Integration of Primary Care into Urgent Care

Reduce Risk by Diversifying Revenue while Improving Quality

California URGENT CARE ASSOCIATION

Garret Tedesco, MPH, MCHES

COPE Health Solutions

COPE Health Solutions
Your Partner to Improve Growth, Quality and Financial Performance

National tech enabled services firm powering success in risk arrangements for payers and providers – growing membership and premium market share

Deep expertise, experience, proven tools, and processes improve financial performance and quality outcomes for all types of payers and providers, de-risking the roadmap to advanced value-based payment

Mission

Improve Quality and Financial Performance through accelerated value-based care transformation

Vision

Our clients are leaders in adding value for consumers through innovations in population health management, talent development, and alignment of financial incentives

Values

- Live and work with **integrity**
- Foster **access** to health care
- Assure the highest **quality**
- Support through **teamwork**
- Generate change through **innovation**
- Succeed by taking **initiative**

ISG

'**Rising Star**' in Healthcare Interoperability
'**Leader**' in Payer Digital Transformation Services
'**Leader**' in Value Based Care
- Healthcare Digital Services 2022

CERTIFIED NCQA DATA AGGREGATOR VALIDATION CERTIFIED DATA PARTNER

ARC Platform has earned Certified Data Partner designation in the new National Committee for Quality Assurance (NCQA) Data Aggregator Validation program.

KLAS RESEARCH

ARC Platform received KLAS Research recognition for providing analytics and visualizations of population health data

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Garret Tedesco, MPH, MCHES is a Director at COPE Health Solutions with more than 15 years experience in Network Management across numerous providers, IPAs and health plans.

Extensive leadership experience in public and private health plans, Independent Physician Associations (IPA), Third Party Administrators (TPA) and in-depth knowledge of the delivery care system

Former Director of Network Management for the largest California IPAs, building Provider networks in multiple states

Topic & Roadmap

Our discussion will be focused on leveraging primary care and select services to access more of the available premium dollars through advanced value-based payment and various risk agreements.

We will outline the steps to integrate primary care and how to incrementally increase risk as capabilities as program build out and performance is accomplished. This will include considerations for medical group or IPA network approaches, as well as MSSP ACO and the expected next version of ACO REACH, along with reviewing key market and strategy considerations.

We will be examining strategies for building out and supporting utilization of existing internal medical infrastructure to best code and manage chronic conditions.

Requirements and options for necessary management capabilities will be reviewed, such as credentialing, advanced population health management, data warehouse and analytics, care management models, workflows and platforms, network management strategies and MCP/ IPA contracting options when considering moving into risk arrangements.

Why Enter the Primary Care Market?

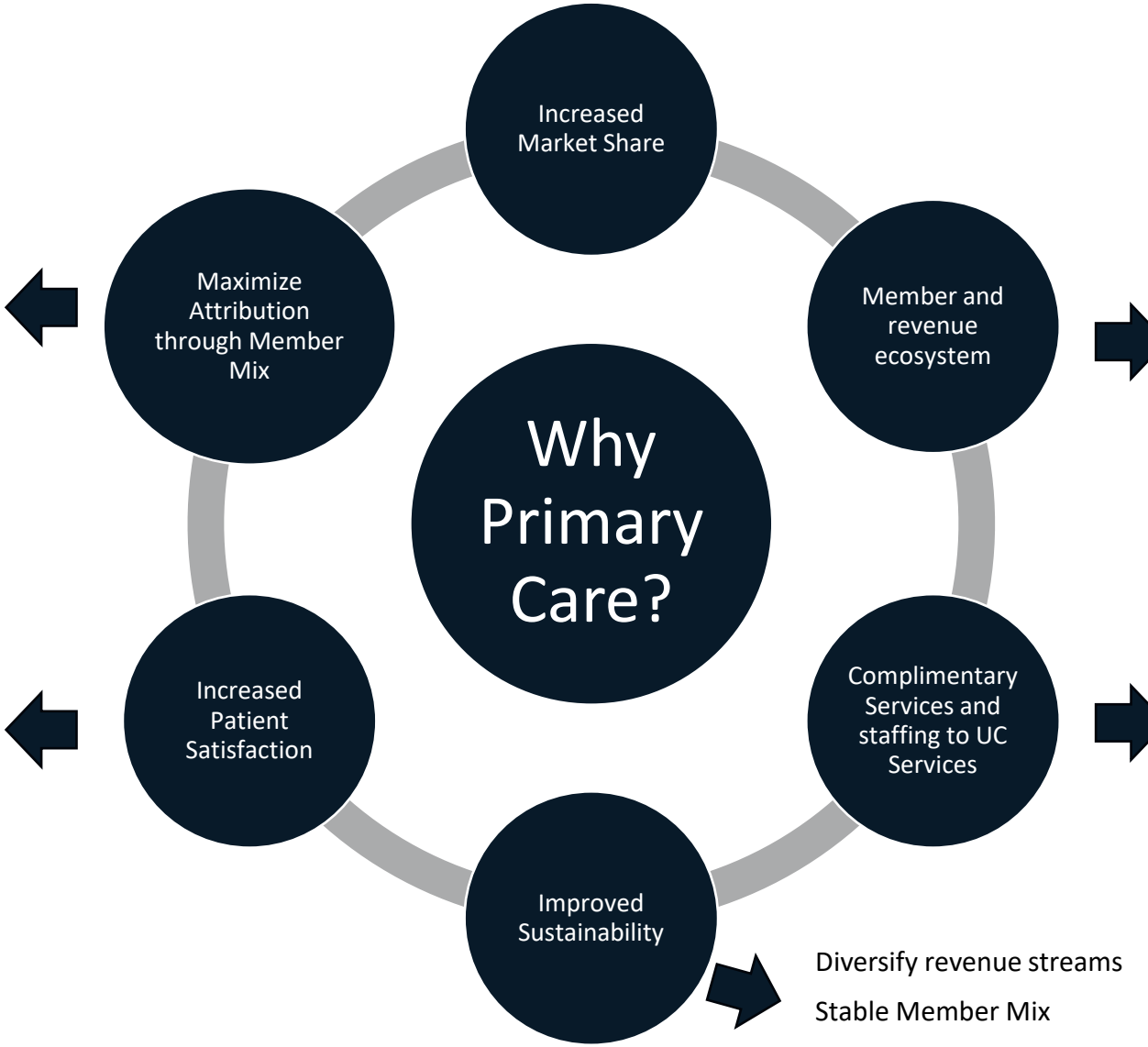
40% of Californians are Medi-Cal recipients

1.6 million beneficiaries are Dual-Eligible

All MCPs are required to have D-SNP programs

5 million Californians are in a Medicare beneficiary plan

14 million Californians enrolled commercial products



Growing your panel through walk-ins

Ability to generate revenue off all patient interactions, as well as primary care capitation for attributed members, quality bonuses and more

Acute care management and care transitions along with chronic, complex and disease management

Diversify revenue streams

Stable Member Mix

Quality and Waiver Incentives

More direct ability to impact

Increased Access and ease of use

Increased Quality of Care

Source: DHCS, 2024

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Market Assessments

Deep Dive into your Market Entry

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Market Assessment Elements

CMS Files

CHS aggregates CMS public files into accessible formats to support high-level Medicare data benchmarking.

State Public Use Files

California aggregates Medi-Cal data by county and health plan to track market trends and assess opportunities.

CHNAs

Key health priorities in populations, focusing on trends, social determinants, and disease prevalence.

Uniform Data Systems

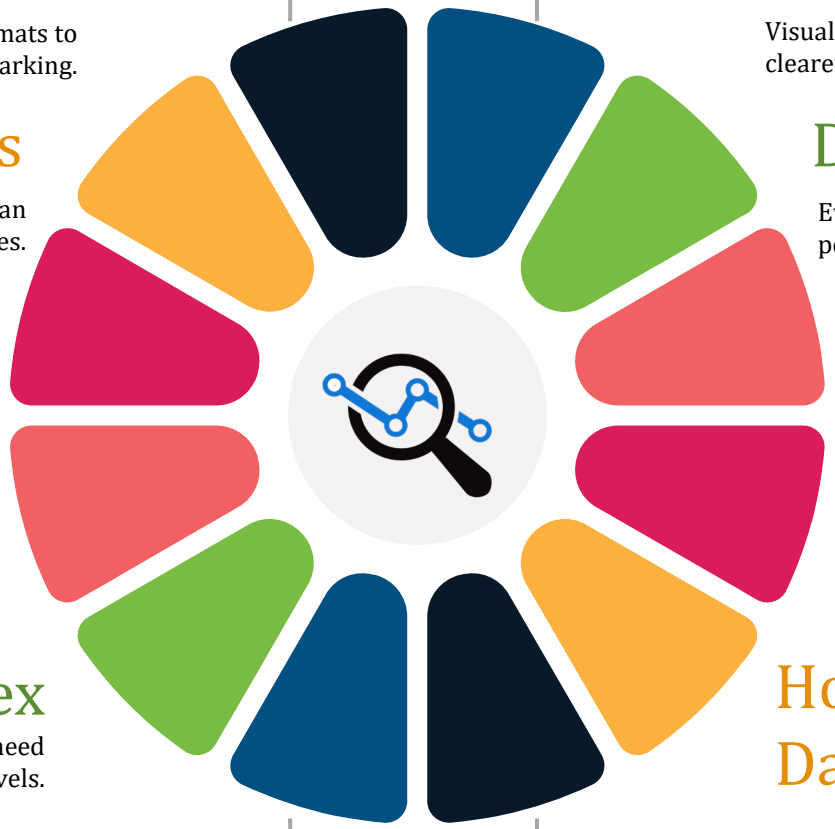
UDS captures FQHC performance and demographic data, enabling patient distribution mapping via the UDS mapper.

Area Deprivation Index

ADI and Social Vulnerability Index assess relative market need for targeted analysis at zip code levels.

American Hospital Directory

Supplies comprehensive data and analytics on over 7,000 hospitals nationwide.



Social Explorer

Visualizes demographic data layered on specific markets for a clearer understanding of market analysis results.

Definitive Healthcare

Evaluates hospitals, IPAs, and provider groups by revenue and performance for partnerships and network adequacy.

Sherlock Benchmarks

Health plan benchmarks that aid in building financial projections and strategic plans.

MACVAT-like Tools

Tool for evaluating product performance using CMS and ACA benefit data.

Hospital Price Transparency Data Aggregator

Details payer-specific prices for services by procedure and item.

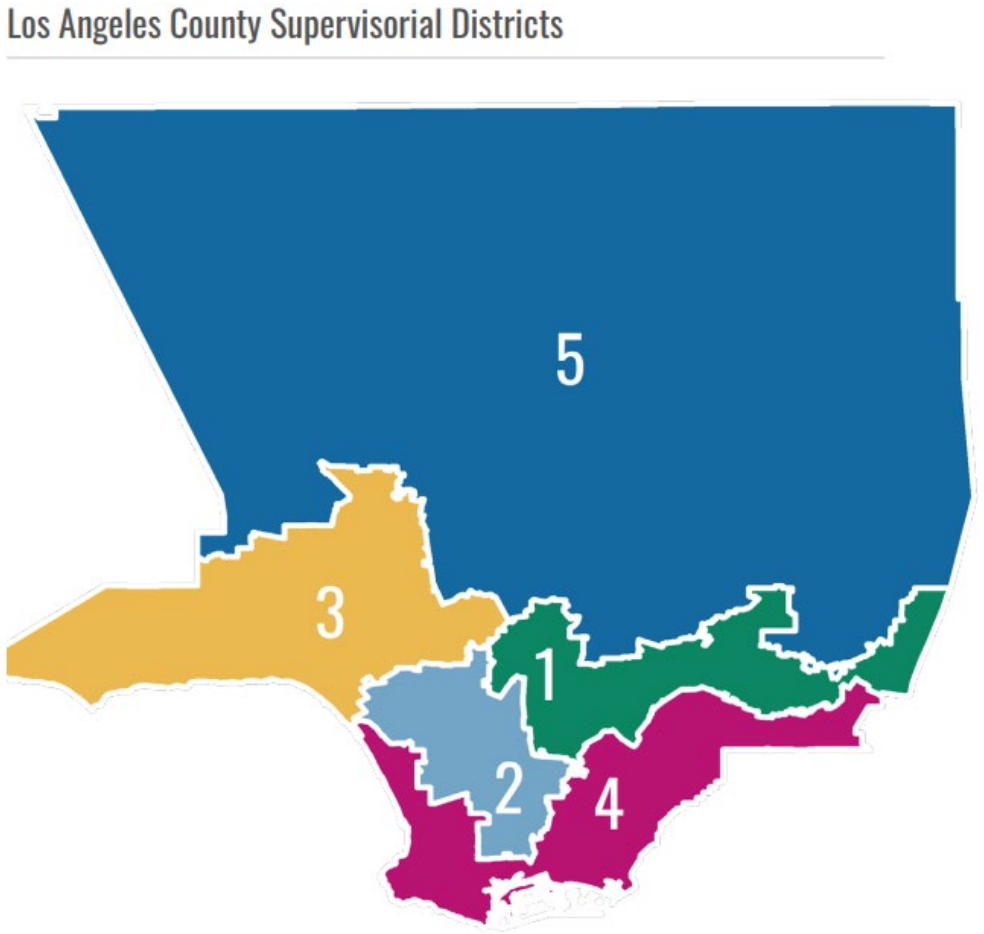
CHS ARC Network Adequacy Module

Analyzes network adequacy compliance for provider access by distance and travel time.

Market Assessment Detail Example

There are significant differences in the Primary Care Provider to population ratio across Los Angeles County

- In California, MCP contracted provider to member ratio is 1 PCP per every 2,000 members
  - The Health Resources and Services Administration (HRSA) considers the standard primary care provider to population ratio to be 29 per 100,000
- MCP network adequacy standards define a service area as either within 10-miles or a 30-minute drive from a location
- Supervisorial District 2 las the lowest primary care provider availability at approximately 54 PCPs per 100,000 people
- Supervisorial District 2 simultaneously has the highest uninsured rate of all LA Supervisorial Districts
- Supervisorial District 3 has the highest PCP availability in the County at approximately 132 PCPs per 100,000 people



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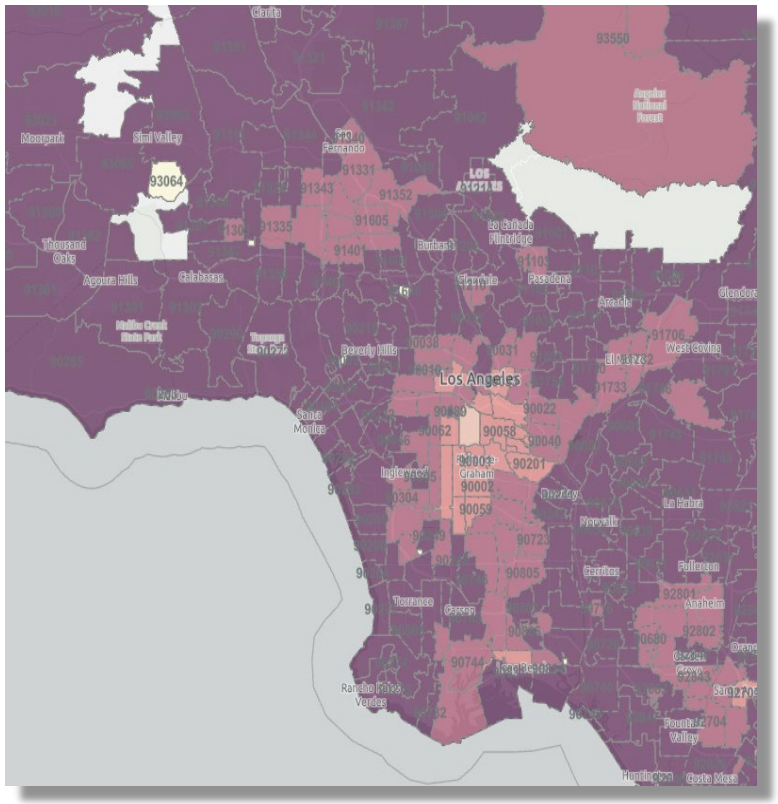
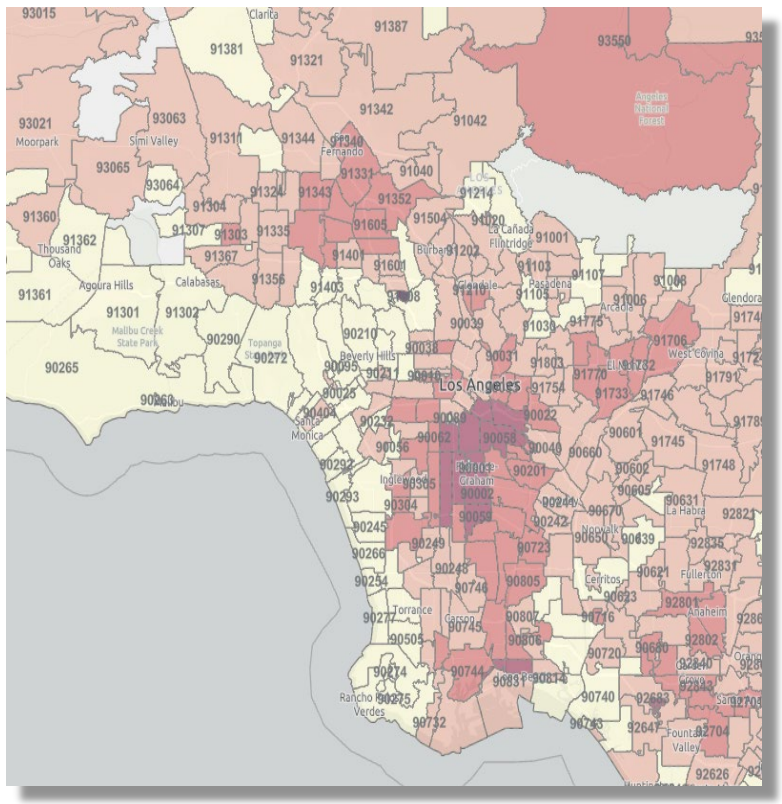
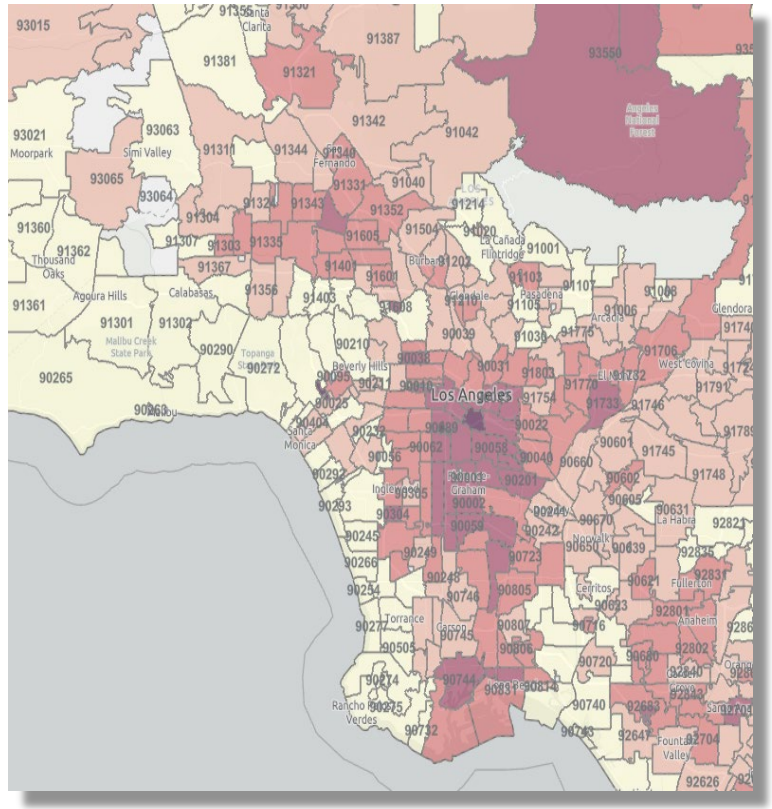
Source: Primary Care Development Corporation; Primary Care Access in Los Angeles County; 2020

County Overviews

Los Angles County is relatively diverse in terms of socioeconomic status, clearly depicted by income levels and insurance coverage estimates







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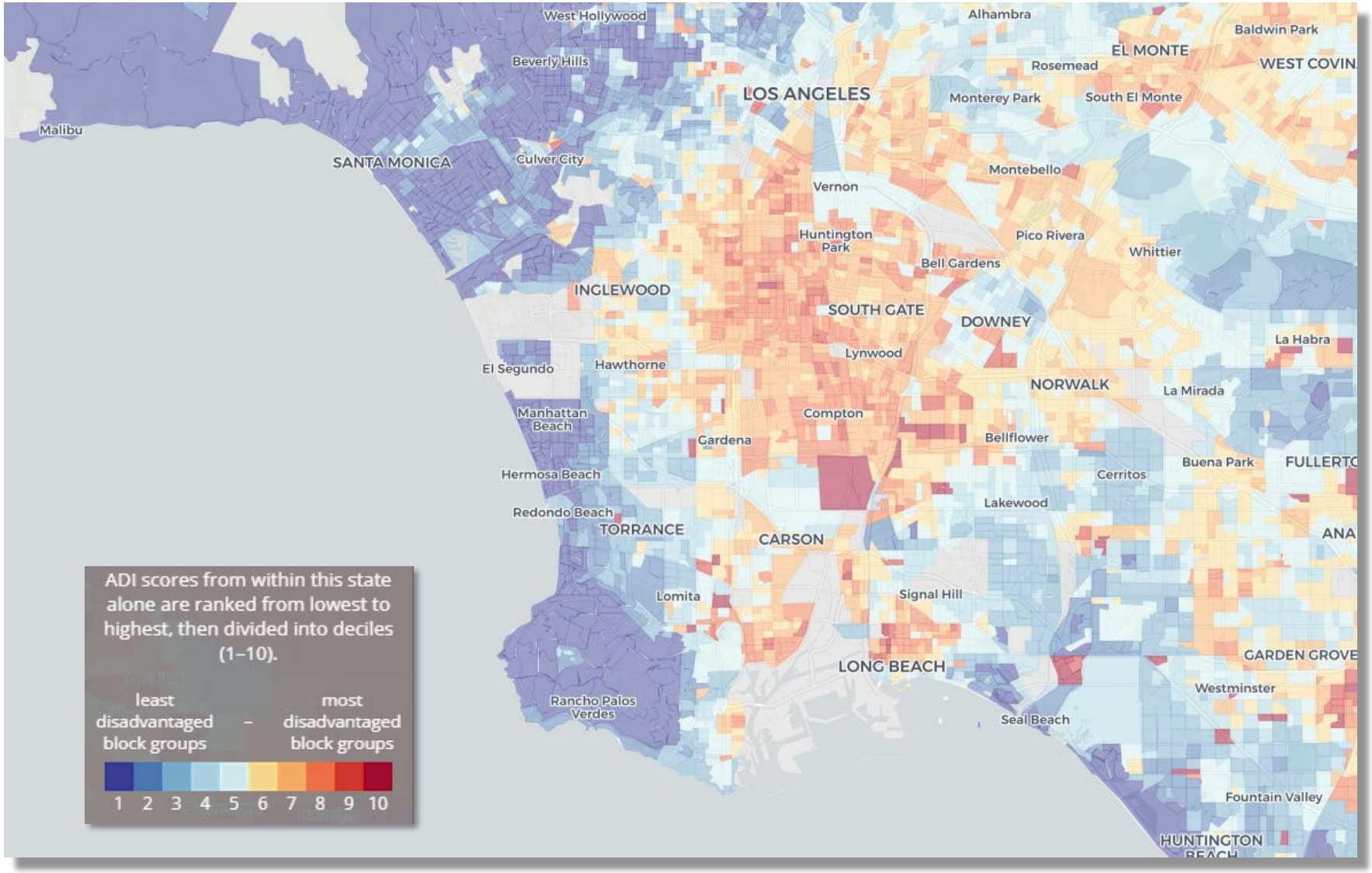
Source: UDS Data, 2022

Area Deprivation Indexes

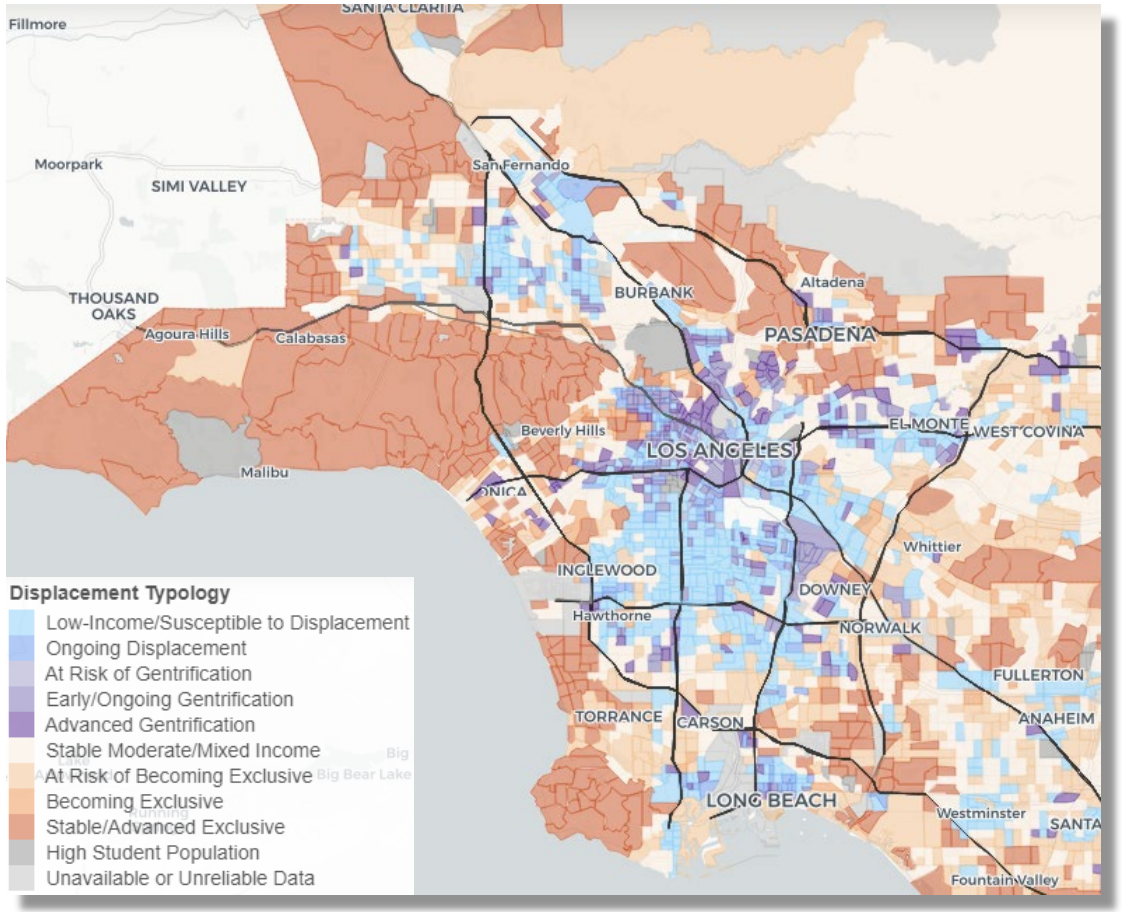
Area Deprivation Index (ADI) is a measure used by HRSA to rank neighborhoods by socioeconomic disadvantage, utilizing factors such as income, education, employment, and housing quality. Living in a disadvantaged area has been linked to higher rates of chronic conditions, higher mortality rates & higher rates of health services utilization.



Source: Neighborhood Atlas, University of Wisconsin

Changing Population Demographics

Like many large cities across the United States, the historically lower income areas of Los Angeles County are experiencing higher rates of gentrification and risk of displacement



- When compared to neighboring counties, Los Angeles County experienced the highest rate of gentrification, with 10% of Census Tracts classified as at risk of gentrification, early/ongoing gentrification, or advanced gentrification
- Most of the Los Angeles County coastline has a stable population
- In central Los Angeles, there are the most pockets of ongoing or advanced gentrification
- Other areas of the County, such as the Inglewood and Westmont neighborhoods, still have a relatively significant low-income population that with current trends would be susceptible to displacement through further gentrification

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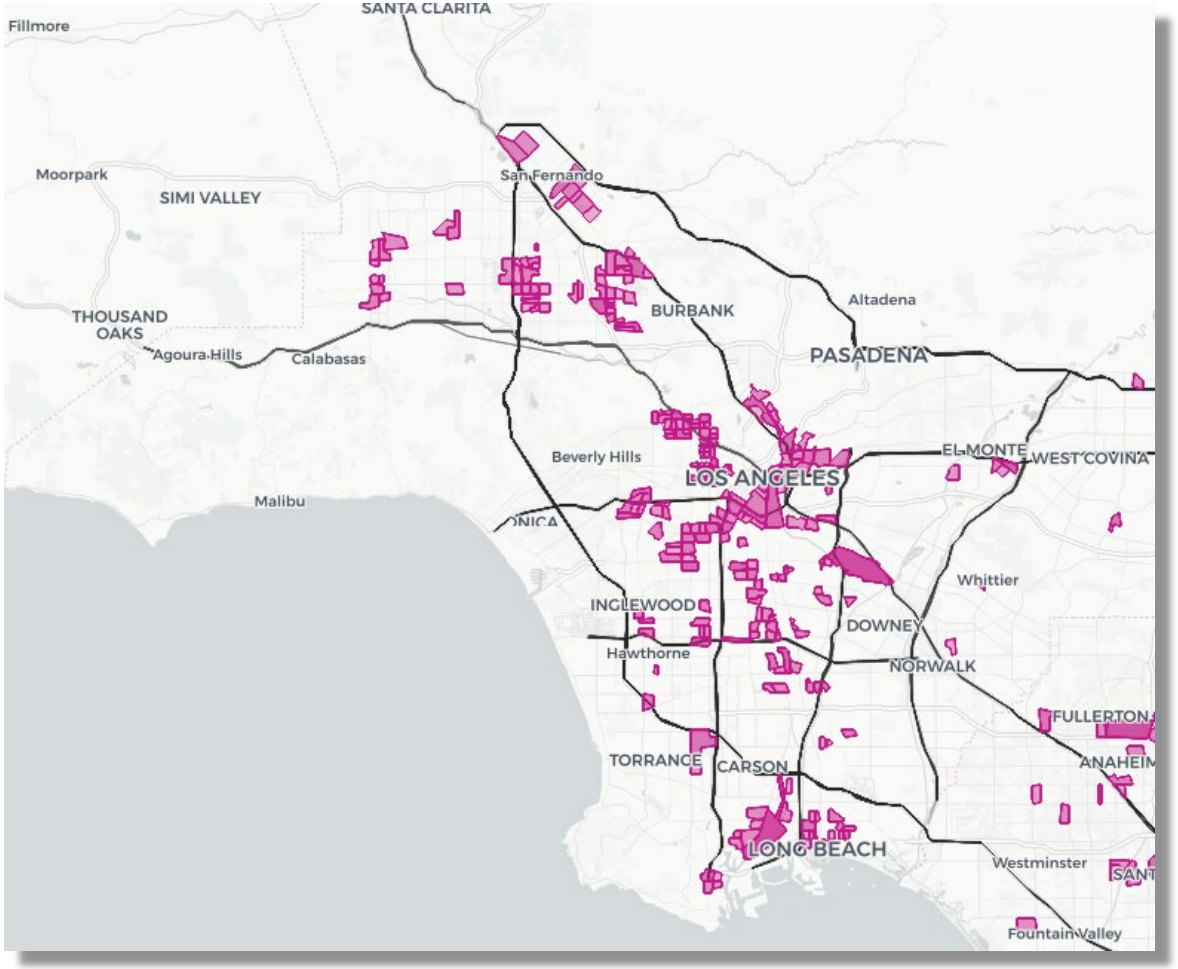
Source: Urban Displacement Project, 2018

Opportunity Zone Mapping

Most of the opportunity zones in Los Angeles County are concentrated in the Downtown Los Angeles and Long Beach areas



- The designated IRS opportunity zones align with the portions of the county that are lower income and are experiencing early-stage gentrification or displacement of low-income residents

Source: Urban Displacement Project, 2018

Functional Requirements to Entry

Considerations for Primary Care

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Functional Requirements to Primary Care

Newco Development	Provider Roster	Provider Credentialing	Capacity & Access
Facility Site Compliance	Ability to Provide Preventive Care	Care Management Capability	Care coordination Capability
Member Risk Stratification and Management	Benchmarking and Participation in QI	Data Reporting Capabilities	Managed Care and/or IPA Contracting

Capacity & Access Standards

Capacity

- In California, the capacity requirement for primary care clinics—particularly under Medi-Cal and Knox-Keene Act standards—requires that each full-time primary care provider (PCP) manage a patient panel of no more than 2,000 members
- Capacity can be expanded through use of Advanced Practice Providers (APP)
  - Maximum of 4 APPs per physician

Access

- The California Department of Managed Health Care (DMHC) mandates that health plans ensure members can access non-urgent primary care appointments within 10 business days of their request.
- Monitored by MCP audits

Source: DHCS, 2024

Facility Site Review Standards

1. Site is accessible and useable by individuals with physical disabilities
2. Site environment is maintained in a clean and sanitary condition
3. Site environment is safe for all patients, visitors and personnel
4. Emergency healthcare services are available and accessible 24 hours a day, 7 days a week
5. Medical and lab equipment used for patient care is properly maintained
6. Professional health care personnel have current CA licenses and certifications
7. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current
8. Health care personnel appropriately identified
9. Site personnel are qualified and trained for assigned responsibilities
10. Scope of practice for non-physician medical practitioners is clearly defined
11. Non-physician medical practitioners are supervised according to established standards
12. Site personnel receive safety and member rights training
13. Physician coverage is available 24 hours a day, 7 days a week
14. There are sufficient health care personnel to provide timely, appropriate health care services
15. Health care services are readily available
16. There is 24-hour access to interpreter services for non- or limited-English proficient members

Source: DHCS, 2024

Facility Site Review Standards

17. Procedures for timely referral/consultative services are established on site
18. Member grievance/complaint processes are established on site
19. Medical records are available for the practitioner at each scheduled patient encounter
20. Confidentiality of personal medical information is protected according to State and federal guidelines
21. Drugs and medication supplies are maintained secured to prevent unauthorized access
22. Drugs are handled safely and stored appropriately
23. Drugs are dispensed according to State and federal drug distribution laws and regulations
24. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations
25. Site meets CPDH Radiological inspection and safety regulations
26. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases
27. Health education services are available to Plan members
28. Infection control procedures for Standard/Universal precautions are followed
29. Site compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act
30. Contaminated surfaces are decontaminated according to Cal-OSHA standards
31. Reusable medical instruments are properly sterilized after each use

Source: DHCS, 2024

Data and Analytics

New Data Sets Needs to Be Managed

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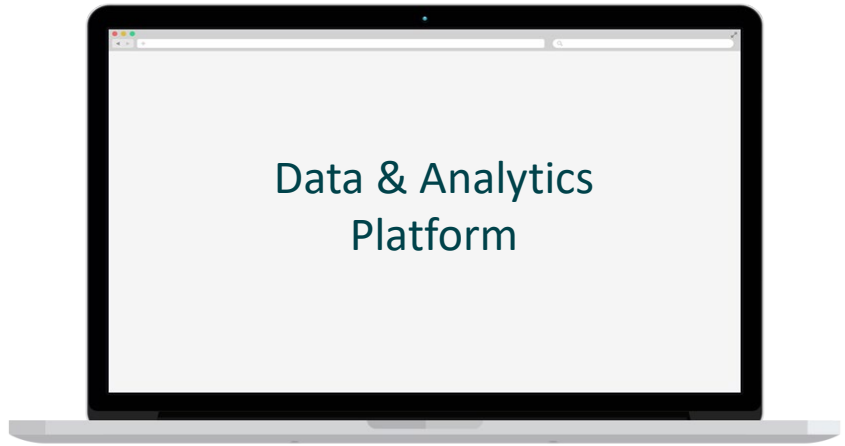
Data Sets to Consider

Membership Panel Management	Member and financial reconciliation Attributed Membership
Chronic Disease Management	HCC Documentation and Care Plan Management
Provider Performance	HCC/ Coding PATSAT Quality performance reporting
Quality Measures	Star Measures Annual Wellness Exams HEDIS/HCC/CAHPS
Member Referral Management	Closed loop referral data Monitor Specialty access and performance Referral and authorization reporting
SDOH/HRSN	Partnership with Community Based Organizations



Source: DHCS, 2024

Data and Analytics Necessary to Succeed

SME Insights

Clinical and/or Financial Insights generated by industry experts with actionable next step to improve performance.

Financial Reporting

Modeling value-based contract performance and revenue forecast. Monitor monthly performance and reconcile against budget.

VBC Analytics

Self-service analytics tools to gain detailed understanding of performance. Comprehensive management reporting across all functional areas.

Provider Performance

Drive PCP and Practice performance that aligns to organization initiatives and goals.

ARC ANALYTICS FOR RISK CONTRACTING

An enterprise data warehouse platform that pull together information from disparate data sources into a single source of truth.

Analytics Consulting

Build and customize reports as required by county/state/federal programs or other funders requirements.

Episodes

Peer to peer specialty performance on a risk adjusted basis with episodes.

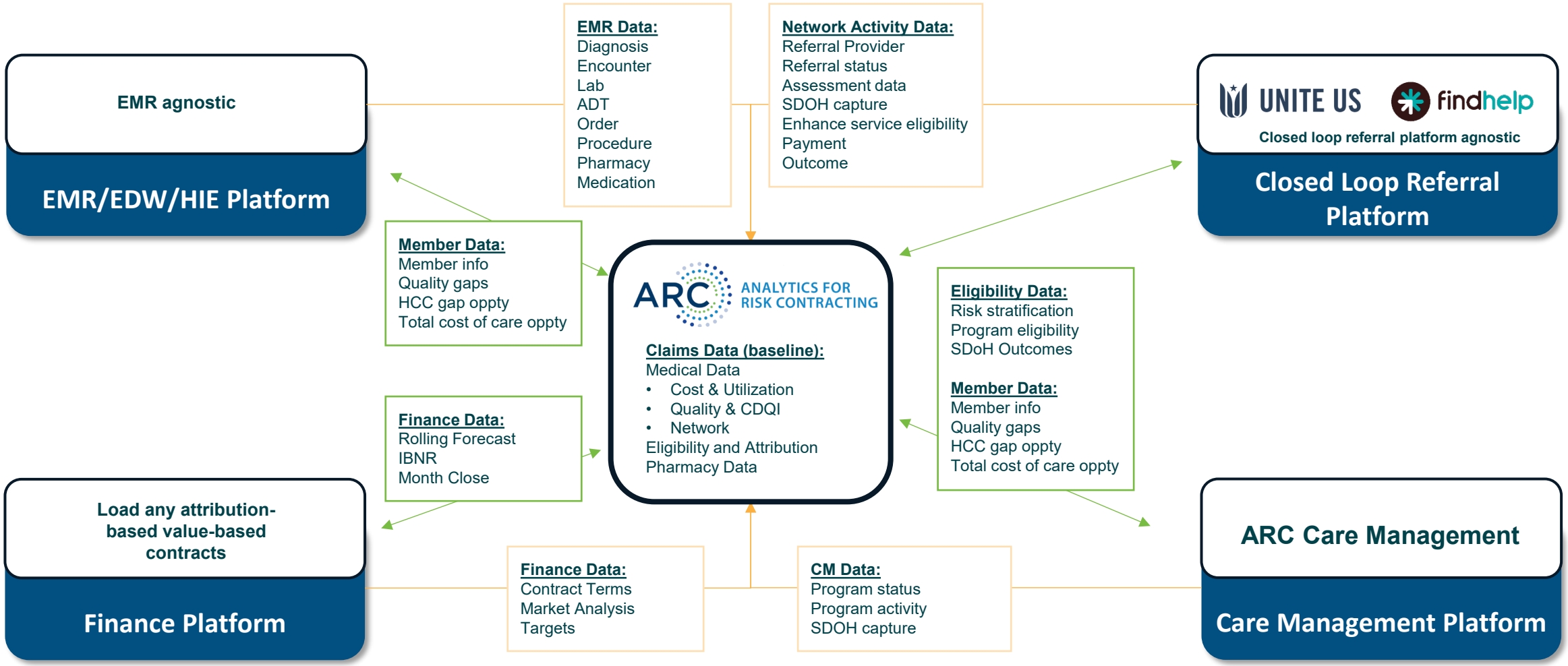
Care Management

Full Care Management workflow solution enabling member assessment, care planning, and closing of quality and clinical documentation gaps.

Patient Care Workflows

Intuitive patient care tool embedded in EMR/CM/HIE platform that identify patient needs, quality gap gaps, HCC and other opportunities via 1-way or 2-way integrations.

ARC: Technology Ecosystem



VBC Analytics Overview

Gain insights from over 15+ self-serve dashboards to identify trends and drivers of variances

Quality Management

Effectively assess quality care gaps and prevention incentives.

- Chronic condition management
- Quality gap assessment at the network, provider, and/or member level
- Improve patient and provider satisfaction, clinical efficiency, and overall effectiveness

Clinical Documentation

Improve HCC clinical documentation for risk score accuracy.

- MCO quality incentive programs
- Membership enrollment reconciliation

Utilization Management

Optimize appropriate utilization through improved care coordination and network management.

Manage total cost of care through evidence-based methodology created by expert clinicians and analysts.

Value Index Performance

Acuity Coding opportunities & AWVs

Quality metrics & Gaps in Care

Total Cost of Care & clinical efficiency metrics

Site of Care Appropriateness

Hospital OP Surgery vs. ASC

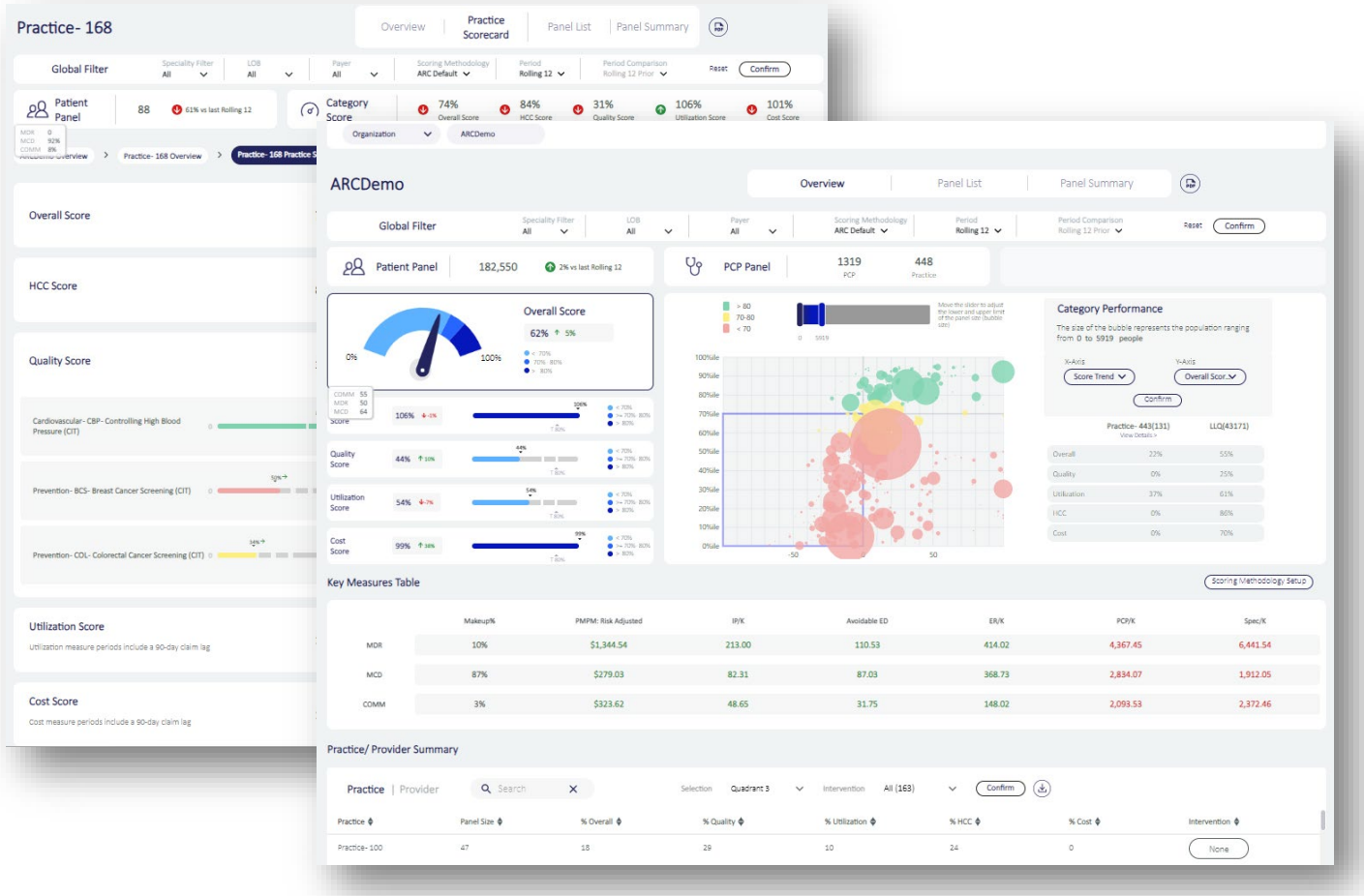
High value In-network referral management

Home care & community services

Provider Performance

Connect clinical goals to provider performance

- Create and setup a standardize way of measuring performance across the organization and in all lines of business
- Visual practice and provider performance relative to peers in Quality, HCC, Utilization, and Cost
- Comprehensive scorecard performance view at practice and provider level. Understand gap to next goal and easily create member chase list to reach target



Management Reporting Package (MRP)

Comprehensive report covering operational, financial & clinical quality metrics and KPIs to help manage your business, including an overview of all payors and lines of business, which is further broken down into line of business & product performance.

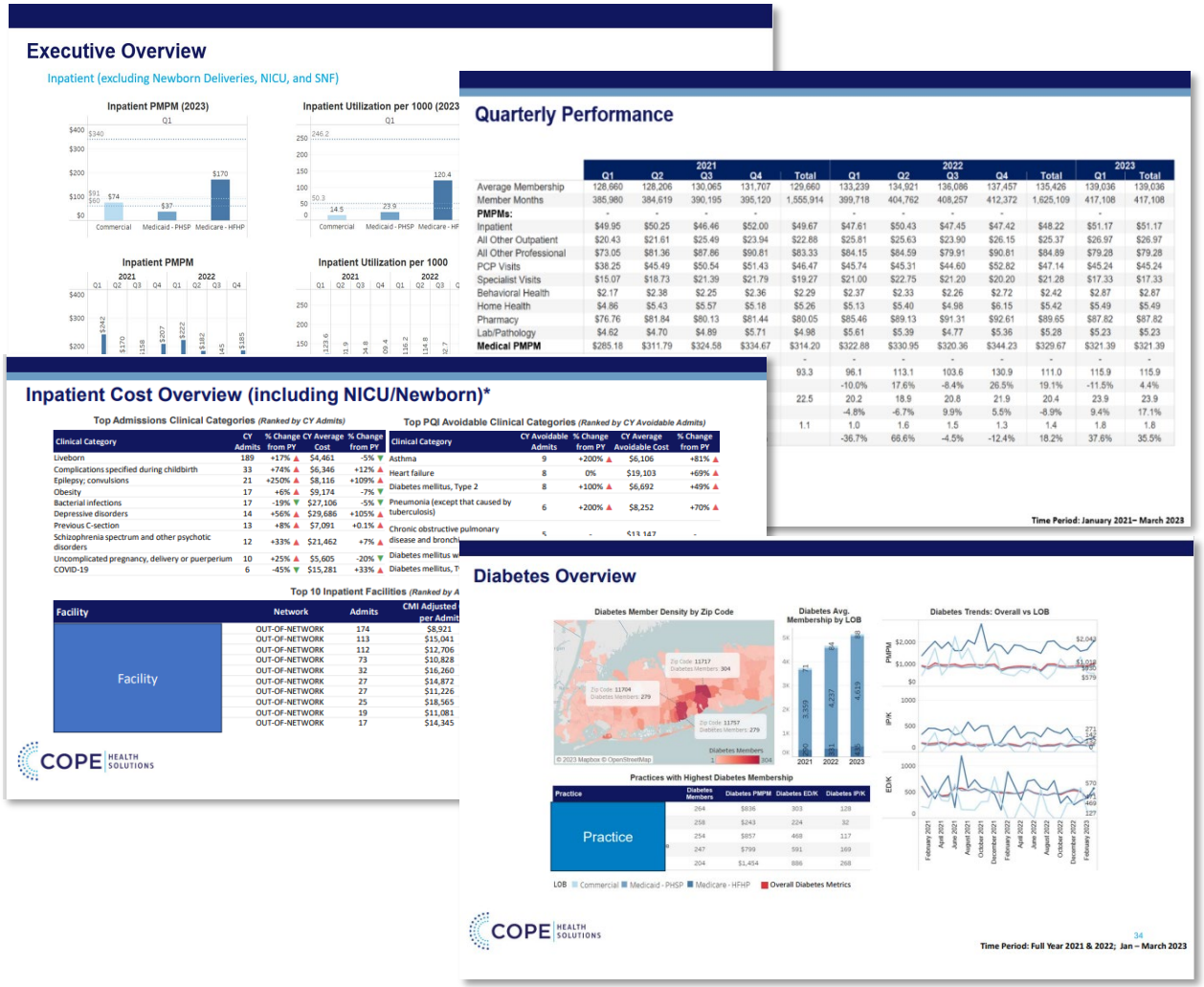
Executive Overview
- Key Performance Indicators for current periods and 8 previous periods

Financial Performance
- Track your financials quarter over quarter – including revenue and MLR

Service Category Performance
- Track spend and usage for inpatient, outpatient, Rx & ambulatory

Population Health
- Identify hot spots for chronic conditions and practices with high patient volumes

Quality
- Track quality measure performance with both claims and EMR data



Clinical Insights

Executive Insights Summary – ACO REACH

#	Insight	Slides	ARC Views
1	**Inpatient Post-Acute Care (PAC):** • Follow-up rates have stagnated through Q2 2023 with a 11.5% decrease from 2022 for 7-day follow-ups and an 11% decrease from 2022 for 14-day follow-ups. 17 practices have 14-day follow-up rate lower than 60% in Q2. • The 30-day all-cause readmission rate has increased by 41.7% from 2022. Clinical categories with highest readmission rates are bacterial infections, heart failure, and pneumonia.	6, 14, 15, 27, 28, 29, 30, 48, 49 & Chase Lists	CIT Scorecard, Inpatient
2&3	**Skilled Nursing Facility (SNF) Cost & Utilization:** • High SNF spend and utilization is being driven by relatively few members ($4.7M generated by 4% of the ACO Reach population). • SNF LOS is greater than the cohort average LOS (21 days) for clinical categories of stroke, hip fracture, heart failure, Parkinson's disease, and pneumonia. • Post-discharge, members freshly out of SNF care are utilizing acute care at high rates. Within 30 days of discharge in the first six months of 2023, 15% of discharged visits had an inpatient stay and 10% had an ED visit.	7, 8, 17, 31 & Chase Lists	Cost & Use
4	**Radiology Cost & Utilization:** • Radiology PMPM and utilization have increased significantly for 2023 compared to prior years. • Increased unit cost for radiology services coupled with increased PMPMs and stable utilizations quarter over quarter for 2023 suggests that higher quantities of complex radiology services are being ordered for the ACO Reach cohort.	10, 21, 33	Cost & Use
5	**Chronic Kidney Disease (CKD) Population Management:** • CKD membership is high cost with high rates of co-morbidity and low engagement. Only 29% of CKD membership has seen a nephrologist in the past two years. • Membership utilizing dialysis services has doubled in the past year, generating $971K of spend in the first six months of 2023 compared with $1M for the entire year of 2022; most of this spend is OON. • Preventing disease progression in this population is imperative to reducing cost and utilization and keeping membership healthy.	9, 33, 37, 39, 44 & Chase Lists	Risk Cohorting, Cost & Use, Inpatient, Emergency Department, Pharmacy, Specialty
6	**Preventable Emergency Department (ED):** • High utilization of ED services for conditions of low acuity. Decreased utilization of urgent cares compared to 2022. • Opportunity to redirect low acuity ED visits and preventable ED visits to urgent cares and PCPs.	11, 19, 20, 34, 48, 49 & Chase Lists	Emergency Department, Cost & Use

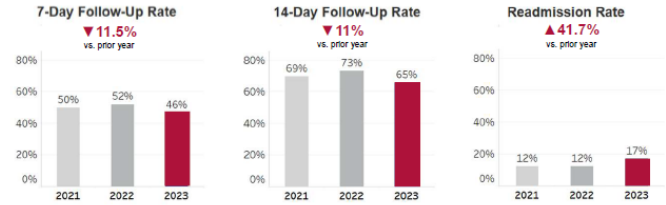
- Subject matter expert (SME) review by line of business
- Collaborate with Client leadership to identify & prioritize opportunities & recommendations to address target areas
- Ability to work with industry experts to implement identified initiatives
- Initiative tracking to determine ROI of any new programs

Insights Derived from Connecting Data Points

- Analytics experts review your data, identifying potential areas of improvement and highlighting high performance that can be leveraged across other areas

Insight #1: As Inpatient Follow-Up Rates Drop, Readmission Rates Rise

- **At 17%, the readmission rate is 42% higher through Q2 2023 than it was for the same member cohort in previous years.** Readmission rates were 12% in both 2021 and 2022.
- **At 46% and 65% respectively, 7-day and 14-day follow-up rates have declined by 11.5% and 11% compared to rates for this cohort under other payors in previous years.** In 2022, the 7-day rate was 52% and the 14-day rate was 73%. Rates have also declined since the January 2023 rates of 49% and 69%.



Recommendation: Improve outcomes of transitions from the hospital to the community.

- **Engage practices with 14-day follow-up rates lower than 60% (see accompanying chase lists) to bring discharged members into in-office or telehealth PCP visits.**
- Assess whether care coordination interventions in the Transitions of Care program are sufficient to prevent all-cause readmissions for high-risk ACO Reach membership. Continue to monitor with subsequent quarters as more data becomes available post program implementation.
- Reduce overall inpatient admissions by engaging with members who have had multiple inpatient stays throughout the duration of the performance year via member outreach.

Risk Stratification

ARC Risk Stratification places members into programs such as Complex Care, Rising Risk, etc. and includes HRSN factors into the calculation to produce acuity scores

Metric Categories	Patient Circumstances	Assigned Risk Points
Total Claims Paid	+$100,000	4 points
Hospital Admissions	5+ Acute Admits 5+ ER Visits	6 points 3 points
ER Visits	3 Visits	3 points
Additional Utilization	7+ Prescription Drugs 3+ Urgent Care Visits	3 points 3 points
High Risk Diagnosis	Abnormal Findings CHF COPD Diabetes Family History – Chronic Diseases Glucose Regulation Disorder Hypertension Overweight/Obesity HRSN Barriers SPMI (Severe Persistent Mental Illness) - Depressive Episode	1 point 3 points 3 points 2 points 1 point 2 points 2 points 7 points 3 points 2 points
High Risk Comorbidities	CHF and Hypertension Diabetes and Hypertension Diabetes and Overweight/Obesity Diabetes and CHF	3 points 3 points 3 points 3 points
	TOTAL	**59 points**

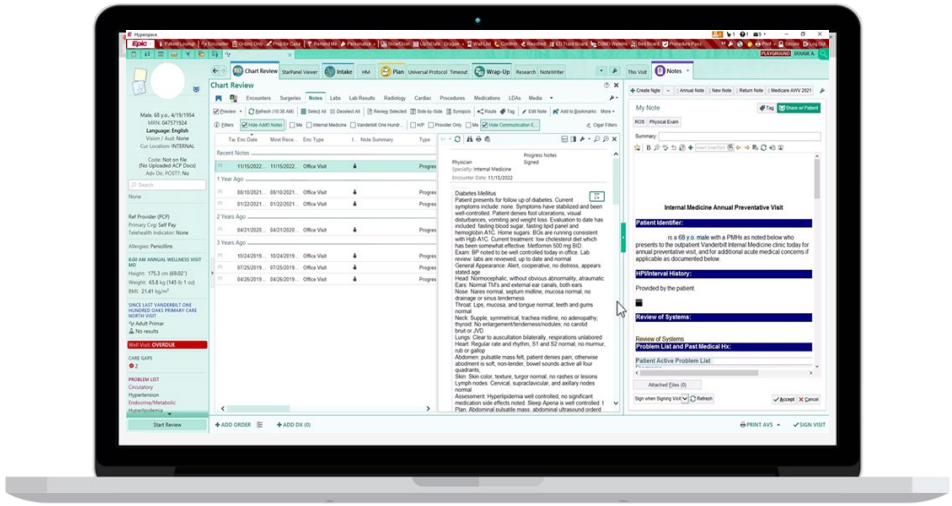
The patient's total risk points put him at a 'medium' acuity. John Doe is enrolled in a tailored CM program to help manage his conditions and prevent an escalation of acuity.

Tier	Range	Acuity
1	80+	Very High
2	60 and 79	High
3	**30 and 59**	**Medium**
4	20 and 29	Low
5	0 and 19	Very Low

Patient Care Workflows – EMR / CM / Closed Loop Referral

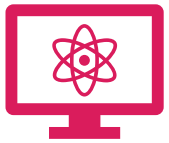
Select from a rich set of standard insights to integrate with your workflows or develop custom insights during discovery process

- Clinical Continuity
- Quality & CDQI Gaps
- Care Management Eligibility & Risk Stratification
- Health Related Social Needs (HRSNs)
- Medication Adherence Alert
- Generic Alternatives
- Confirm Diagnosis
- Custom Workflow Design



- Track Clinical Quality Measures (ex. A1C)
- Patient Outreach
  - Next Scheduled Visit
  - Care Gap Quality data updated with EMR data
  - Recent utilization
- Identify HRSN needs through ICD and LOINC
- Identify CDQI opportunities
- Enhance Risk Stratification

Financial Insights: Planning and Reporting Simplified



Web Based Models

Web based access to robust dashboards focused on financial, operational, and quality performance tailored to appropriate health system and network stakeholders

- Easy accessibility that allows user to continuously view changes to contracts or operational outcomes
- Ability to monitor performance monthly

Flexibility in Modeling

Evaluate and manage year to year contractual arrangements to assess profitability for a variety of VBP agreements and models such as:

- Commercial global risk, capitation, upside and downside shared savings, quality programs for all managed lines of business
- CMS Models: ACO REACH, Making Care Primary, MSSP Track Option Modeling
- Medicaid
- Medicare Advantage
- ASO / self insured

Data Driven

Effectively manage clinical and operational performance

- Periodic estimate of current year performance
- Accounting accruals
- Historic trends and forecast of results
- Membership growth projection
- Market share (CMS, Medicare Advantage, Private) and benchmarking data

Care Management – Crucial to Success

Care Management provides coordination of all appropriate services and equipment in the most appropriate setting for the member and often supports alternatives to institutional care, such as physical therapy and services delivered in the home.

Chronic Care Management	Care Coordination	Complex Case Management	Transition of Care Management
Appropriate for members with chronic disease states *Members with specific diseases and conditions that are well managed but may need follow up to keep them on track*	*Involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care*	*High level Case Management for members who have experienced a critical event or those with complex medical and/or social determinant of health needs, including member with special care needs and serious and or persistent mental illness*	*Readmissions prevention executed through member engagement, medication reconciliation and adherence, self-management education, and care coordination within 30 days of post-discharge period*

Payer Partners

Managed Care Plan vs. Independent Physician Association (IPA)

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IPA vs. MCP Contracting: Finding the right payer partner

Managed Care Plans

- Majority of California membership has been attributed to IPAs
- MCPs in certain counties will not execute direct network contracts
- Hold higher control over rates and a higher administrative burden
- Patient volume may be lower to begin with and take longer to increase
- May involve multiple payment arrangements (FFS, capitation, value-based, etc.)

VS.

IPA

- Access to incentives with IPAs looking to expand their network
- Improved reimbursement rates with exclusive/semi-exclusive agreements
- Support for growth opportunities and marketing events
- Enhanced quality incentives
- Flexibility with risk-arrangements
- May involve multiple payment arrangements (FFS, capitation, value-based, profit share, etc.)

Understanding 1115 Medicaid Waiver Opportunities

Funded services that align with Primary Care

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Medi-Cal Transformation

Medi-Cal Transformation, formerly known as California Advancing and Innovating Medi-Cal (CalAIM) is a multi year initiative to transform California's Medi-Cal program and enable it to work more seamlessly with other social services. As of June 2024, it became formally known as "Medi-Cal Transformation."

Led by the California Department of Health Care Services (DHCS), its goal is to improve outcomes for Medi-Cal patients, including those with the most complex needs.

CalAIM Revenue Opportunities Through Enhanced Infrastructure & Care Delivery

Enhanced Care Management

- **~$100: Initial outreach funding** to engage & enroll eligible members **(~8-10% of Medi-Cal pop.)**
- **$325-$450+ PMPM** per enrollee for ECM services*
- **Funding outside of premium dollar** for ECM services

*Majority of health plans pay on a PMPM basis, LA Care & Health Net are FFS

Community Supports

- In most cases, **paid outside of the MLR by the MCP directly.**
- **Additional revenue outside of premium ($7 - $7,500 depending on services type)**
- **Funding for 14 services** through MCPs (per diem, PMPM & one-time depending on service)

Community Health Worker

- CHW benefit & funding available for non-ECM eligible members
- **Covered Medi-Cal Benefit ($9 - $26 per 30 min. unit)**

Incentive Payment Program

- **$600 million in 2023 & 2024 for Infrastructure improvements paid directly from MCPs** to community organizations

Providing ACCESS and Transforming Health (PATH) Initiative

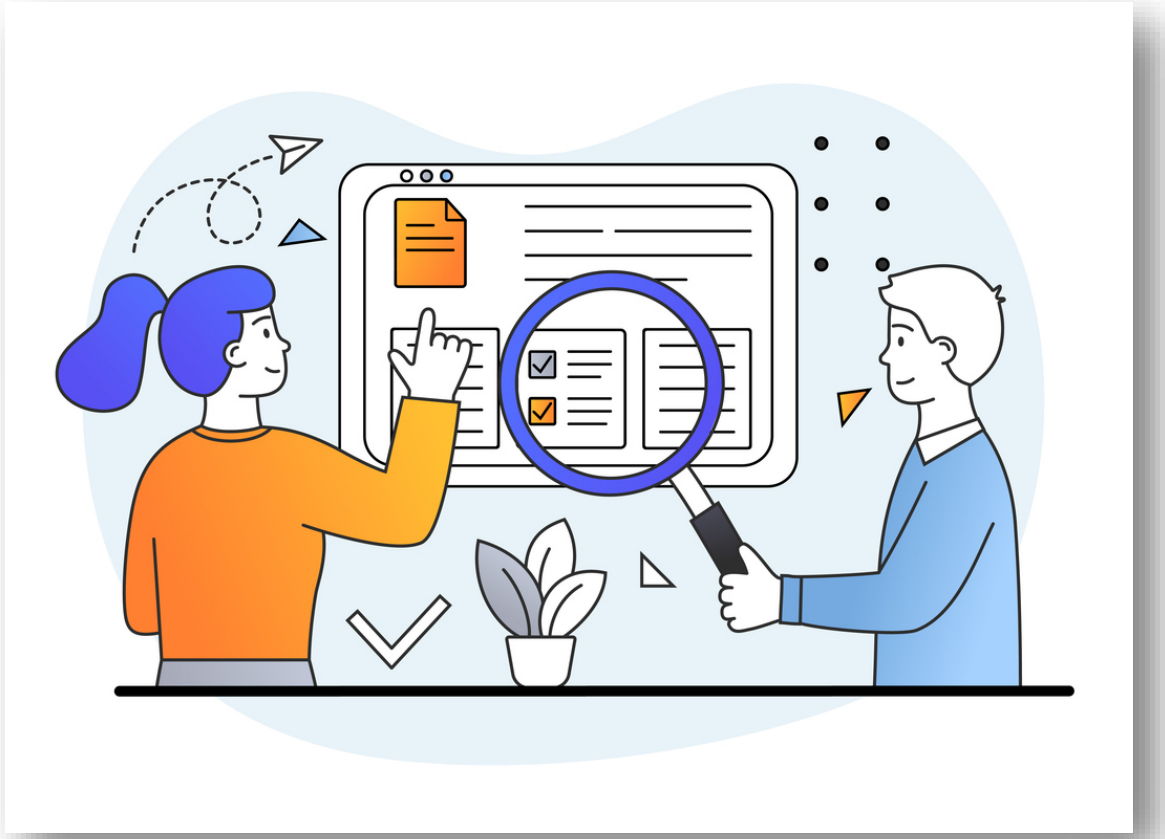
- **$1.85 billion in funding to build up the capacity and infrastructure**
- **CITED:** Funding awarded directly to providers **(typically twice a year)**
- **PATH TA:** Funding awarded to technical advisor

PATH Technical Assistance (TA) Marketplace

Providing Access and Transforming Health (PATH) is a $1.85 Billion Initiative, approved under California's Section 1115 Waiver that provides funding to counties, providers, community-based organizations, and other local entities to expand capacity to implement key Medi-Cal Transformation (formerly known as CalAIM) components, including Enhanced Care Management and Community Supports, statewide.

The PATH Technical Assistance (TA) Marketplace is a component of the PATH initiative that provides funding **to state approved vendors** to help Enhanced Care Management (ECM) and Community Supports (CS) providers build out or reconfigure their programs.

TA PATH's online portal opened for recipients in ***February 2023*** and is set to run through 2026



The TA Marketplace Offers TA Services in Seven Different Domains

COPE Health Solutions has executed projects in all 7 domain

Our firm has decades of experience working with organizations to help manage total cost of care, quality & clinical outcomes.

Support the development of value propositions to utilize with managed care plans & partnering entities.

Translate Medi-Cal Transformation (formerly known as CalAIM) contract and programing requirements to align with value-based payment arrangements & population health infrastructure to maximize quality, clinical outcomes & bottom-line for all organization types & scale.

Example Project for Each Domain

Building Data Capacity

- Configuration of analytics and data models to meet Medi-Cal Transformation requirements
- Development of data processes and workflows to make data easy to use & access
- Risk stratification for high-risk member identification, outreach & enrollment
- Self-service tools for in-house analytics, managed care plan reporting & team performance management
- Platform & technology best practices to accelerate member engagement, data aggregation, sharing & improve clinical quality outcomes

Community Supports

- Assessment of community support services offered within service area
- Project plans to develop or reconfigure current CS service offerings
- Gap assessments, workflows, training, documentation, staffing, and member engagement strategies for CS services

Engaging in CalAIM through Medi-Cal Managed Care

- Staffing & financial models
- Application development support
- Payer collaboration & engagement
- Contract term and reimbursement structure advisory
- Billing, reporting & documentation best practices

Example Project for Each Domain

Enhanced Care Management

- Organizational readiness assessment against Medi-Cal Transformation requirements for success
- Outreach and engagement strategies for POF
- Care plan development to support effective engagement of high-needs patient populations
- Strategies and workflows for coordinating with CS, BH, and social services providers, including primary care coordination

Promoting Health Equity

- Development and implementation of engagement strategies for marginalized or under served communities and POF
- Development of data processes, tools, and dashboards related to health equity, to support identification and engagement with members

Supporting Cross-Sector Partnerships

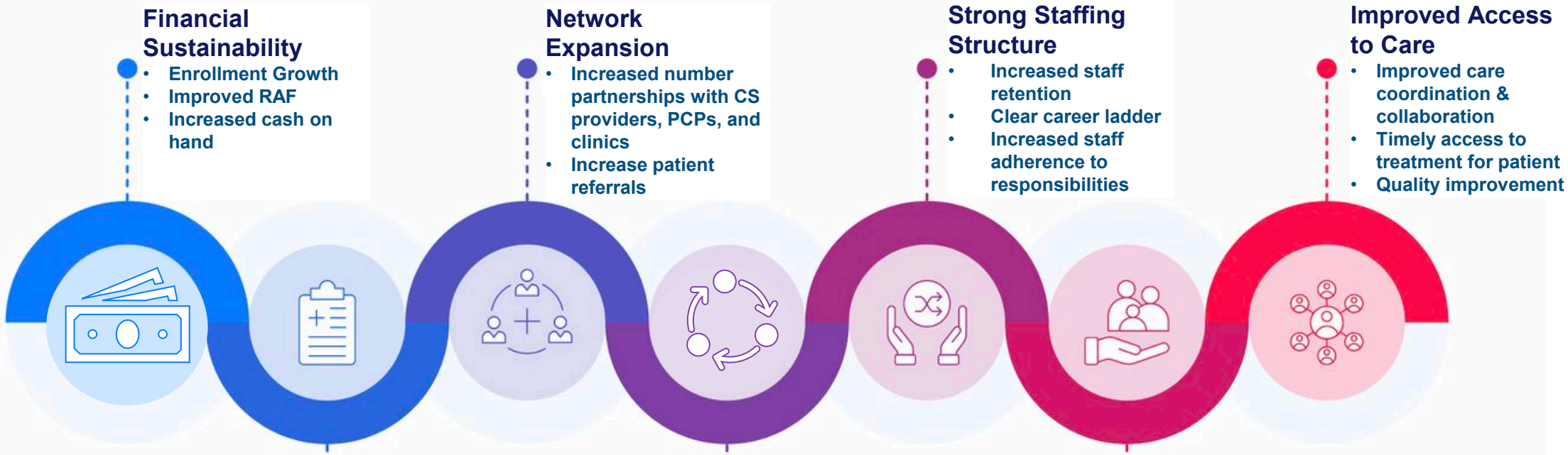
- Assessment of potential cross-sector partners within service area
- Support engaging with partners and developing shared contracts to increase service offerings
- Development and implementation of shared cared plans with identified partners
- Development of shared team models

Workforce

- Development and implementation of customized competency-based training programs (e.g., care models, member engagement & care coordination)
- Development and implementation of hiring processes, employee engagement and training and performance management tools

ROI for our TA Marketplace Clients

The TA PATH provides funding that enables us to assist our clients in improving their internal operations, enhancing care delivery practices, improving patient outcomes, and increasing direct revenue for services rendered



Financial Sustainability
- Enrollment Growth
- Improved RAF
- Increased cash on hand

Network Expansion
- Increased number partnerships with CS providers, PCPs, and clinics
- Increase patient referrals

Strong Staffing Structure
- Increased staff retention
- Clear career ladder
- Increased staff adherence to responsibilities

Improved Access to Care
- Improved care coordination & collaboration
- Timely access to treatment for patient
- Quality improvement

Regulatory Compliance & Risk Mitigation
- Improved coding & documentation
- Improves scores for MCP audits
- Improved P&Ps

Improved Program Operations
- Improved patient satisfaction
- Reduce MLR
- Improved patient outcomes
- Improved member retention

Patient Center Care Models
- Improved patient outcomes
- Improved member retention
- Improved adherence to treatment

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