Listening Session Part 3 on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Presenters:

Subject Matter Experts

- **Chris Chen, MD**, Chief Executive Officer, ChenMed
- **Palav Babaria, MD, MHS**, Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services, and
- **Paul Leon, RN, BSN**, Founder, CEO and President, Illumination Foundation

Presentation:
ChenMed

Chris Chen, MD
Chief Executive Officer
ChenMed

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Chief Executive Officer

ChenMed

Strictly confidential. Not to be distributed further without the written approval of ChenMed.

ChenMed: InFocus

a company *snapshot*

Exclusively focused on Medicare beneficiaries

One of the largest family-owned, physician-led primary care providers

Pioneer in risk: decades-long experience and track record delivering successful clinical, service, and financial outcomes in "global full risk" models

Pursuing a vision to be America's leading primary care provider, transforming care of the neediest populations by delivering on our mission of honoring seniors with affordable VIP care that delivers better health

Over 4,500 diverse team members, employing several hundred primary care physicians

Serving the neediest populations: ~40% dual eligible, two-thirds African-American and other underrepresented minorities, average patient has ~5 major chronic conditions, clinics located in underserved neighborhoods

Honoring seniors and delivering better health through 3 brands (Chen Senior, JenCare Senior, and Dedicated Senior Medical Centers) in more than 100 medical centers across 14 states (and growing)

Source: ChenMed internal data.

Our Results

We're expanding rapidly as we grow to meet the need for healthcare that delivers better health. Our year-over-year membership has grown for 10 consecutive years.

35% FEWER Emergency Room Visits

(Risk Adjusted)

51% FEWER Hospitalizations

(Risk Adjusted)

93.7% of respondents indicated they were highly satisfied with the care received from their provider (top 2 box ratings)*

*Based on Q1 2021 ChenMed third party survey results

94.7% of surveyed patients said their doctor listened carefully to them (top 2 box ratings)*

*Based on Q1 2021 ChenMed third party survey results

"Love... it's the number one thing you get here." - INGA • PATIENT

Source: ChenMed internal data compared to CMS; year 2019.

True Impact on Better Health

Patients per PCP on average

345

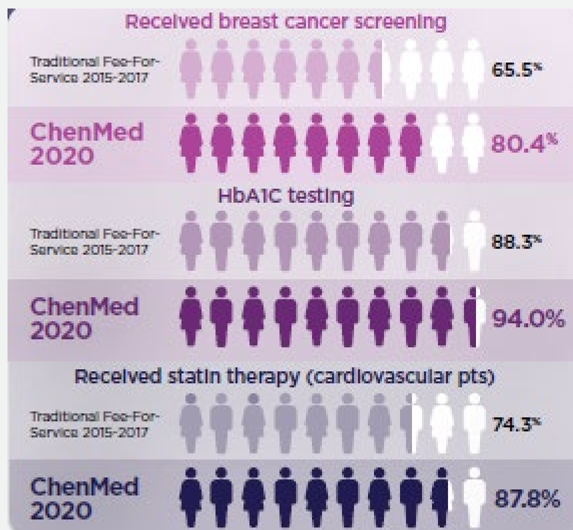
(maximum of 450)

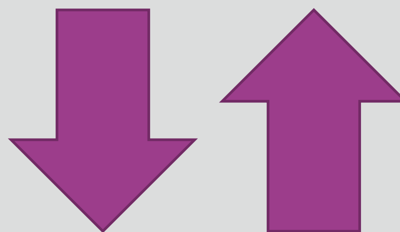
3 to 4

Hours

"Face Time"
Per Patient/Year

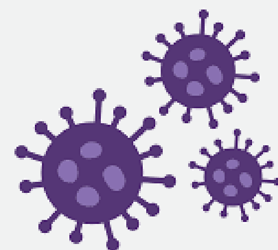
Higher screening and care management rates during the Pandemic than industry averages before it





22% **lower**: The risk of stroke for patients with >1 year tenure at ChenMed vs. short tenure patients

Double: The 6-month survival rate of cancer for patients with >6 months tenure at ChenMed vs. short tenure patients



Higher vaccination rates

Lower hospitalization rates

Smaller differences than industry between duals and non-duals and African American and White patients

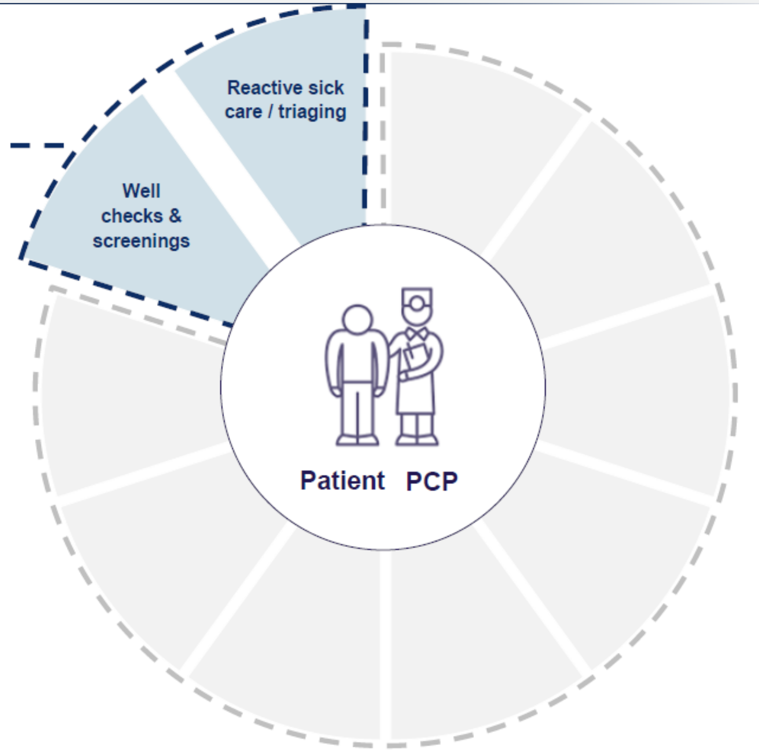
Source: ChenMed internal data compared to CMS

The Three Versions of Primary Care

Traditional Primary Care in America

+ Provide the minimum components of basic care on reactive basis (when sought by the patient)

Only a sliver of the need is met



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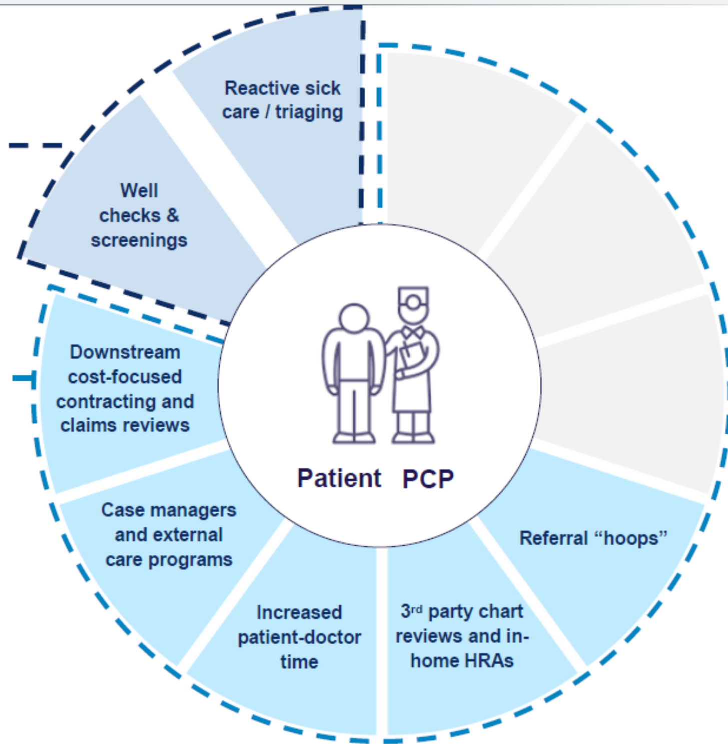
Traditional Primary Care in America

+ Provide the minimum components of basic care on reactive basis (when sought by the patient)

"Advanced" Primary Care

+ Build a risk-adjustment apparatus
+ Negotiate down unit costs
+ Apply aggressive utilization management oversight

Gaps left by typical primary care are filled in with a "wrap around" strategy related to revenue and cost containment



The Three Versions of Primary Care

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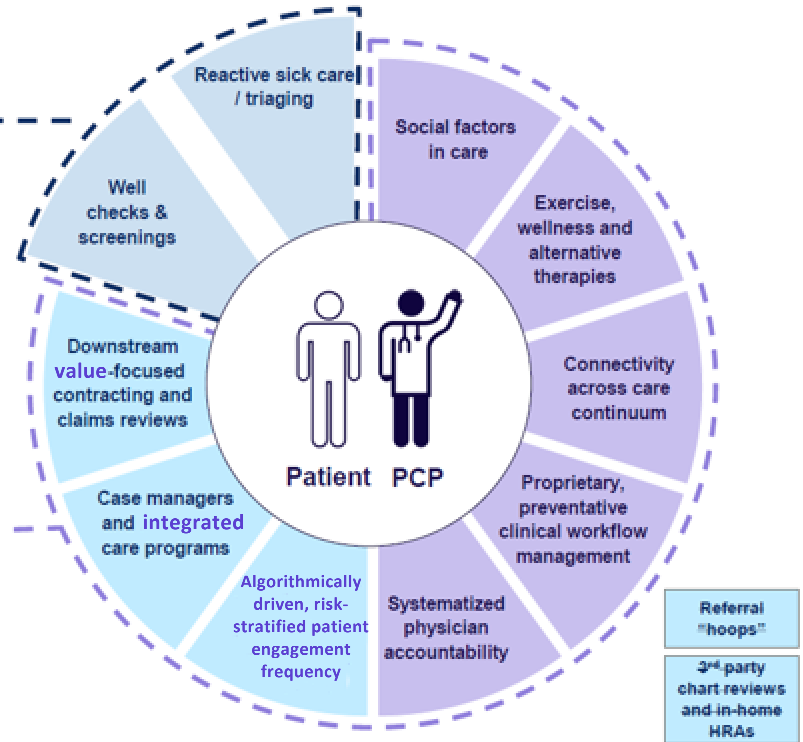
"Advanced" Primary Care

+ Build a risk-adjustment apparatus
+ Negotiate down unit costs
+ Apply aggressive utilization management oversight

JenCare's comprehensive primary care

+ Proactive detection and management of disease
+ Holistic clinical, relational, social care
+ PCP coordination and accountability through care continuum

Gaps left by typical primary care are filled in with a primary care-led approach to *health* – byproducts end up including revenue and cost containment



Patient Care Journey

TOTAL COST OF CARE
PRIMARY CARE HOLDS ACCOUNTABILITY FOR 100% OF THE CARE PROVIDED ACROSS ENTIRE CARE CONTINUUM

Global capitation given to ChenMed, who then directly provides, or arranges to provide, all clinical services needed by the patient

“Downstream” can be paid FFS or in a VBC arrangement – up to owner of TCOC risk

Comprehensive Primary Care

- Screening
- Disease prevention
- Chronic condition mgmt.
- Well check
- Social determinants

Primary care physician-led teams **coordinate** the entire patient journey for vulnerable seniors

<u>What if patient needs something PCP can’t do:</u>
PCP “quarterbacks” services that are medically necessary and must be provided in the community of specialists, ancillary services providers, hospitals, etc.

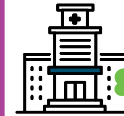
<u>ChenMed value add:</u>
Leverage **internal specialty consultants** and **data-driven insights** to identify where service can be delivered to maximize **value** (right care, price, place, coordination, access, service)

Patient referred to curated network of providers

Patient (and clinical information) returns to ChenMed for ongoing mgmt.

Independent Community Providers Services

Inpatient Services



- Emergency
- Inpatient stay
- Complex procedures

Ambulatory or Post-Acute Services

- Specialty
- Imaging
- Home health
- SNF, IRF, LTCH

Acute and specialty care are provided by a curated network of high-quality providers with track record of appropriate clinical care. Patients receive coordinated care.

Getting more truly "Comprehensive Primary Care"

1. True risk, not partial:
   Need "carrot and stick"; prevent "squeeze the balloon"

2. Need appropriate risk adjustment:
   Improve, don't eliminate current system (more SDOH, more reliance on PCP)

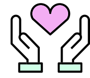
3. Put risk with Primary Care: This is the natural general contractor (status quo has a "bank" as the general contractor")

4. Need to help providers get there:
   180 degree shift requires funds to reappropriate tech & workflows, and protections from market power of insurers and hospitals

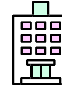
5. Status quo/FFS must be less comfortable (and physician training has to be outside the FFS norm)

6. Trust that health equity is best solved locally – create the right incentives for the PCP and the results will come

Locations



100 + CENTERS & GROWING



30 + CITIES

14 STATES

Our Locations

- Broward, FL
- Miami-Dade, FL

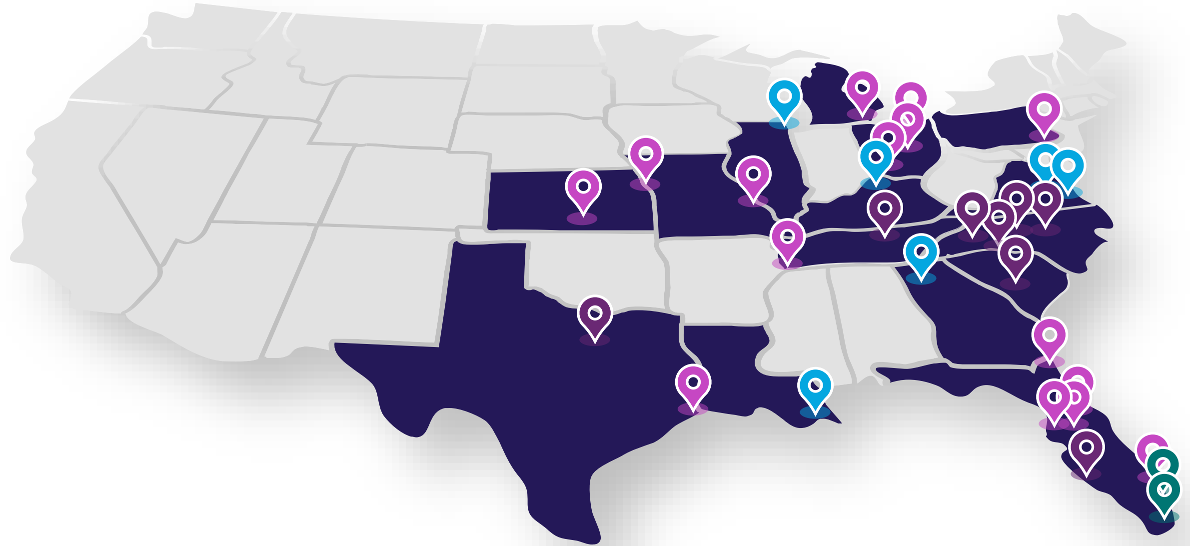
- Atlanta, GA
- Chicago, IL
- Louisville, KY
- New Orleans, LA
- Richmond, VA
- Tidewater, VA

- Cincinnati, OH
- Cleveland, OH
- Columbus, OH
- Detroit, MI
- Houston, TX
- Jacksonville, FL
- Kansas City, MO
- Lakeland, FL
- Memphis, TN
- Orlando, FL
- Palm Beach, FL
- Philadelphia, PA
- St. Louis, MO
- Tampa, FL
- Wichita, KS

Coming Soon*

*Subject to change

- Burlington, NC
- Charlotte, NC
- Columbia, SC
- Dallas, TX
- Ft. Myers, FL
- High Point, NC
- Nashville, TN
- Winston-Salem, NC



Our Services

Access to your doctor's personal cell phone and telehealth appointments

On-site and home delivery prescription pick-up services

On-site diagnostics, selected specialists, and care coordinators

Door-to-doctor transportation

Between frequent visits, we keep in touch with patients just to see how they're feeling, if they need anything or if they just want to talk to someone who cares — during the pandemic, we made over

1.5 million calls. And counting.

Clinics also provide education, social, physical, and other activities regularly

Our centers are designed to be a medical home purpose built to address each patient's needs and provide clinical and social support

Transportation only provided in association with Medicare Advantage Plan benefits

ChenMed named to Fortune's "Change the World" list.

The only healthcare delivery company to make the grade.

We were both honored and humbled by our inclusion in Fortune magazine's 2020 "Change The World" list, which highlights companies around the globe that are impacting lives and tackling society's toughest challenges and collective problems.

We pledge to build upon the ways in which we are transforming medicine and serving those around us, improving communities and changing lives.

THE WALL STREET JOURNAL.

Wall Street Journal-Medical Quarterbacking

Medical Economics

Medical Economics-How one primary care practice innovated to improve outcomes for high-risk Medicare patients

Forbes

Forbes-Concierge Medicine for The Poorest

Modern Healthcare

Primary-care provider ChenMed to enter five new markets

SOUTH FLORIDA BUSINESS JOURNAL

2022 BEST PLACES TO WORK

The Economist

The Economist–Private health care: The problem-solvers

The Cigna Well-Being Award

The Guardian

The Guardian-What a US company could teach

Presentation:

Payment Innovation in Medicaid and Systems of Care for Underserved Populations

Palav Babaria, MD, MHS

Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services,

and

Paul Leon, RN, BSN

Founder, CEO and President, Illumination Foundation

Near and far-sightedness on total cost of care: CalAIM and Medi-Cal's vision for the future

Palav Babaria, MD, MHS
Chief Quality Officer
Deputy Director, QPHM

Quality and Population Health Management

Addressing immediate needs
with upstream interventions

California Advancing and Innovating Medi-Cal (CalAIM)

DHCS launched CalAIM – a multi-year initiative – to improve the quality of life and health outcomes for Californians by implementing broad delivery system, program and payment reform across the Medi-Cal program.

CalAIM Seeks To:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Drivers of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Why Enhanced Care Management & Community Supports?

Issues ECM is Designed to Address

Over half of Medi-Cal spending is attributable to the **5% of enrollees with the highest-cost needs**

Medi-Cal enrollees typically have **several complex health conditions**

Enrollees with complex needs must often engage in **several delivery systems to access care**

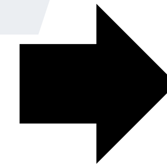
ECM, alongside Community Supports, was informed by Previous Tests

Whole Person Care Pilots (WPC)

- Limited pilot program supported by Section 1115
- Coverage and delivery system agnostic (Medicaid Managed Care, Fee For Service, or uninsured); no requirements for interfacing with managed care plans (MCPs)
- Administered by county based "Local Entities"

Health Homes Program (HHP)

- Benefit (State Plan service) in select counties
- Medi-Cal Managed Care members only
- MCP administered with care management contracted out to providers



Enhanced Care Management

- Care coordination as a MCP contract requirement
- Medi-Cal Managed Care members only
- MCP administered with care management delivered through community providers

Community Supports

- Optional services, but strongly encouraged
- Medi-Cal Managed Care members only
- MCP administered with services delivered through community providers and integrated with ECM

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans have the option to provide "in lieu of" or to help avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically-Tailored Meals or Medically-Supportive Foods
- Sobering Centers
- Asthma Remediation

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

PRESENTED BY

Paul Leon, RN, BSN, PHN, Founder and CEO

CAUTION
CUIDADO
CAUTION
CUIDADO
CAUTION
CUIDADO

Recuperative Care (408) beds

Fullerton

Anaheim

Midway City

Unity House, Fullerton, St. Jude

Whittier

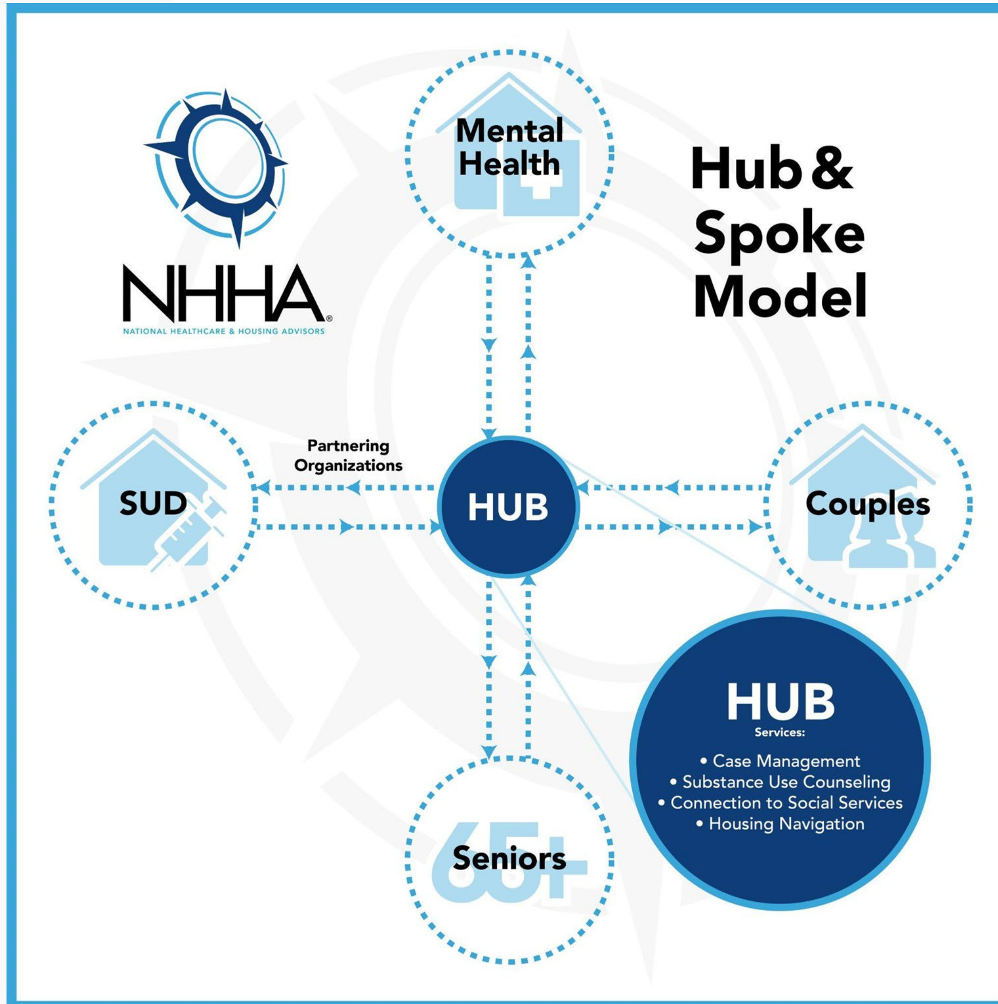
Olive View-UCLA Medical Center, Sylmar

Riverside

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Hub & Spoke Model



- Vulnerable homeless are stabilized at hub then moved to micro-community clusters when housing-ready
- If clients at micro-communities relapse or require more intensive services, they are moved back to hub and stabilized again
- Hub is base of operations for supplemental staff to support housing teams working in micro-community clusters
- Single hub and spoke system can easily accommodate 200-300 clients in operationally integrated and cost-effective manner

Micro-Communities (21 homes, 241 doors)

Supportive Housing:

- Create critical mass of clients within geographical cluster for operating efficiency
- Rooms/units from large SFR, multiplex units, and apartments

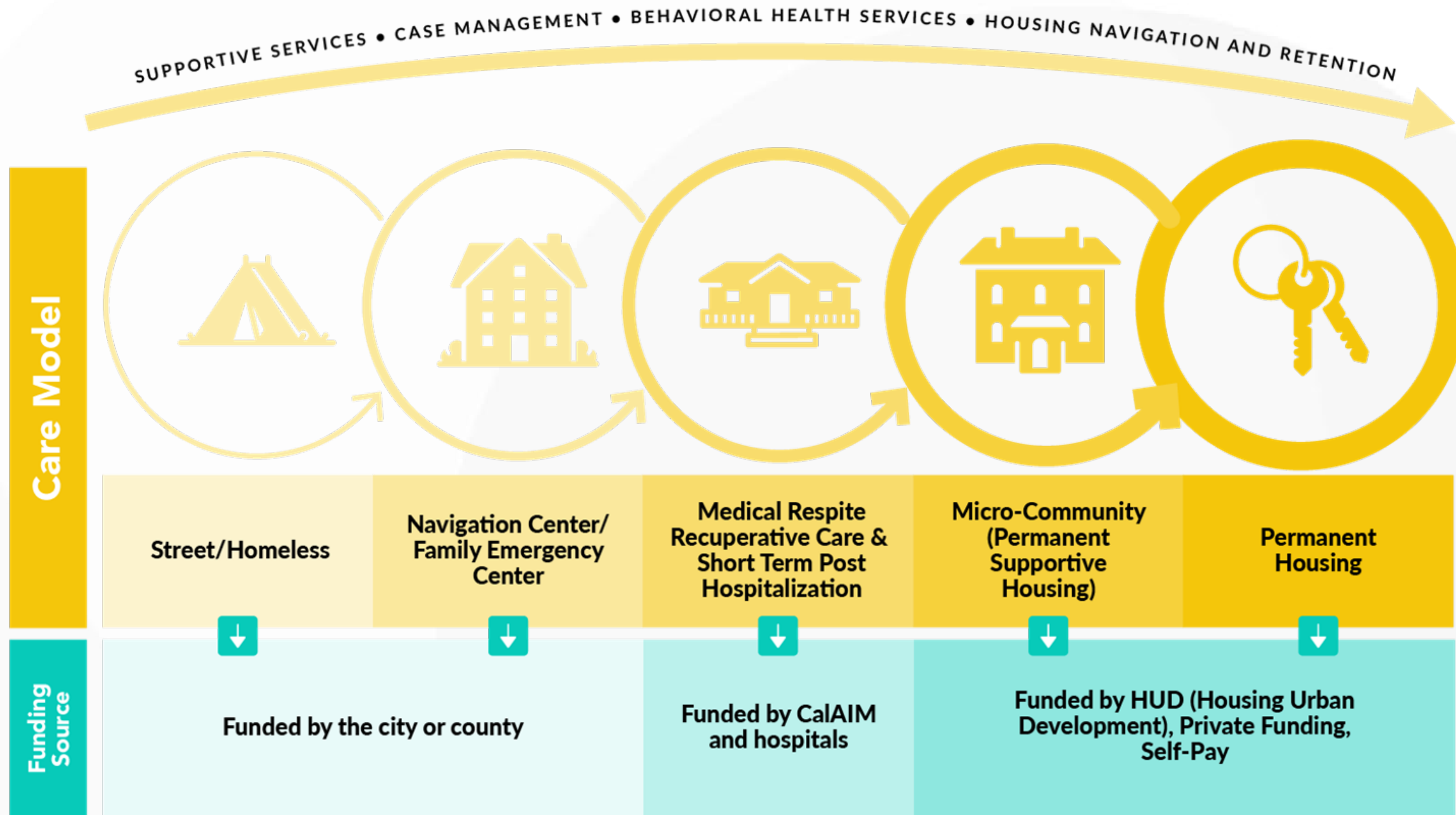
Services provided by cluster team include:

- Intensive Case Management Services (ICMS)
- Behavioral health follow up
- Housing Tenancy and Sustaining Services
- Focus on social determinants of health
- Foster creation of community to mitigate social isolation

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Street2Home System of Care



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Our Data-Driven Approach – Risk Summary

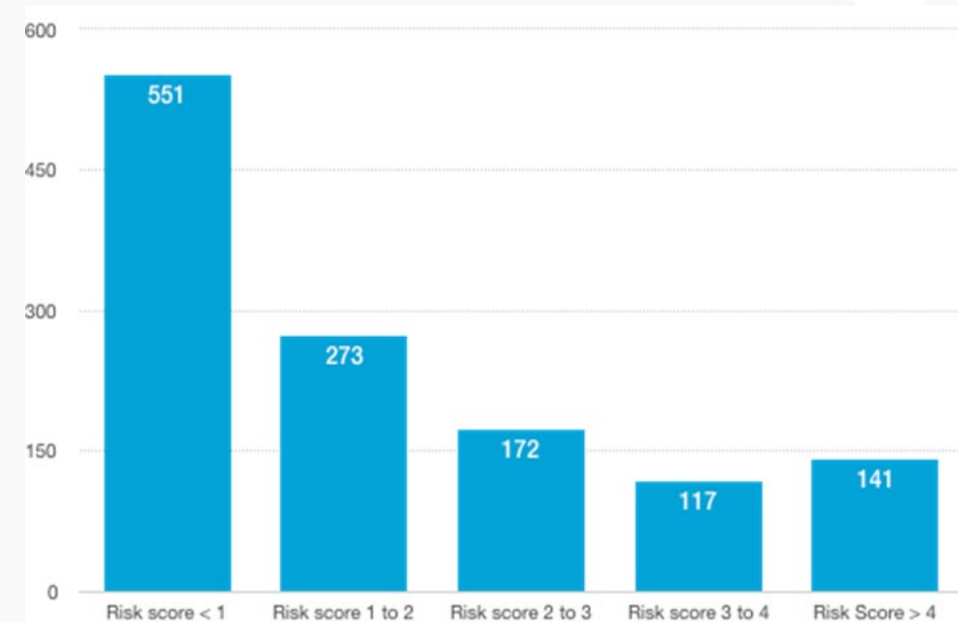
- **Average CalOptima HCC Risk Score – 2.079 (twice as risky as the average Medicaid/Medicare client in the population)**
- **Highest Risk Score – 10.98**
- **Clients with 10 or more distinct HCC diagnostic groups – 245**

Clinical risk analytics performed using the CMS **HCC predictive model**

Source: Foresight Health Solutions LLC

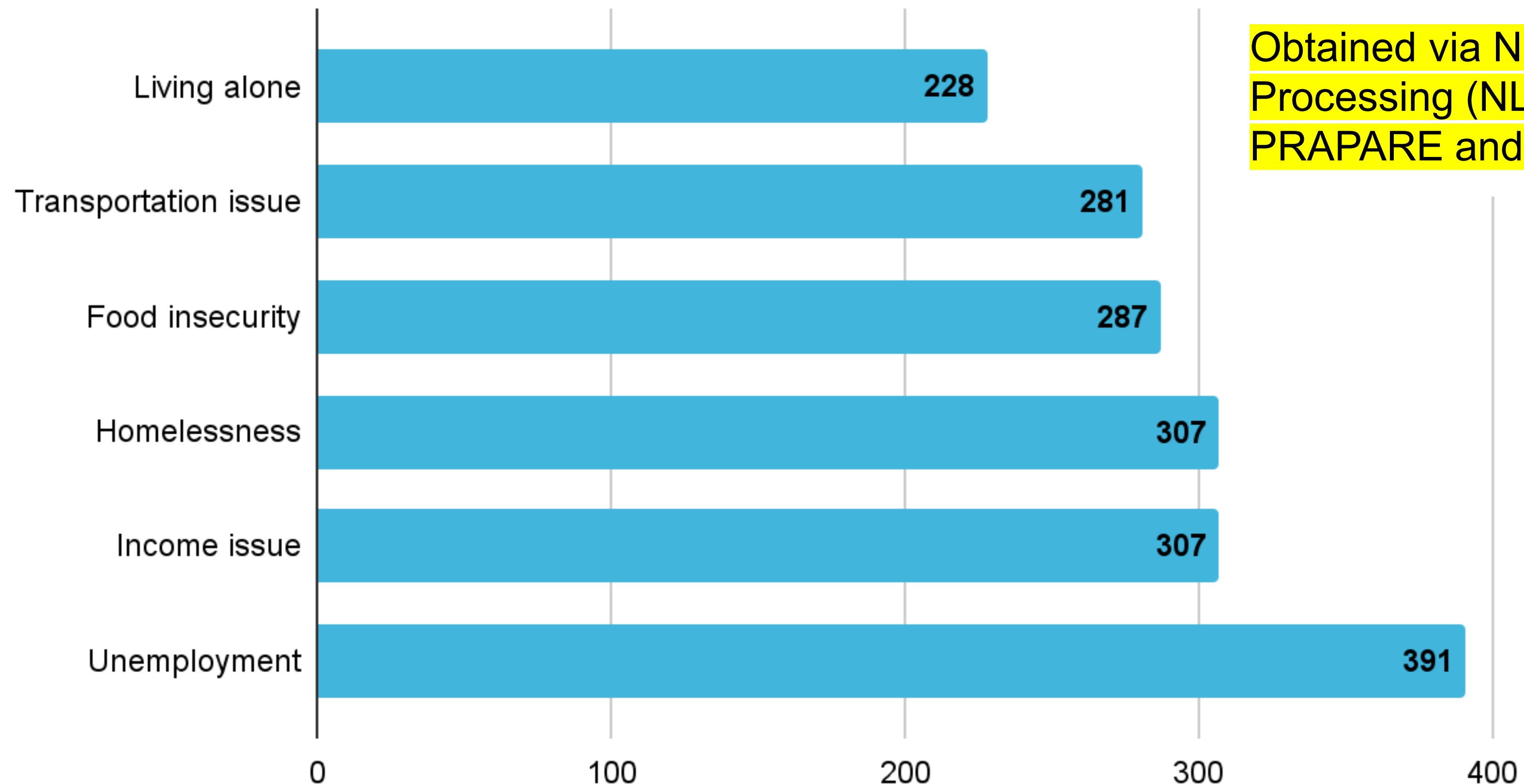
Population Breakdown by Risk Score

Risk Score	Count	Percent
Risk score < 1	551	44%
Risk score 1 to 2	273	22%
Risk score 2 to 3	172	14%
Risk score 3 to 4	117	9%
Risk Score > 4	141	11%
TOTAL	**1254**	



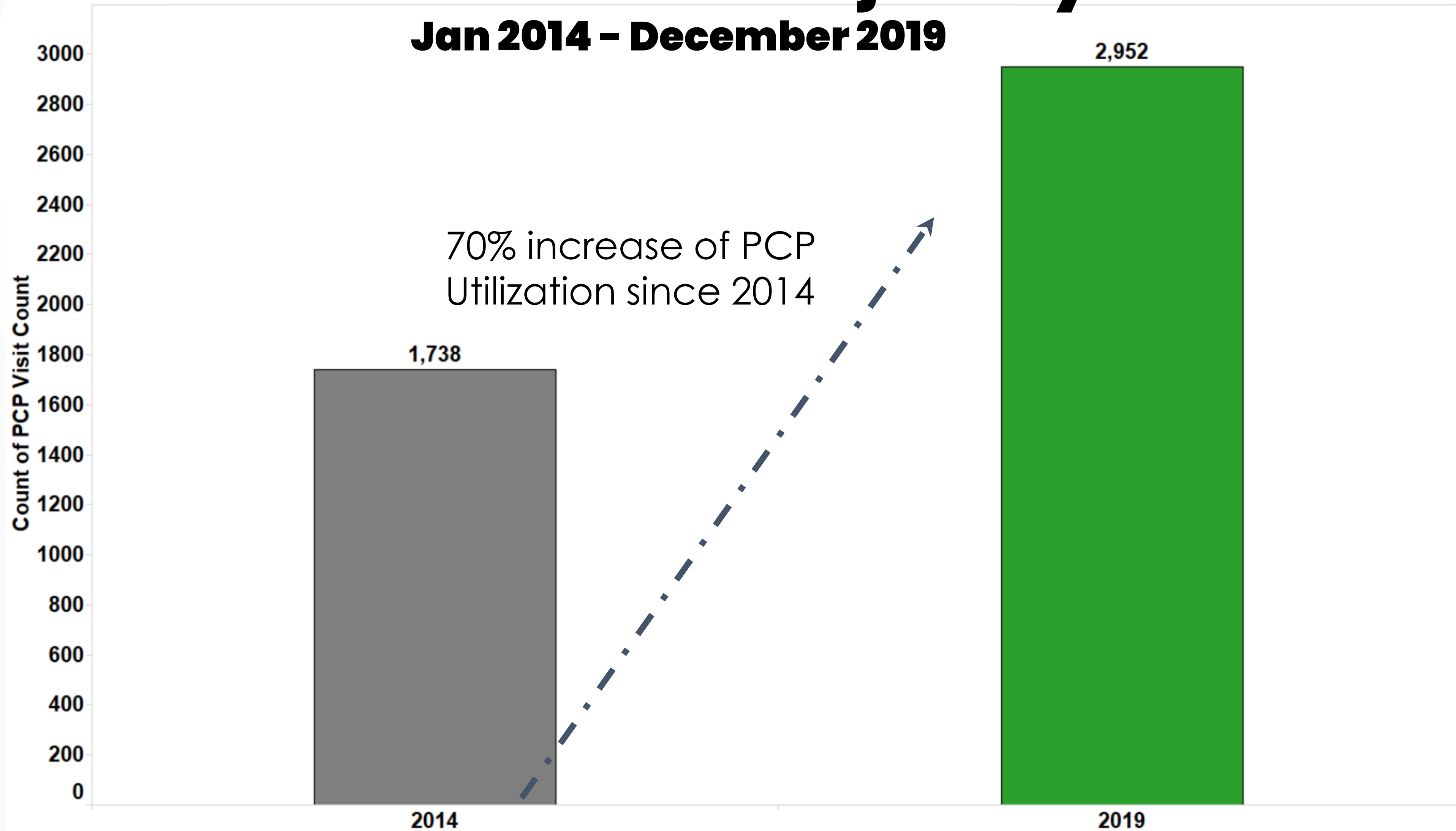
Source: Foresight Health Solutions LLC

Top SDoH Risk Contributors for CalOptima Members - Dec '21



Obtained via Natural Language Processing (NLP) of EMR notes, PRAPARE and other surveys

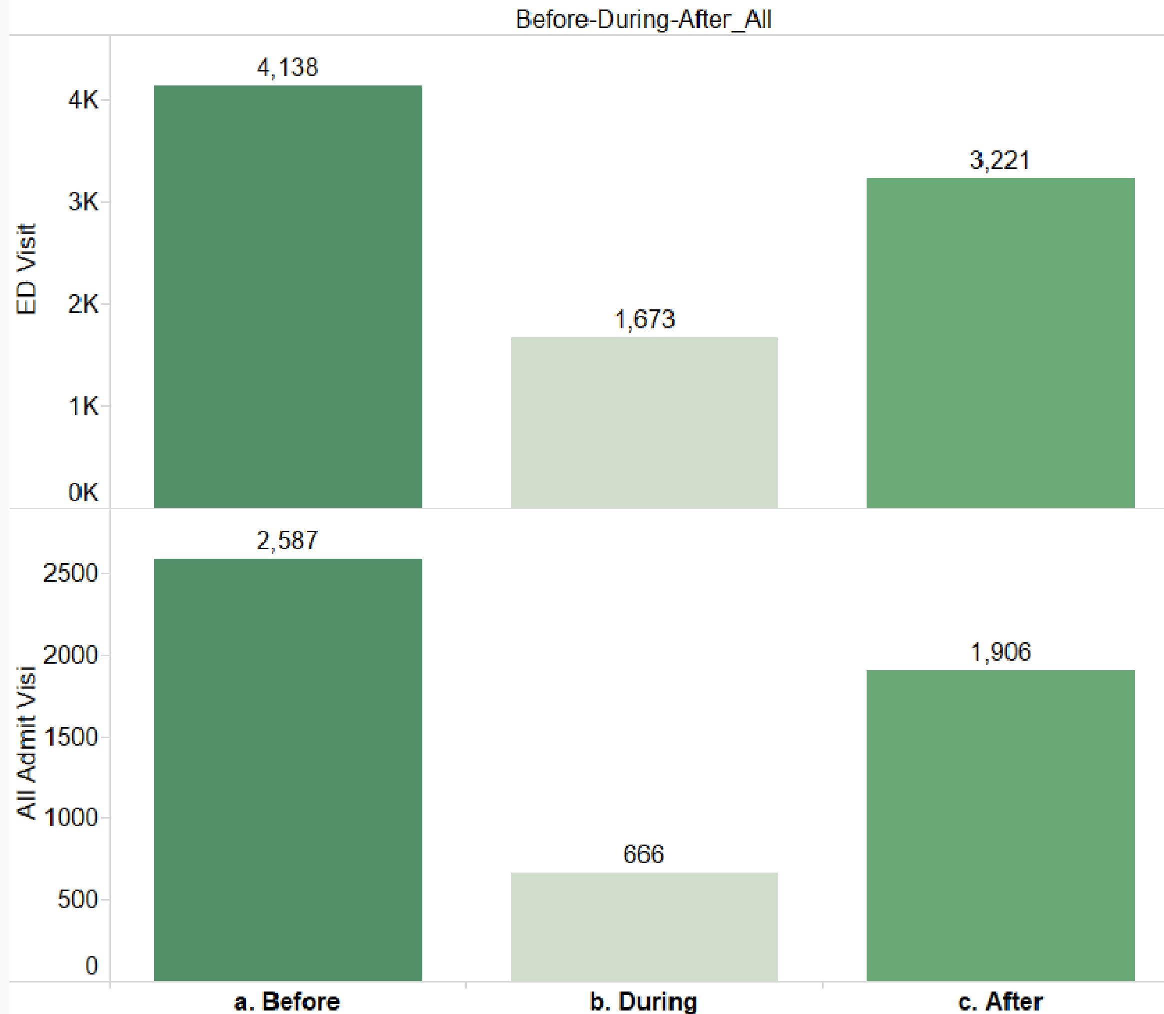
PCP Utilization Trajectory



ILLUMINATION FOUNDATION
DISRUPTING THE CYCLE OF HOMELESSNESS

Source: CalOptima Enterprise Analytics Department

ED and Admit Utilization (Before/During/After)

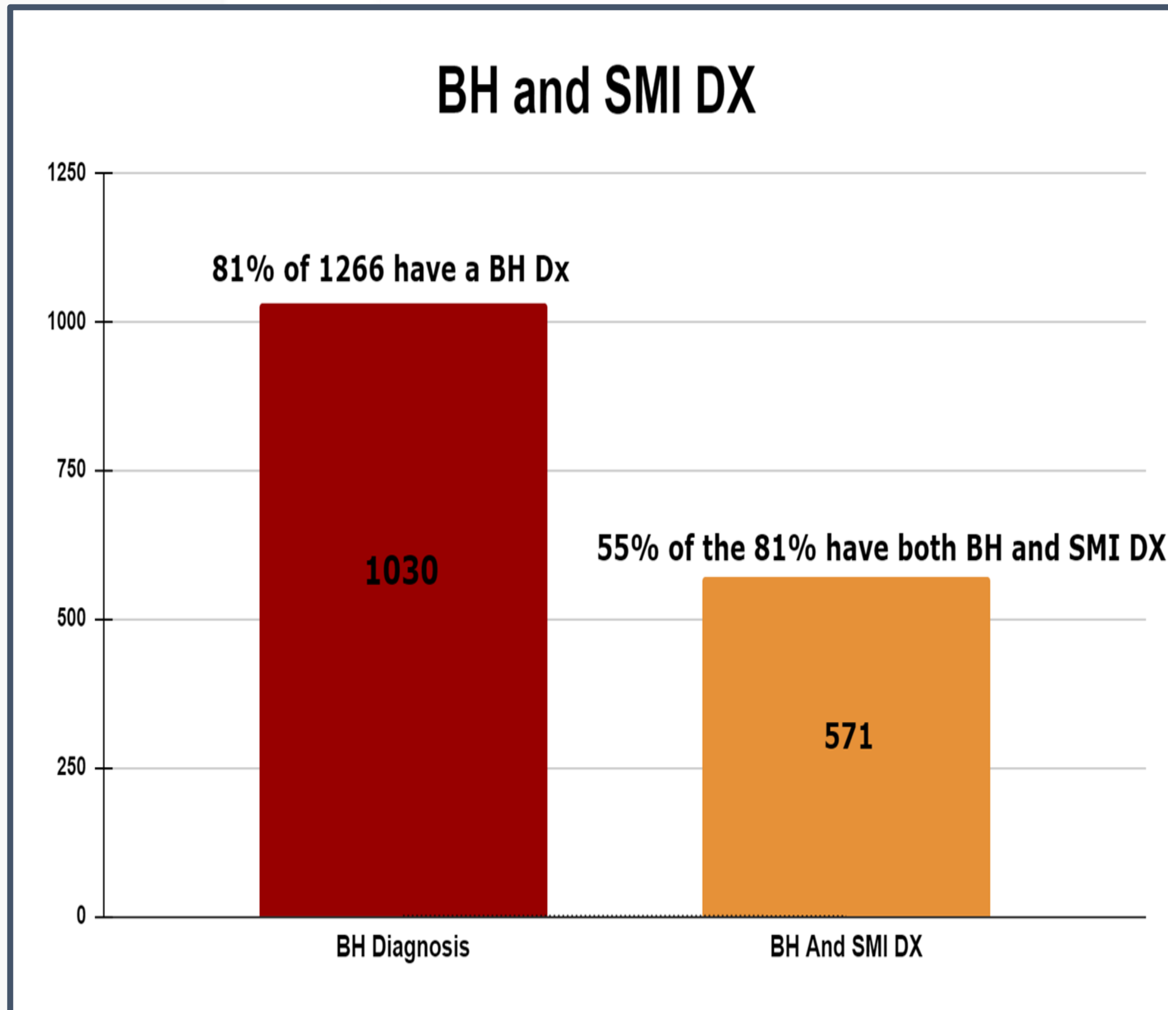


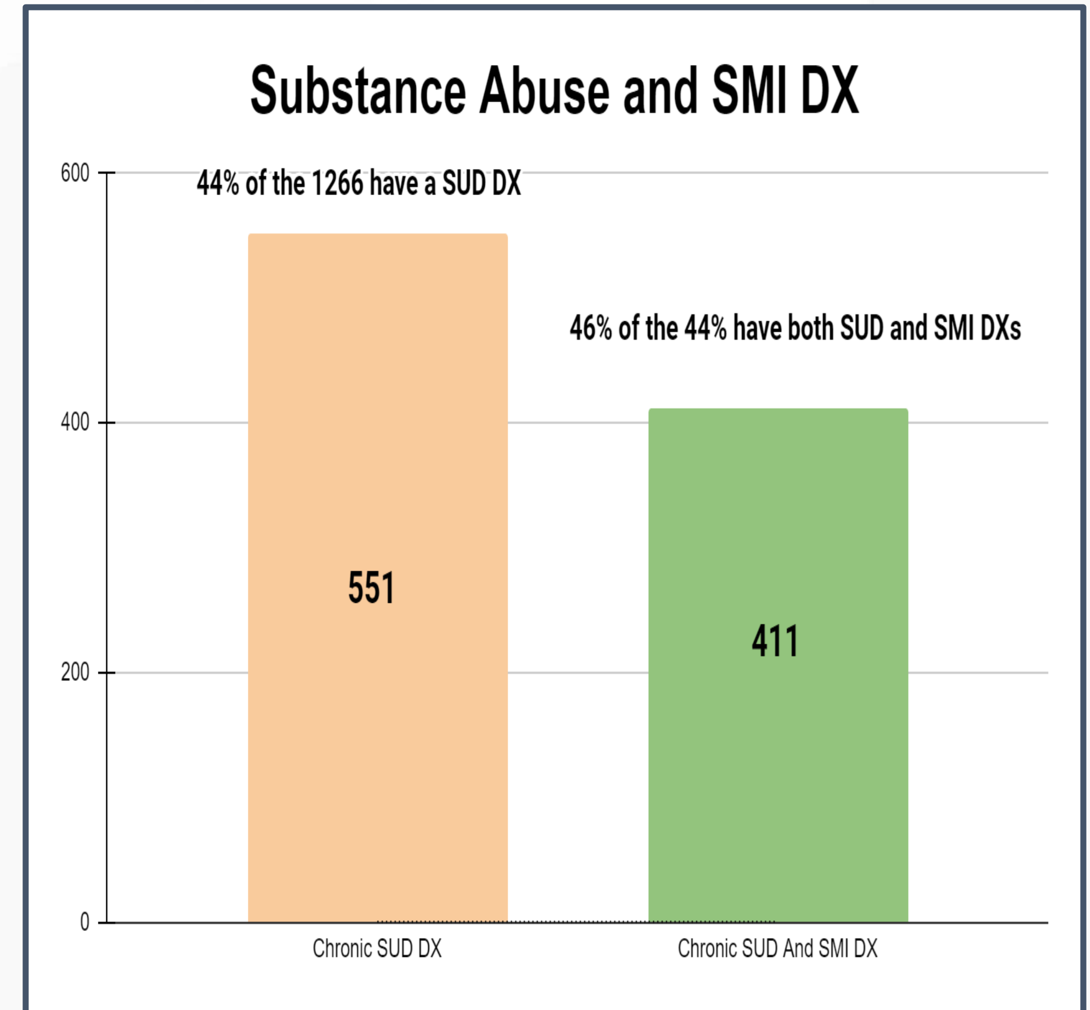
ER and Admit Utilization*			
Status	Before	During	After
ER Visits	4,138	1,673	3,221
Admit Counts	2,587	666	1,906

***Before/During/After Calculation:**
The before, during, and after time period is simply filtering down any services that occurred beyond a year before or a year after their initial intake and final exit respectively. During has no time restraints beyond the date of service falling within their initial intake date and final exit date.

Source: CalOptima Enterprise Analytics Department

Behavioral Health And Substance Abuse





Source: CalOptima Enterprise Analytics Department

Comparative Cost Savings in a 6-Month and 1-Year Post-Intervention Period

Service Category	PMPM Savings after 6 months	PMPM Savings after 1 year
Behavioral Health Therapy Sessions	$814.54	$964.02
OTC Medication Assistance and Counseling	$805.22	$1007.95
Multidisciplinary Team Action	$652.33	$1066.25
Information Meet and Greet	$590.49	$873.35
Crisis Intervention	$517.59	$754.78
Medical Advocacy	$489.53	$883.27
Medical and Case Management Education	$440.06	$740.84
Housing Case Management	$17.21	$218.14
Basic Needs Assistance	($33.007)	$31.40
Transportation	($203.99)	$152.86

Cost Savings

Saved Health Plan more than $17 Million while clients were in Illumination Foundation's recuperative care program, compared to the year before they entered (based on 1,266 clients).

Before, During, After Breakdowns			
Data Point	**Before**	**During**	**After**
Cost Breakdown	$25,698,776	$7,946,497	$17,797,206

CalAIM Financial Projections

REVENUE

Claim Type	January 2022	February 2022	March 2022	April 2022	May 2022	Grand Total
ECM	$45,076.82	$43,192.05	$48,439.16	$64,818.89	$25,108.56	$226,635.48
Housing	$84,945.00	$104,616.00	$186,106.00	$245,284.00	$192,252.00	$813,203.00
OC Accompaniment	$5,320.00	$7,860.00	$11,340.00	$11,420.00	$5,280.00	$41,220.00
Recup	$206,338.00	$288,828.00	$439,796.00	$534,994.00	$494,933.00	$1,964,889.00
Grand Total	$341,679.82	$444,496.05	$685,681.16	$856,516.89	$717,573.56	$3,045,947.48

MONTHLY BREAKDOWN

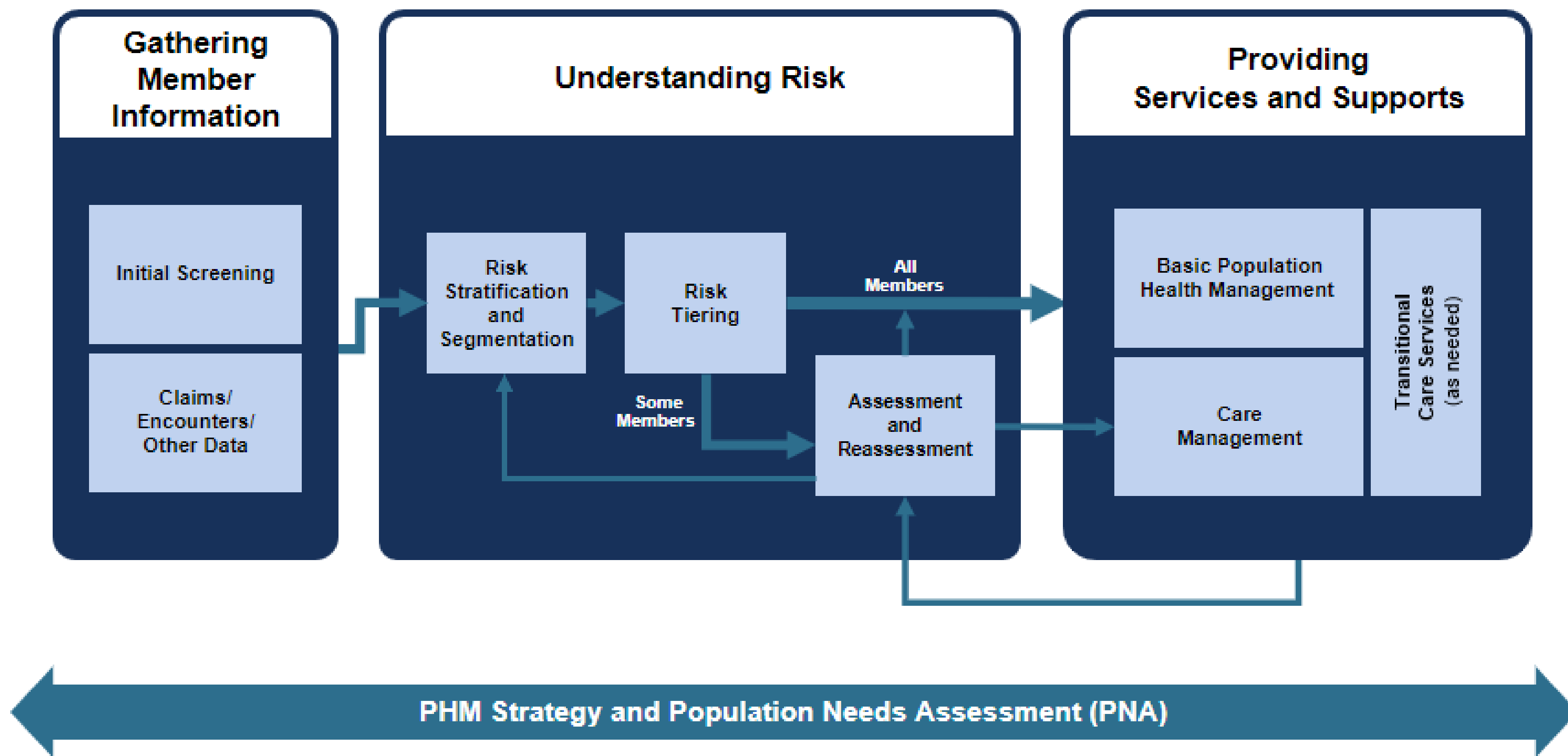
Month Filter | April 2022

Claim Type	Health Plan	Units		Rate		Amount
ECM	Anthem	5	Client(s)	$396.64		$1,983.20
	Blue Cross Blue Shield	8	Client(s)	$120.00		$960.00
		11	Client(s)	$320.36		$3,523.96
	HealthNet	3	Client(s)	$34.41		$103.23
	LA Care	3	Client(s)	$302.00		$906.00
		110	Client(s)	$400.00		$44,000.00
	Molina	25	Client(s)	$533.70		$13,342.50
					Total	$64,818.89
Housing	Blue Cross Blue Shield - Hou..	21	Client(s)	$324.00		$6,804.00
	CalOptima - Housing Navig..	156	Client(s)	$449.00		$70,044.00
	CalOptima - Housing Sustai..	50	Client(s)	$475.00		$23,750.00
	IEHP - Housing Navigation	222	Client(s)	$535.00		$118,770.00
	IEHP - Housing Sustainabili..	27	Client(s)	$525.00		$14,175.00
	Kaiser IE - Housing Navigati..	4	Client(s)	$449.00		$1,796.00
	Kaiser LA - Housing Navigat..	2	Client(s)	$449.00		$898.00
	Kaiser OC - Housing Naviga..	3	Client(s)	$449.00		$1,347.00
	Kaiser OC - Housing Sustain..	2	Client(s)	$450.00		$900.00
	LA Care - Housing Navigation	12	Client(s)	$430.00		$5,160.00
	LA Care - Housing Sustaina..	2	Client(s)	$430.00		$860.00
	Molina - Housing Navigation	1	Client(s)	$350.00		$350.00
	Molina - Housing Sustainab..	1	Client(s)	$430.00		$430.00
					Total	$245,284.00
OC Accompanim..	CalOptima	571	Unit(s)	$20.00		$11,420.00
					Total	$11,420.00
Recup	CalOptima	1,667	Day(s)	$226.00		$376,742.00
	IEHP	84	Day(s)	$119.00		$9,996.00
		646	Day(s)	$226.00		$145,996.00
	Kaiser IE - Recup	2	Day(s)	$226.00		$452.00
	Kaiser OC - Recup	8	Day(s)	$226.00		$1,808.00
					Total	$534,994.00
					Grand Total	$856,516.89

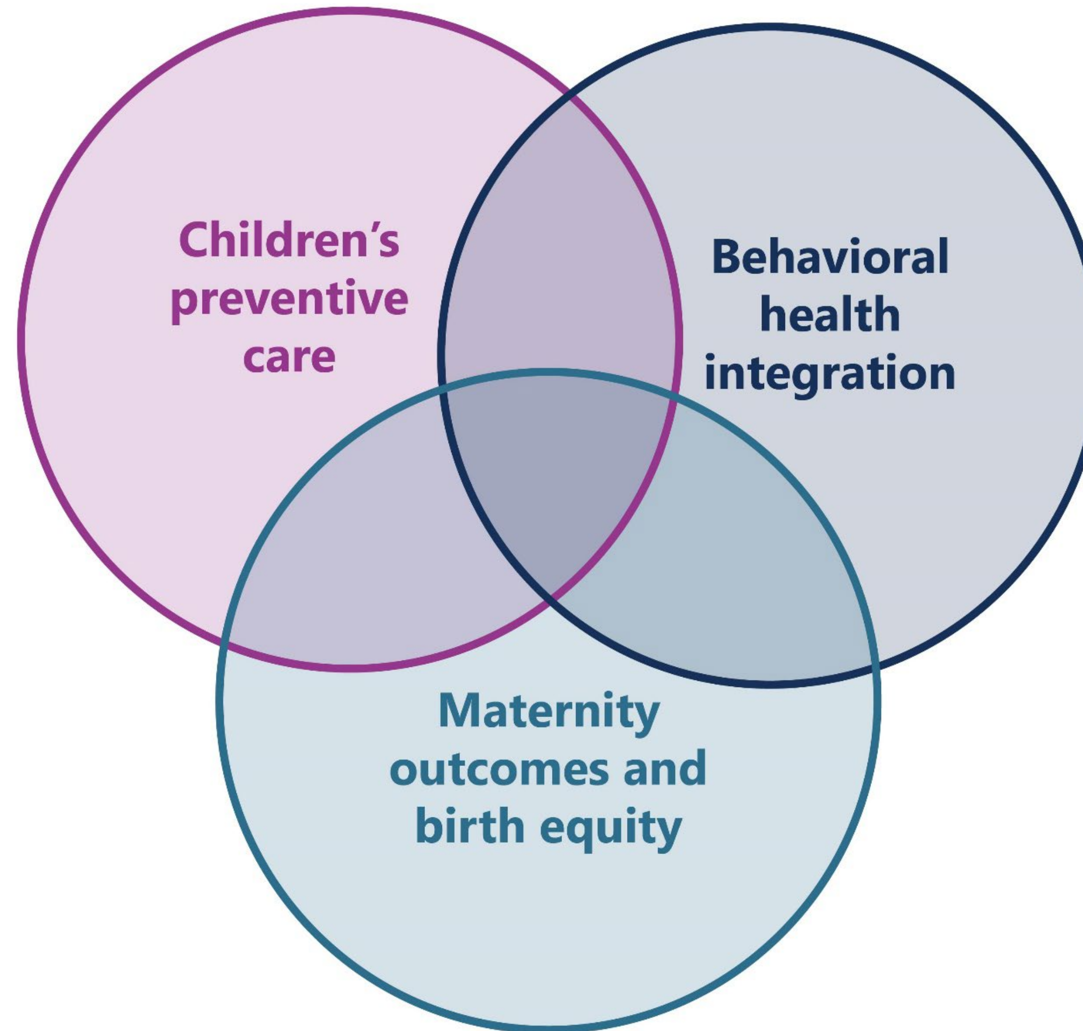
Taking the long view of health and wellness

DHCS' 2022 Comprehensive Quality Strategy

PHM Framework Overview



The long view of health and wellness in California



Thinking big:

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

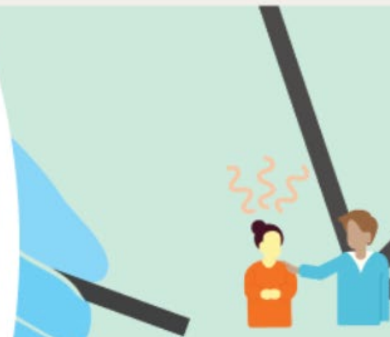
Re-Centering Primary Care

NATIONAL ACADEMIES *Sciences Engineering Medicine*

About Us Events Our Work Pub

Implementing High-Quality Primary Care

Implementing High-Quality Primary Care:
Rebuilding the Foundation of Health Care



- Investing in primary care transformation
- Reporting on % of spending on primary care
- Alternative payment model arrangements
- Integration with public health and social services