A Proven Model Managing California's Medicaid Populations

Innovation in an aggressive Medicaid market

INTEGRATED HEALTH PARTNERS
of Southern California

Our Inspired Leadership Team

Amanda Simmons
Executive Vice President

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- Amanda is accountable for setting the vision and ensuring stellar performance of the Clinically Integrated Network (CIN), Accountable Care Organization (ACO), and Health Center Controlled Network (HCCN) to positively impact member health centers and the communities they serve.
- Prior to IHP, Amanda was a Principal over the Premier Strategy, Innovation, and Population Health (SIPH) Value Based Transformation pillar and the Medicaid and Managed Medicaid Transformation Consulting line for seven years.
- Amanda has dedicated her career to bringing equity and transformation to vulnerable populations.

Our Inspired Leadership Team

Dr. Jay W. Lee, MPH
Medical Director

Email | jlee@ihpsocal.org

- Dr. Lee has nearly two decades of experience leading and innovating in family medicine and primary care delivery systems.
- Dr. Lee most recently served as CMO at Share Our Selves, an FQHC serving vulnerable patients in Orange County, CA, and was the recipient of the Primary Care Collaborative's 2020 Advanced Primary Care Practice Award.
- Dr. Lee is a past president of the California Academy of Family Physicians (CAFP) and co-founded the Family Medicine Revolution, a grassroots social media brand.

What is Medi-Cal?

Medi-Cal is California's Medicaid program, a public health insurance program that provides free or low-cost healthcare to millions of low-income Californians. It's jointly funded by the state and federal governments and administered by the California Department of Health Care Services (**DHCS**).

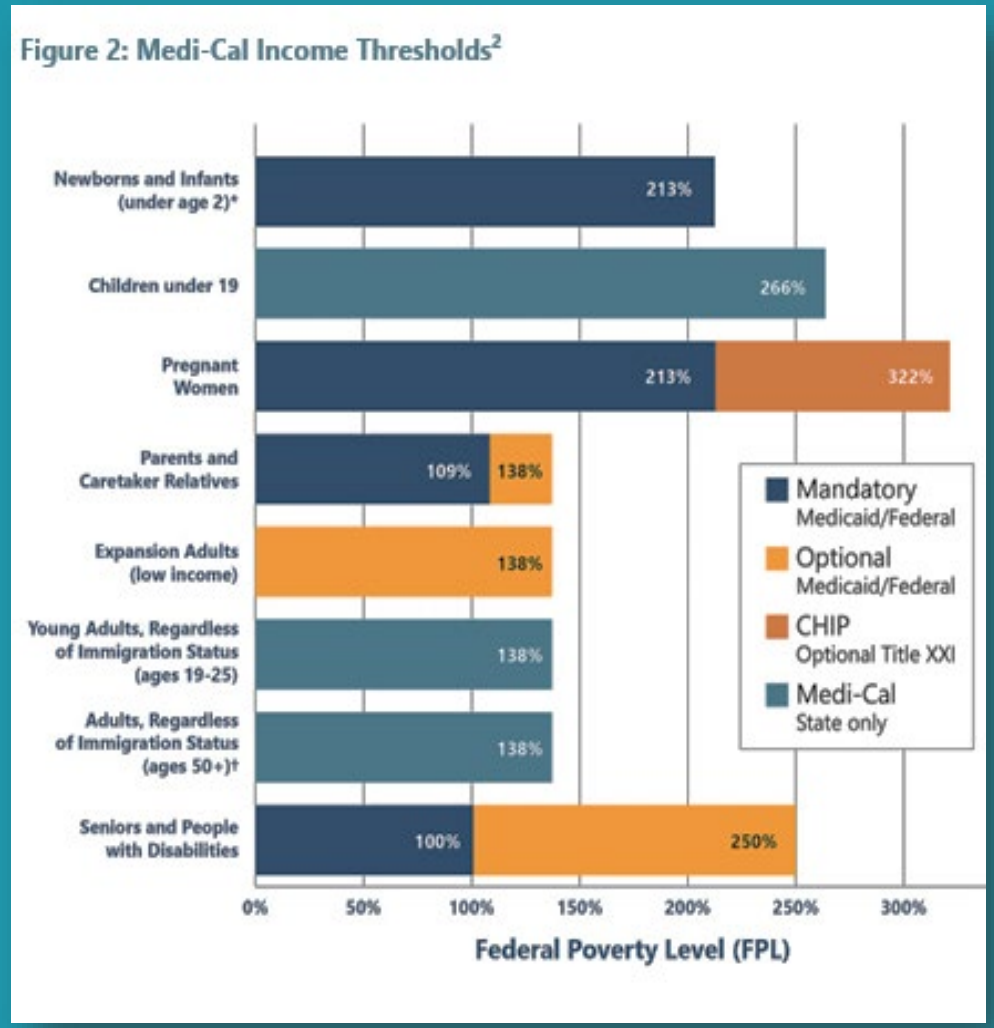
Enrollment: Nearly 14.5 million enrolled (~38% of Californians) - *California Health Care Foundation*

Eligibility Groups: Low-income adults, children and foster youth, seniors and people with disabilities, pregnant individuals, undocumented individuals (138% FPL), people experiencing homelessness or serious chronic illness

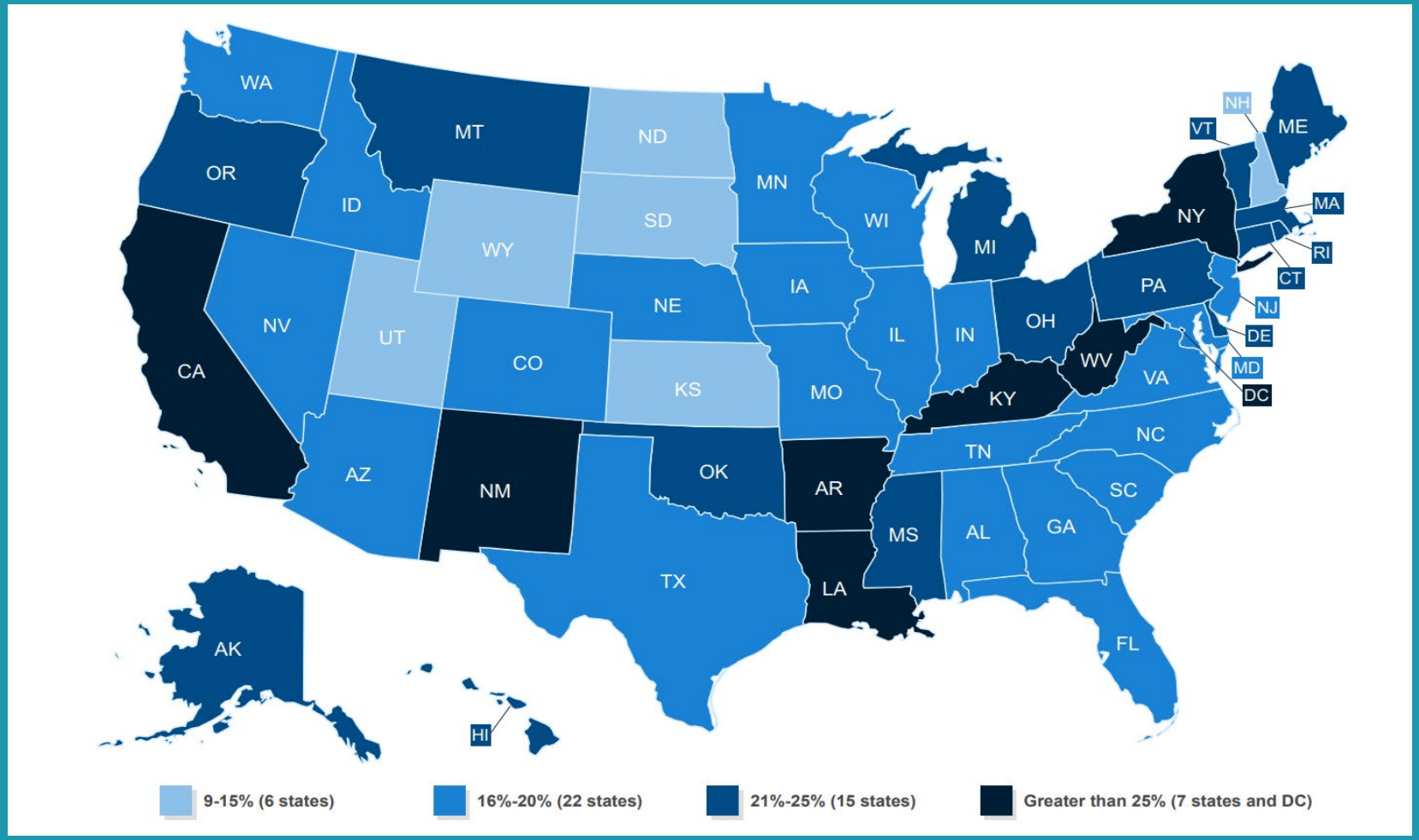
Benefits: Primary care, emergency services, hospitalization, maternity care, mental health and substance use treatment, dental (Denti-Cal), vision, long-term care, and support service

Supports Key Medi-Cal Programs

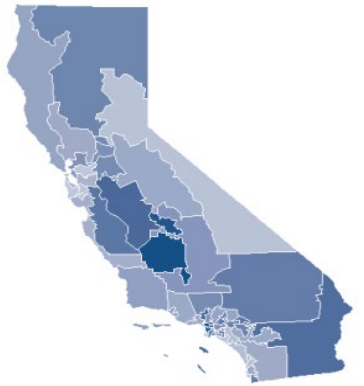
- CalAIM (California Advancing and Innovating Medi-Cal)
- Enhanced Care Management (ECM)
- Community Supports (ILOS)
- Dental (Denti-Cal)



California Statistics



Medicaid covers from 18% to 66% of people in CA's congressional districts



In California, Medicaid covers…

Births	40%
Children	43%
Adults ages 19-64	23%
Working-age adults w/ disabilities	48%
Medicare beneficiaries	25%
Nursing home residents	61%

What Makes Medi-Cal Different

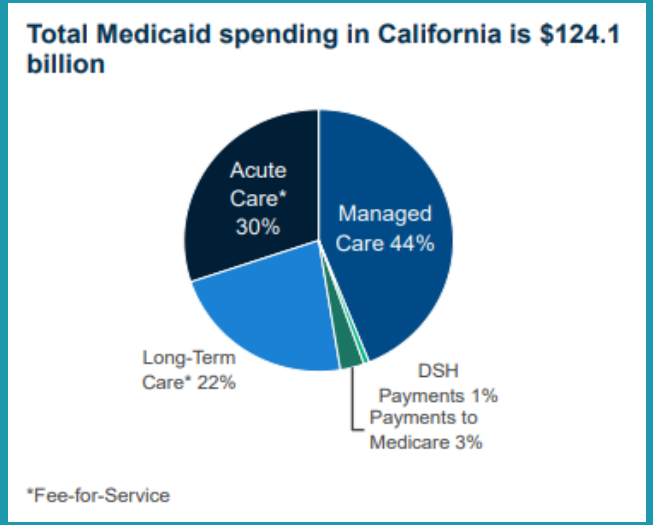
California	
Undocumented Coverage	Full-scope Medi-Cal regardless of immigration status *Medi-Cal enrollment for UIS patients frozen January 1, 2026
Whole-Person Care	CalAIM, Enhanced Care Management, Community Supports
Managed Care Reach	Requires most member to enroll in Managed Care Plan, (90%+ enrolled in an MCP)
Use of Waivers	Aggressive use (e.g., 1115) for innovation funding

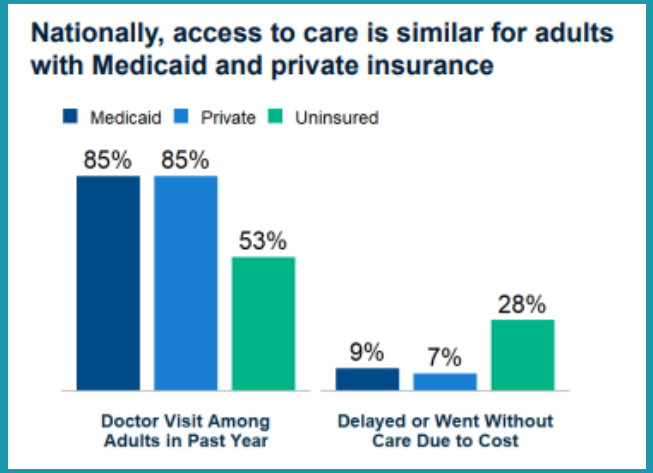
Other States	
Undocumented Coverage	Typically, excluded or limited eligibility
Whole-Person Care	Limited integration of social determinants
Managed Care Reach	Varies—many rely on fee-for-service structures
Use of Waivers	More cautious or limited utilization

Impacts & Key Takeaways

California leads the way in coverage expansion, whole-person care, and integration. ECM and Community Supports are becoming mandatory for high-risk groups, which is unique.

- **Equity Focus:** Coverage now includes all income-eligible adults regardless of immigration status
- **Innovation Hub:** CalAIM, ECM, ILOS, and Managed Care reform set a national example
- **Improved Access:** Emphasis on social needs (housing, nutrition), integrated behavioral health
- **Policy Driver:** Uses federal waivers (1115, 1915(b)) to push boundaries
- **Future Outlook:** Medi-Cal stands as a model—balanced between progressive goals, financial sustainability, and political feasibility.

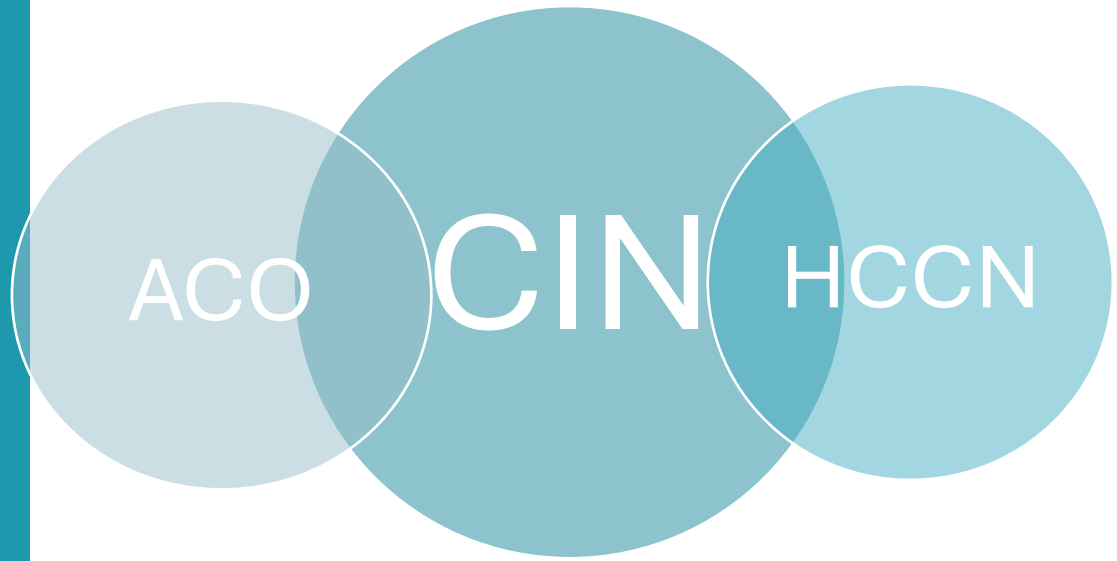




Leveraging a Family of Companies to Drive Innovation

A Family of Companies

Leveraging Thought Leadership and SME Across Disciplines



TIME TO SHINE IN VALUE & OBTAIN SUSTAINABLE GROWTH

Federal and state healthcare dynamics provide an opportunity to lean-into challenges using our historic performance and success to launch growth for new business ventures.

FUN FACT

Over 50% of Fortune Five Hundred companies were created in a crisis or recession

Focus to Value

Value Based Care/Payment

Expand the VBC/P concept to additional payer markets to get closer to the premium dollar and impact quality of care to drive value to health centers

Grow & Scale

Leverage Proven Concept & Meet Member Needs

Utilize the proven network value proposition to scale services and expand membership

Innovate

Rapid Innovation

Meet market, member, and patient needs utilizing existing data to develop innovative models complimentary to the network

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Mission and Vision

Mission

To develop a network of health centers dedicated to equity in health care by becoming a community-based resource that drives change through quality, innovation, and providing access.

Vision

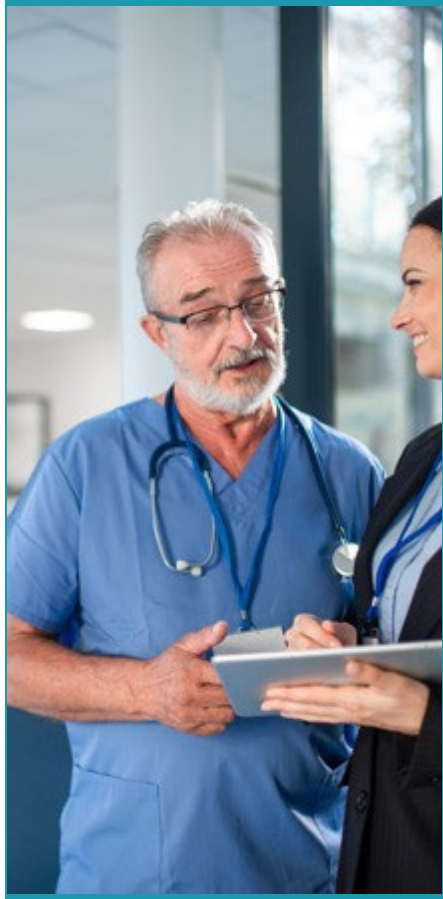
Improve Quality & Health Disparities through:

- Engagement
- Empowerment
- Education
- Enhancement to Care
- Advancing Technology

Primary Care Networks

Ten years of being a powerful advocate for primary health care service providers and their patients, striving to create a stronger health care safety net by:

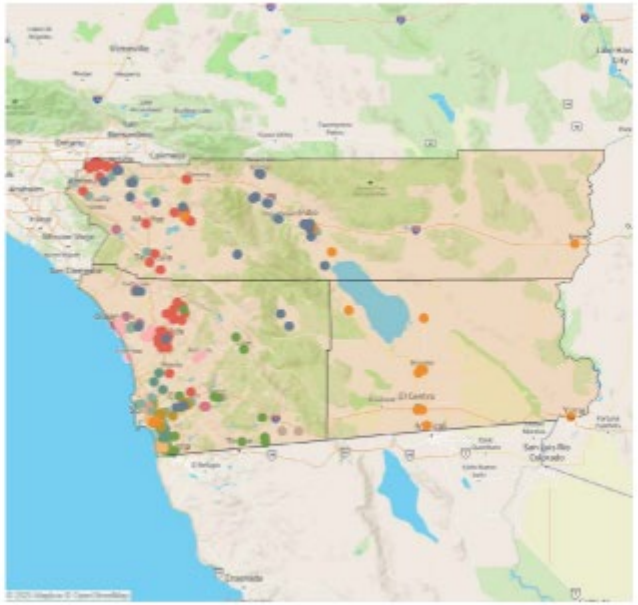
- Delivering higher quality of care and achieving new levels of performance and accountability.
- Developing stronger relationships with payers while improving the network's ability to perform at optimal efficiency in managed care contracts.
- Helping FQHCs respond to the changing environment for payment reform.
- Focusing on health equity and disparities in the community to improve access and health for all through network collaboration.



Network by the Numbers

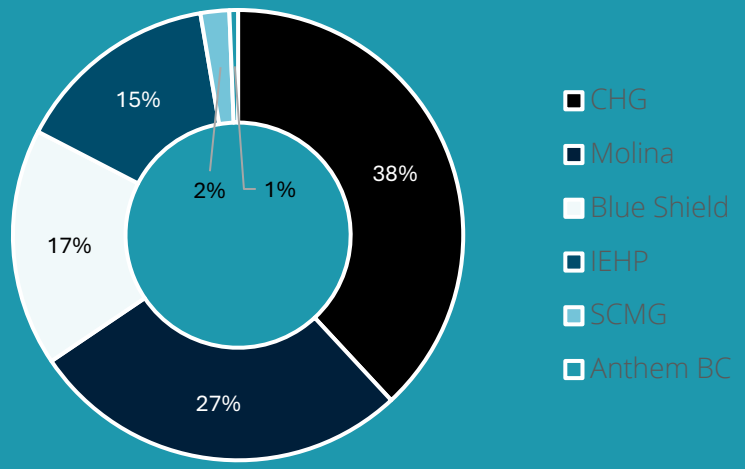
Nine Health Center Members

- Community Health Systems, Inc.
- DAP Health
- Imperial Beach Community Clinic
- Indian Health Council, Inc.
- Innercare, Inc.
- La Maestra Community Health Centers
- Neighborhood Healthcare
- OpSam Health
- Planned Parenthood of the Pacific Southwest, Inc.
- San Diego American Indian Health Center
- San Diego Family Care
- San Ysidro Health
- Southern Indian Health Council, Inc.
- Sycuan Medical Dental Center
- TrueCare
- Village Health Center
- Vista Community Clinic



Total Enrollment	March 2025
Covered CA	11,382
Medicare & Medi-Medi	11,786
Medi-Cal	346,442
Total	**369,610**

IHP Network Payer Mix



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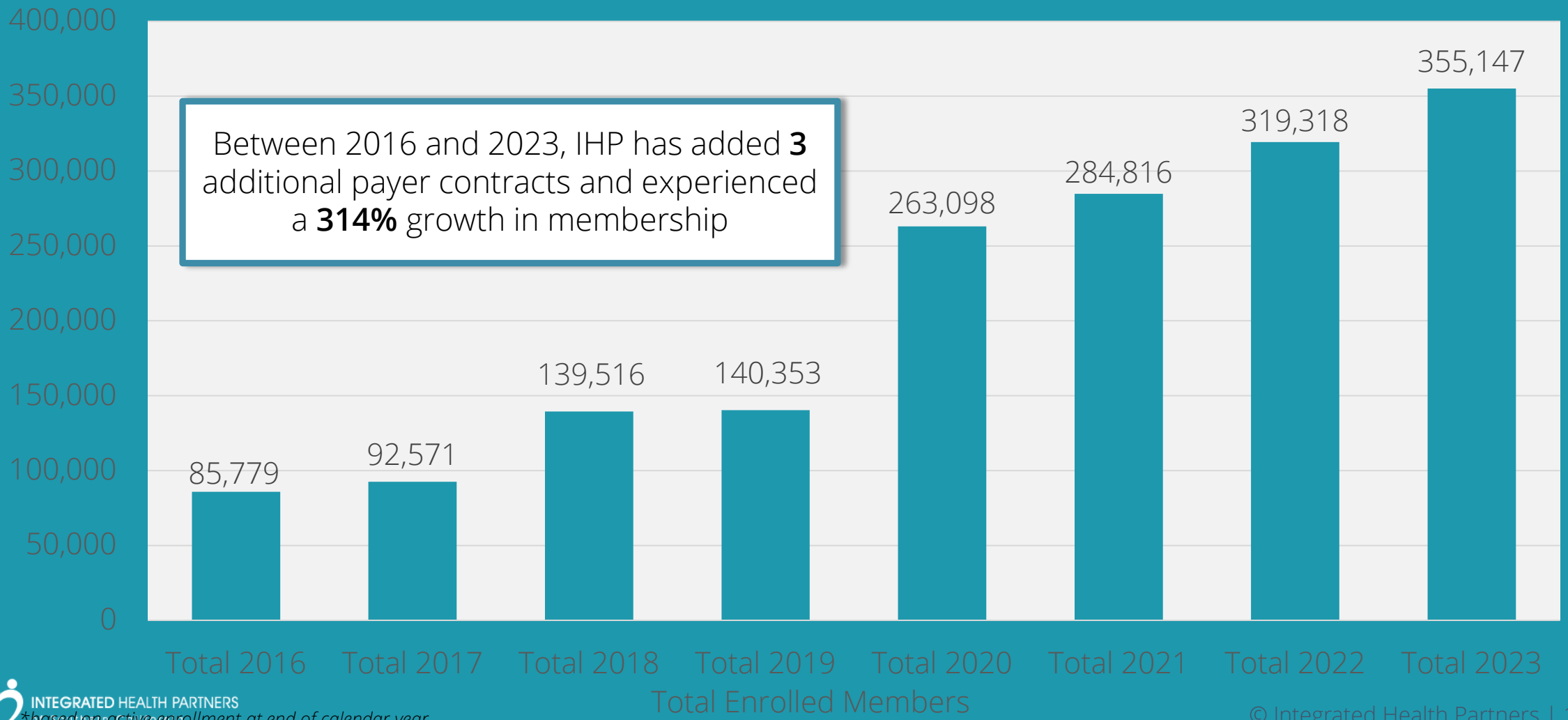
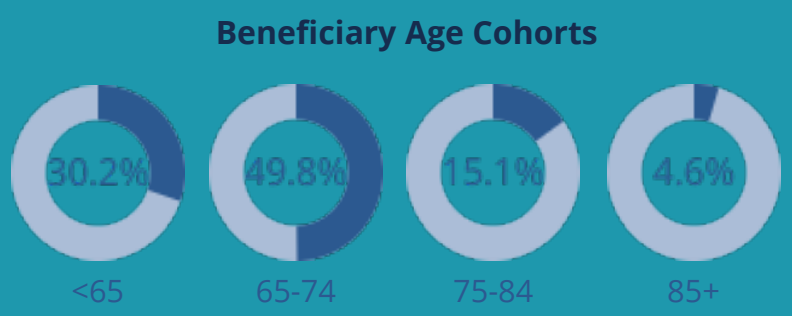
IHP: Year-Over-Year Enrollment* Trends

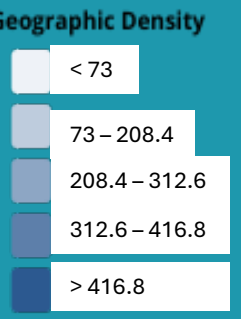


*based on active enrollment at end of calendar year

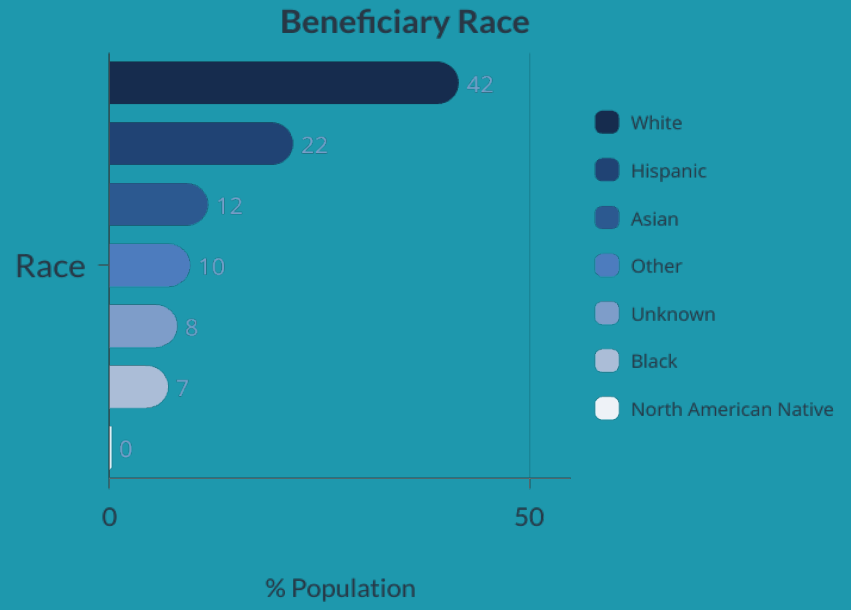
ACO by the Numbers

ACO Beneficiaries
January 2025: 5,672





42.4% Male Beneficiaries
57.6% Female Beneficiaries



Community Health Systems, Inc.
Father Joe's Villages
Village Health Center
Imperial Beach Community Clinic
OPSAM HEALTH
Caring for the Community Since 1973
SAN DIEGO FAMILY CARE
A California Non-Profit Corporation
SAN YSIDRO HEALTH
truecare

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HCCN by the Numbers

HCCN Objectives

Objective 1: Data Management and Analytics
Objective 2: Interoperability and Data Sharing
Objective 3: Data Modernization
Objective 4: Additional Value-Based Care (elective)
Objective 5: Strengthening Cybersecurity Support (elective)

Value Proposition

IHP is a powerful advocate for primary health care service providers and their patients, striving to create a stronger health care safety net by:

- Delivering higher quality of care and achieving new levels of performance and accountability.
- Developing stronger relationships with payers while improving the network's ability to perform at optimal efficiency in managed care contracts.
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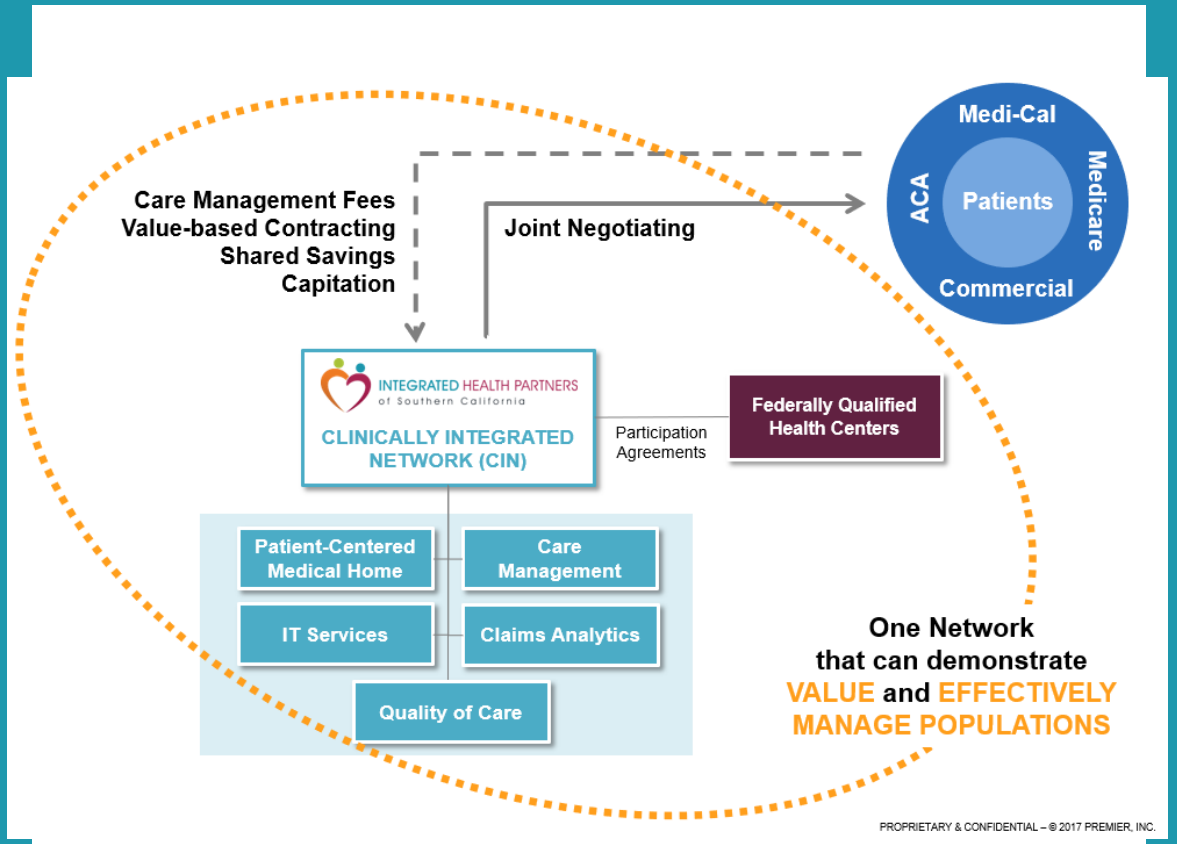

Core Elements of the CIN and ACO

Clinical Quality Improvement

Clinical practice protocols

Practice guidelines

Risk-based coding with payers

Clinical Committee

Clinical Information Systems

Analytics strategy for clinical technology including the population health data aggregation tool

Informatics & Technology Committee

Participation Criteria

Network performance standards

HEDIS measure thresholds

Utilization Control Mechanisms

Utilization management by MSO

Data validation

Operational Committee

Centralized Network Staff

Population health leadership

Finance

Contracting

Quality

Billing

Revenue Cycle

Informatics

Network Improvement Framework

Future Planning with Measurable Goals — **Transparency and Accountability** — **Aligned Incentives and Improvement Efforts** — **Value-Add to Network, Providers, Patients, and Community**

Tactical Pillars of Success

Governance and Strategy

- Define Vision and Measurable Expectations
- Partnership / Affiliations
- Create Value Proposition
- Align Committee Focus and Deliverables
- High-Value Network

Data and Analytics

- Population Health Tool
- Prioritize Quality and Operational Metrics to Maximize Impact and Return
- Payer Data Set Utilization
- Dashboard Development with Benchmarks and Goals

Care Transformation & Operations Optimization

- Population Health Strategies
- Evidence-Based Medicine
- Community-Based Partnerships
- SDoH / Health Equity
- MSO Performance Improvement

Payer Diversification and Payment Reform

- Senior Strategy
- Full Professional Risk
- Cost of Care
- Maximizing Existing MCO Contract Incentives

Strategic Highlights

Arcadia

Harnessing Data to Drive Value-Based Care

About Arcadia

- Comprehensive population health platform
- Aggregates clinical, claims, and social determinants of health (SDOH) data

Network Use

- Identifying care gaps and high-risk populations
- Tracking performance on quality measures
- Supporting provider alerts and care team coordination

Benefits

- Real-time insights for targeted interventions
- Better alignment between clinical and social care efforts

Enhanced Care Management

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit that supports members with complex physical, behavioral, and social health needs.

Through partnerships with managed care plans, Integrated Health Partners delivers ECM services that connect members to the right care and resources, improving coordination and overall well-being.

Goal

- ✓ Improve health outcomes
- ✓ Reduce unnecessary ED and hospital use
- ✓ Care Coordination to ensure member engagement
- ✓ Address barriers like housing, food, transportation, and behavioral health

Clinician Responsibility

- Complete whole-person assessments (medical, behavioral, social)
- Develop individualized, member-centered care plans
- Coordinate across medical, behavioral, and social services
- Conduct outreach and maintain member engagement
- Resolve barriers and connect members to resources

IHP & MCP Collaboration

- MCP identifies eligible members to refer to provider
- Exchange of member data, care plans, and updates
- Jointly support members through coordinated services
- Track and share outcomes (ED reduction, quality measure improvement)

Reducing Emergency Room Visits

To reduce avoidable emergency department (ED) visits, IHP Social Care Management team identifies patients with ED visits and reconnecting them to their PCPs through enhanced care coordination, and patient engagement strategies.

Reduced ED Visits by 2.2%

Reduced Readmission by 7%

Reduced UC Eligible ER Visits by 1.6%

Patient Identification	Risk Stratification	Patient Enrollment	Case Management	Progress Evaluation
Utilize Claims and Arcadia Data to identify patients with a history of frequent urgent care-eligible ED visits.	Focus on at-risk populations, specifically those with three or more urgent care eligible ED visits.	Care Management (CM) team coordinates efforts to reconnect Patient to PCP and health center.	Delegate CM to health centers with existing programs. Address barriers and improve patient self management through education and support.	Ongoing communication with PCPs and the care team to assess patient progress, adjust care plan, and support graduation from the program

Appendix

- **CalAIM Overview:**
  - Multi-year Medi-Cal transformation initiative, approved under a Section 1115 waiver (2021–2026)
  - Launched statewide Population Health Management (PHM) in 2023 under CalAIM as a data-driven approach that proactively coordinates whole-person care across physical, behavioral, and social needs to improve health outcomes and advance equity for all Medi-Cal members

- **Enhanced Care Management (ECM):**
  - Targets high-need groups (e.g., institutional risk, homelessness, high ED utilizers)
  - Provides a Lead Care Manager to coordinate medical care, behavioral health, social services, long-term supports, transitions, and referrals

- **Community Supports (ILOS):**
  - Optional wrap-around services that substitute for costlier Medi-Cal services (e.g., ER visits, hospital stays)
  - Examples include housing transition support, recuperative care, short-term non-medical respite, home-based services, and sobering centers

Boot Camp for Medicare ACOs

Progressive Learning: From Basic to Advanced

The Boot Camp Series is for MSSP and REACH employees at all levels to learn about ACO optimization, innovation, and advancement in data analytics and clinical operations.

Fundamentals

- On-demand videos
- Free to members

Boot Camp 101

- Data/Analytics and Clinical Operations tracks
- Live, virtual event June 2026
- 2025 recordings available for purchase

Boot Camp 201

- Live, virtual events
- Data/Analytics January 2026
- Clinical Operations January 2026
- Registration opens soon

January Boot Camp 201

Live, virtual events at intermediate-to-advanced level on Medicare accountable care and population health strategy and redesign

Single Purchase: $795 for members ($995 non-members)
Bundle Package: $1,195 for members ($1,495 non-members)

Data/Analytics on January 21-23

- Policy update
- Fraud, Waste and Abuse
- Shadow Bundles
- Strategic Predictive Analytics
- Data Solutions Lab
- Cost and Utilization Trends
- Quality Performance Analytics
- BCDA Files to Capture Data Trends
- Calculating Risk/Risk Adjustment Models
- Integrating Data Insights
- Telemedicine & Remote Monitoring Analytics

Clinical Operations on January 28-30

- Policy Update
- Reconciling & Aligning VBC Contracts
- Success in Health System Integration/Independent Practice
- Specialty Engagement with CQM Reporting
- Patient Engagement
- Documentation for eCQM Reporting
- HCCs
- Post Acute – Coordinating Next Level of Care
- Leadership Churn
- Partnership with Community Organizations
- Clinical Guidelines

2026 Regional Meetings Coming to You

VBC presentations and discussions with regional leaders from ACOs, provider groups, and payers

Members Get Complimentary Registrations!

Northeast
- March virtual
- July in person

Mid-Atlantic
- December virtual
- June in person

Southeast
- September virtual
- February in person

Mid-West
- February virtual
- July in person

South Central
- August virtual
- January in person

Northwest
- March virtual
- August in person

Southwest
- May virtual
- November in person

Save the Date! Spring 2026 Conference

Broadening Reach, Deepening Value

April 22-24 in Baltimore

Keynotes from CMS and health system leaders

Plus 16 breakouts on how to:

- Partner across CMMI models
- Revolutionize home-based primary care
- Boost your bottom line with risk taking
- Elevate high-value providers
- Engage community health centers
- Structure successful contracts with payers
- Maximize shadow bundles

Affinity Groups: Recently Restructured

- Affinity Groups : peer-to-peer role-focused discussion groups our members can join to exchange information, ideas, and brainstorm on current issues.

  - **Operations and Executive Affinity Group**
    Meets: January 20, 2026, from 3–4 pm ET
  - **Data and Analytics Affinity Group**
    Meets: January 27, 2026, from 3–4 pm ET
  - **Clinical and Performance Improvement Affinity Group**
  - Meets: February 10, 2026, from 3–4 pm ET
  - **Compliance and Legal Affinity Group**
    Meets: February 17, 2026, from 3–4 pm ET.
  - **Federal Government Lobbying Affinity Group**
    Meets: October 16, 2025, December 18, 2025, from 2–3 pm ET.
    - Participation is limited to NAACOS members and business partners that are registered federal lobbyists or policy professionals.

Deep Dive Roundtables

- **Deep Dive Roundtables:** Topic-focused discussion groups for members to share best practices and design policy solutions on key topics across value.

  - **Patient and Community Engagement**
    Meets: December 2, 2025 (1st Tuesday, bimonthly) from 2–3 pm ET.
  - **High Needs Patients**
    Meets: October 21, December 16, 2025 (3rd Tuesday, bimonthly) from 2–3 pm ET.
  - **Medicare Advantage**
    Meets: November 18, 2025 (3rd Tuesday, bimonthly) from 1–2 pm ET.
  - **ACO REACH**
    Meets: November 20**, 2025 (4th Thursday, bimonthly) from 12–1 pm ET.
  - **Rural and Underserved**
    Meets: November 13, 2025 (2nd Thursday, quarterly) from 2–3 pm ET.
  - **Quality Implementation**
    Meets: November 12, December 10 (2nd Wednesday, monthly) from 2–3 pm ET.