for Medicaid and other government programs.

Medicaid Health
Information Mgmt.

Non-risk fee based fiscal agent services, business process outsourcing, and care and utilization management.

Healthcare
Direct

Company owned or company operated primary care community clinics.

No other company in the Medicaid space can do all three

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Presence in key Medicaid markets

Health plan footprint includes 4 of 5 largest Medicaid markets

1. Total enrollment relates to effective memberships as of March 31, 2015.
2. Puerto Rico commenced operations on April 11, 2015 and is not reflected in the total membership count.
<table>
<thead>
<tr>
<th>Description</th>
<th>What is it?</th>
</tr>
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<tbody>
<tr>
<td>HEDIS</td>
<td>Measurement of preventive and chronic disease care (well child visits, diabetes management, blood pressure, immunizations, etc.).</td>
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<tr>
<td>MMA/LTC Performance Measures</td>
<td>Combination of HEDIS and Florida defined measures included in MMA and LTC Contract – significant dollars at risk for non-performing plans</td>
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<tr>
<td>CAHPS</td>
<td>Member satisfaction with plan and providers</td>
</tr>
<tr>
<td>STARS</td>
<td>Assessment of Medicare member care and operations</td>
</tr>
<tr>
<td>Provider Surveys</td>
<td>Provider Satisfaction with plan practices, including member services, claim operations and utilization management</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Basic standards of health plan operations to maintain quality member care; Combination of policies, procedures, healthcare operations and HEDIS/CAHPS scores</td>
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What is quality?

• For over 35 years, quality has been at the foundation of Molina Healthcare.

Quality means:

• Improving access
• Removing barriers to care
• Providing a positive customer experience
• Delivering preventive and diagnostic care
• Enhancing health outcomes for our members
• Assist in ensuring right care, setting, time
Molina Care Model

The Model of Care confirms/reestablishes the member’s connection to their Medical Home. Ensures appropriate use of services and facilities.

- High touch
- Focus on care transitions
- Prevention of hospital admissions/readmissions
- Appropriate ER utilization
Healthcare Outreach

• Proactive Outreach
  – Identification of preventative needs (HEDIS)
  – Community Connector program – removal of barriers to care

• Clinical Collaboration
  – Transitions of Care – assistance from one healthcare setting to the next
  – Case Management for high risk, disease conditions and social issues
  – Prescription management and reconciliation

• Emergency Room Diversion
Network adequacy and access to care

**What they cover today**

- Ratios of number of providers for each member
- Time and distance
- Originally built in response to competitive procurement

**Future Considerations**

- Provider quality
- Whether the provider offers expanded access
- Electronic medical records
- Whether the provider is accepting new members
- Patient centered medical homes

Result is large, broad networks

Empirically, little correlation has been demonstrated between the size of a network and the quality of care provided as measured by CMS hospital performance metrics

<table>
<thead>
<tr>
<th>Hospital based value purchasing score</th>
<th>Patient experience: % who would recommend the hospital</th>
</tr>
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<tbody>
<tr>
<td>Broad network</td>
<td>45.90% 45.90% 46%</td>
</tr>
<tr>
<td>Narrow network</td>
<td>70.40% 71.90% 71%</td>
</tr>
<tr>
<td>National Average</td>
<td></td>
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</table>

CMS hospital performance measures by network breadth (n = 2,100)

- Broad network standards add no discernable value to the quality of care provided as evidenced by a 2014 McKinsey study & other empirical analyses
- They result in low member/provider ratios so providers don’t have an incentive to pay attention to the care coordination and care management efforts of partner health plans because the number of affected patients is so small
- They tend to drive up costs by reducing the leverage a health plan has to negotiate lower unit costs with the provider

Source: "Hospital networks: updated view of networks on exchanges", McKinsey Center for US Health System Reform, 02-2014
## Value based reimbursement (VBR) continuum

<table>
<thead>
<tr>
<th>Phase</th>
<th>Payment opportunity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Base Medicaid / Medicare Compensation</td>
<td>Initial contracting period of FFS payments and expertise with government-sponsored health program fee schedules (Medicaid/Medicare)</td>
</tr>
</tbody>
</table>
| II    | Quality Bonus Partner Programs:  
• Pay-For-Performance  
• Patient Centered Medical Home Incentive | Additional compensation opportunity for (i) PCP performance tied to quality measures such as HEDIS, and (ii) PCMH qualification with credentials and modules certifications |
| III   | Quality Bonus Partner Programs:  
• Coordination of Services Incentive  
• Hospital Improved Outcomes | Additional compensation opportunity for (i) provider coordination of services and care transition support, and (ii) hospital outcomes based measures such as ER visits and readmissions |
| IV    | Risk Sharing and ACOs:  
• Gain Share or Shared Risk Models  
• Accountable Care Contracting | Additional compensation from share in savings or risk resulting from improved care quality and outcomes with potential to move to accountable care contract including upside/downside risk based on benchmark data and quality measures |
<table>
<thead>
<tr>
<th>Description</th>
<th>Pre- MMA 2014</th>
<th>MMA Q3 14</th>
<th>MMA Q4 14</th>
<th>MMA Q1 15</th>
<th>Total MMA</th>
</tr>
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<tbody>
<tr>
<td>Member months</td>
<td>478,634</td>
<td>207,107</td>
<td>341,253</td>
<td>476,410</td>
<td>1,024,770</td>
</tr>
<tr>
<td>Premium revenue ($000s)</td>
<td>$127,577</td>
<td>$48,002</td>
<td>$79,723</td>
<td>$112,863</td>
<td>$240,588</td>
</tr>
<tr>
<td>Direct medical costs ($000s)</td>
<td>$104,102</td>
<td>$46,907</td>
<td>$74,406</td>
<td>$112,420</td>
<td>$233,733</td>
</tr>
<tr>
<td>Medical cost ratio</td>
<td>81.6%</td>
<td>97.7%</td>
<td>93.3%</td>
<td>99.6%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Per member premium</td>
<td>$266.54</td>
<td>$231.77</td>
<td>$233.62</td>
<td>$236.90</td>
<td>$234.77</td>
</tr>
<tr>
<td>Per member medical cost</td>
<td>$217.50</td>
<td>$226.49</td>
<td>$218.04</td>
<td>$235.97</td>
<td>$228.08</td>
</tr>
</tbody>
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Note: Target MCR set at 87% - 88% MCR; target of 2% margin
Hospital Contracting

• Hospital rates to health plans have increased over time and more recently under MMA:
  – Hospitals critical component of network
  – Procurement offered differential (higher) scoring for contracts with providers and hospitals, rather than Letters of Intent or other interim agreements.
  – Contracts with defined rates and length were executed prior to MMA implementation and plan MMA contract execution with AHCA.
  – Policy change in July 14 lowered Medicaid FFS rates
    • Proviso language did assist plans
    • Not all contracts tied payment rates to Medicaid FFS rate
  – Statutory protections for specialty children hospitals
Value of managed care

- Texas study conducted by Milliman
- Medicaid managed care resulted in cost reductions of nearly $4 billion over 6 years
- Projected to save an additional $3.3 billion over the next 3 years
- Amounts compared to what prior fee for service model would have cost
- Bulk of savings come in Year 3 of program and forward – plans need time to implement quality and healthcare outreach programs
- AHCA Waiver report to CMS (budget neutrality) shows $5.7 billion in savings last fiscal year
Why we are here

Single mother with six children under the age of 7. Mother and children had not received any preventative care prior to joining Molina. With Molina’s assistance, all needed preventative and follow up care was provided. Molina also linked the family to community resources for other needs.