Arkansas Health Care Reform Legislative Task Force

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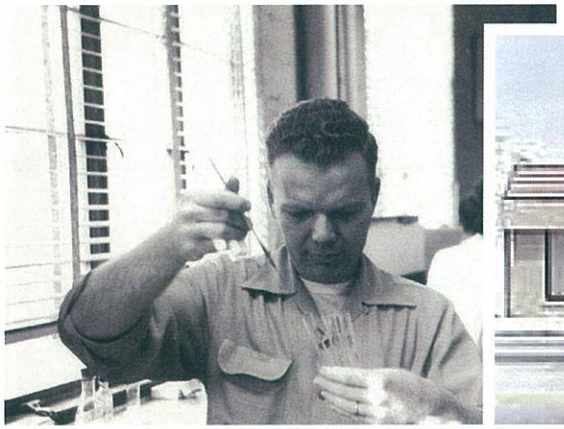

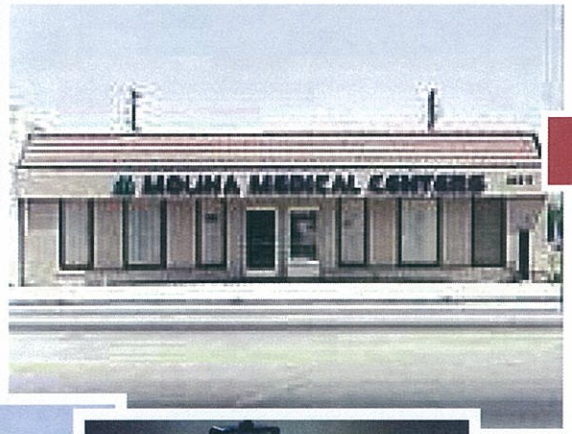

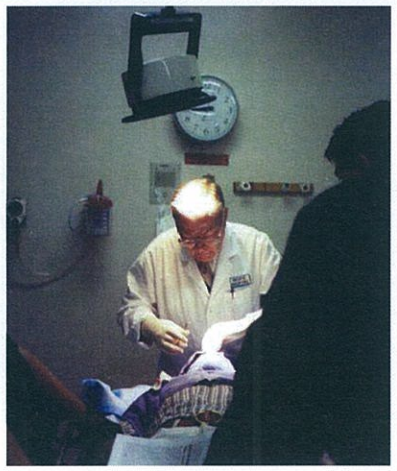

Founded in 1980 by Dr. C. David Molina

Single clinic

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

Fortune 500 company that touches over 7 million Medicaid beneficiaries

16 states & 2 territories

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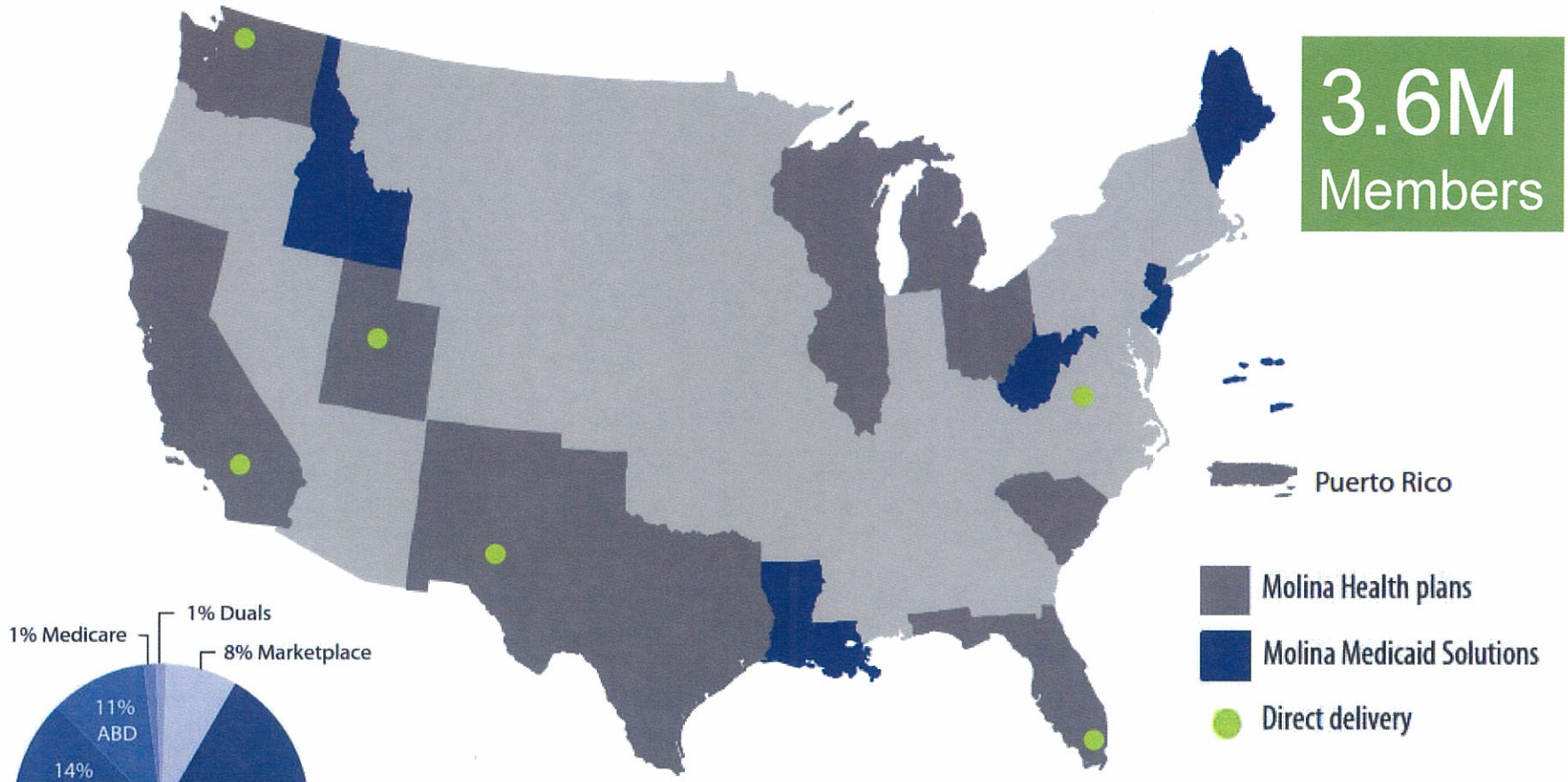
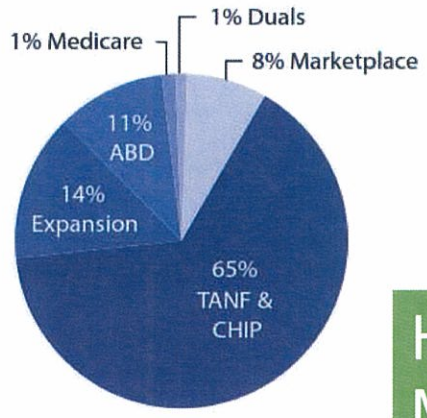
Presence in Key Medicaid Markets





Health Plan footprint includes 4 of 5 largest Medicaid markets

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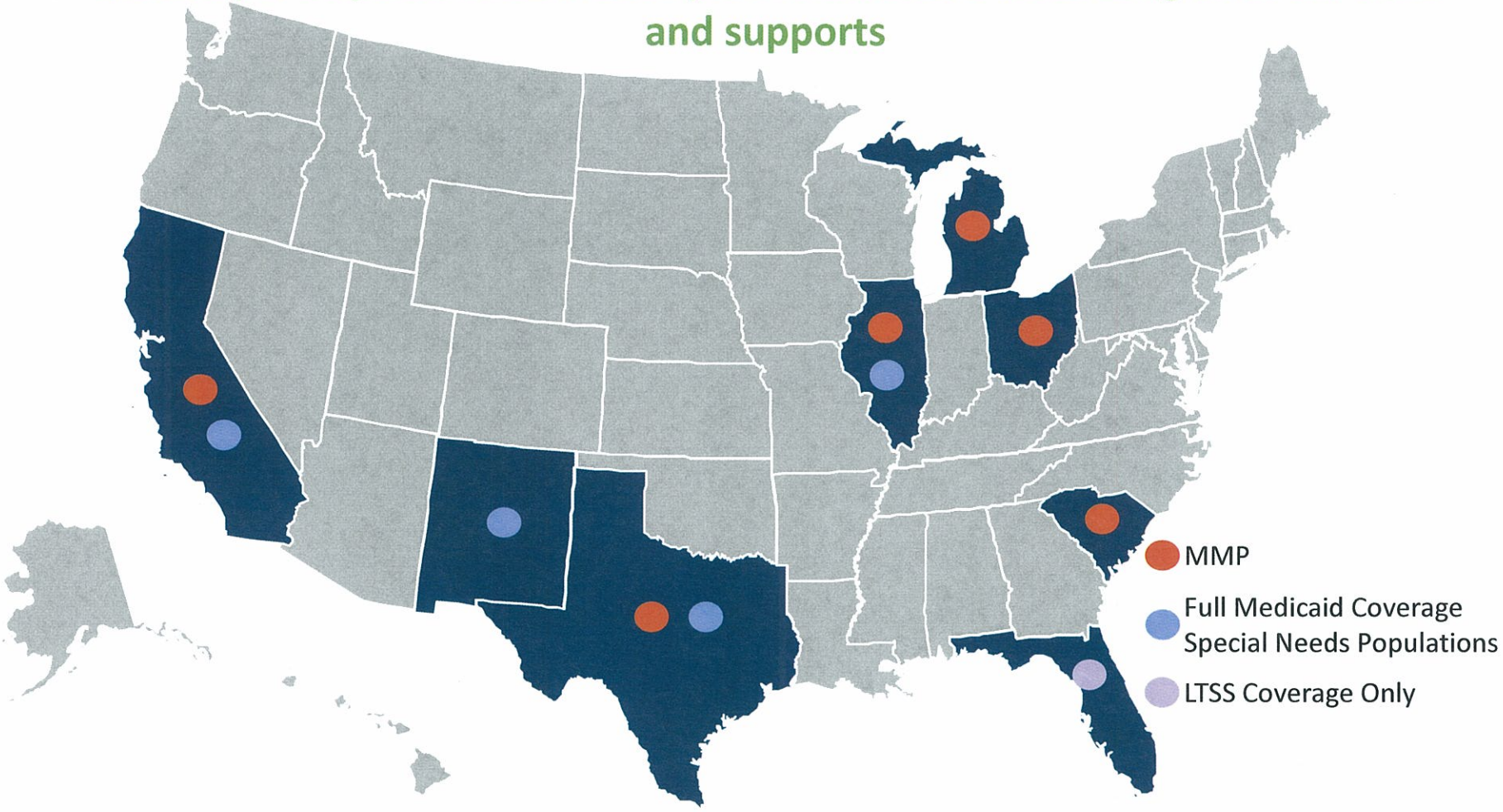
Molina National Experience – LTSS

Molina participates in 12 health plan locations: 8 have Long term services and supports



54,051 Molina MMP Members[1]

The most among all plans

[1]As of Aug 2015

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Managed Care Goals

Improving quality and access while decreasing cost

Quality must come first

Maintain highest quality of life in the least restrictive setting possible

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The Molina Model of Care

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

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Effective Care Management – Meet Members Where They Are

Opportunity: Our experience indicates that MLTSS populations do not respond to telephonic, mailed communications

Solution: Research teams and Community Connectors

Research teams

- Mine data to find member information: claims data (including Rx), community databases, public databases, internet searches
- Telephonic outreach: member (including family, friends), physicians, pharmacies, housing authorities, community organizations

Community Connectors

- Local, non-clinical members of the community
- Strong relationships with community based organizations, ADRC, others
- Feet on the street – find the members, build relationships, pave the way for Care Coordinators

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Transition from Institutional Care

Molina transitioned 1,600 individuals back to the community (approximately 8%)

Highest in programs where Molina directly manages all aspects of patient care (i.e. no service carve-outs)

Individualized care plans including:

- Enrollee
- Caregiver
- Primary Care Physician
- LTSS providers
- Molina Case Managers

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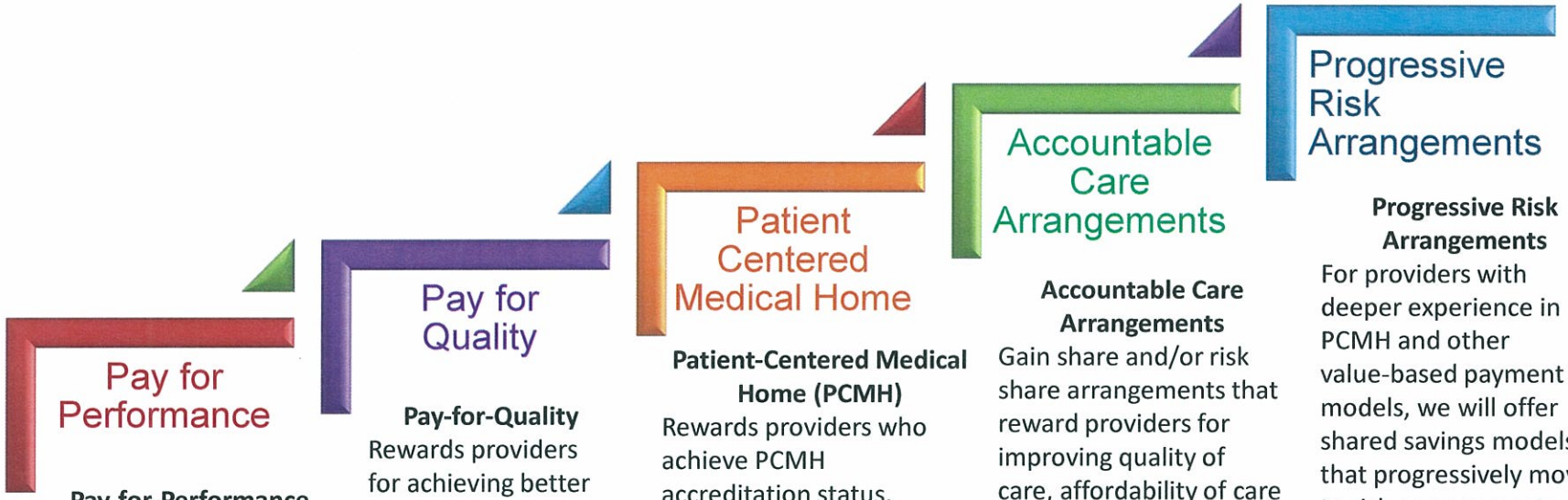
Value Based Provider Reimbursement Strategies: The Continuum



Pay-for-Performance
Rewards providers if they demonstrate core competencies to provide quality care, enhance access, and improve health outcomes (e.g. after hours care, open panel, etc.) - often used as a stepping stone to PCMH.

Pay-for-Quality
Rewards providers for achieving better performance on a broad spectrum of HEDIS/STAR measures and utilization metrics for their member panel.

Patient-Centered Medical Home (PCMH)
Rewards providers who achieve PCMH accreditation status. Compensates providers for engaging in practice and team-based transformation that increases the level of care coordination for our members while having them agree to do key activities that have shown to improve quality of care, access to care and improves health outcomes and member satisfaction.

Accountable Care Arrangements
Gain share and/or risk share arrangements that reward providers for improving quality of care, affordability of care and member care coordination, while lowering the overall cost of care.

Progressive Risk Arrangements
For providers with deeper experience in PCMH and other value-based payment models, we will offer shared savings models that progressively move to risk arrangements over time.

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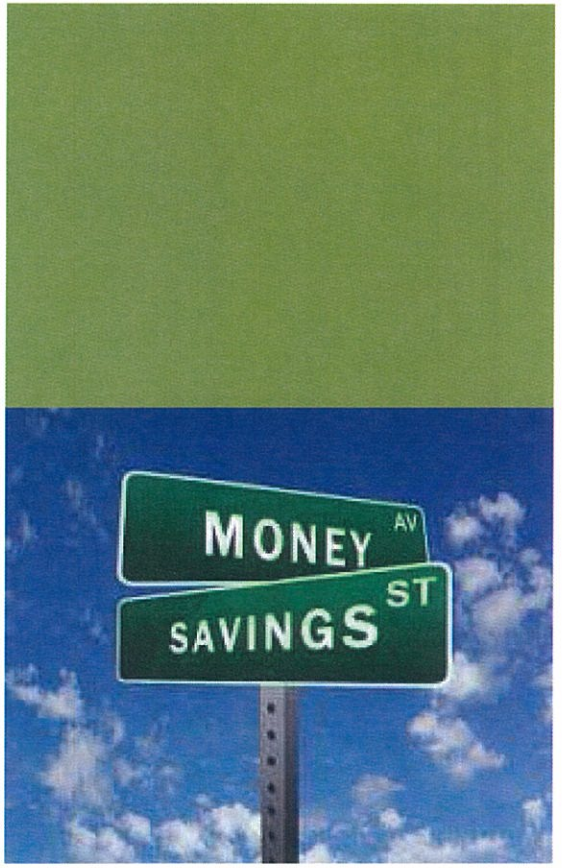
Cost Savings

- Managed care will yield costs savings in areas that increase quality
  - Transition from Institutional Care
  - Reduction to inpatient admissions
  - Elimination of duplicative and unnecessary pharmacy costs
- FL Home and Community Based rates decreased effective September 2015
- Molina has had 3 year reductions in traditional TANF rates - OH, TX, UT, WA
  - Between 1% and over 6% reduction



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