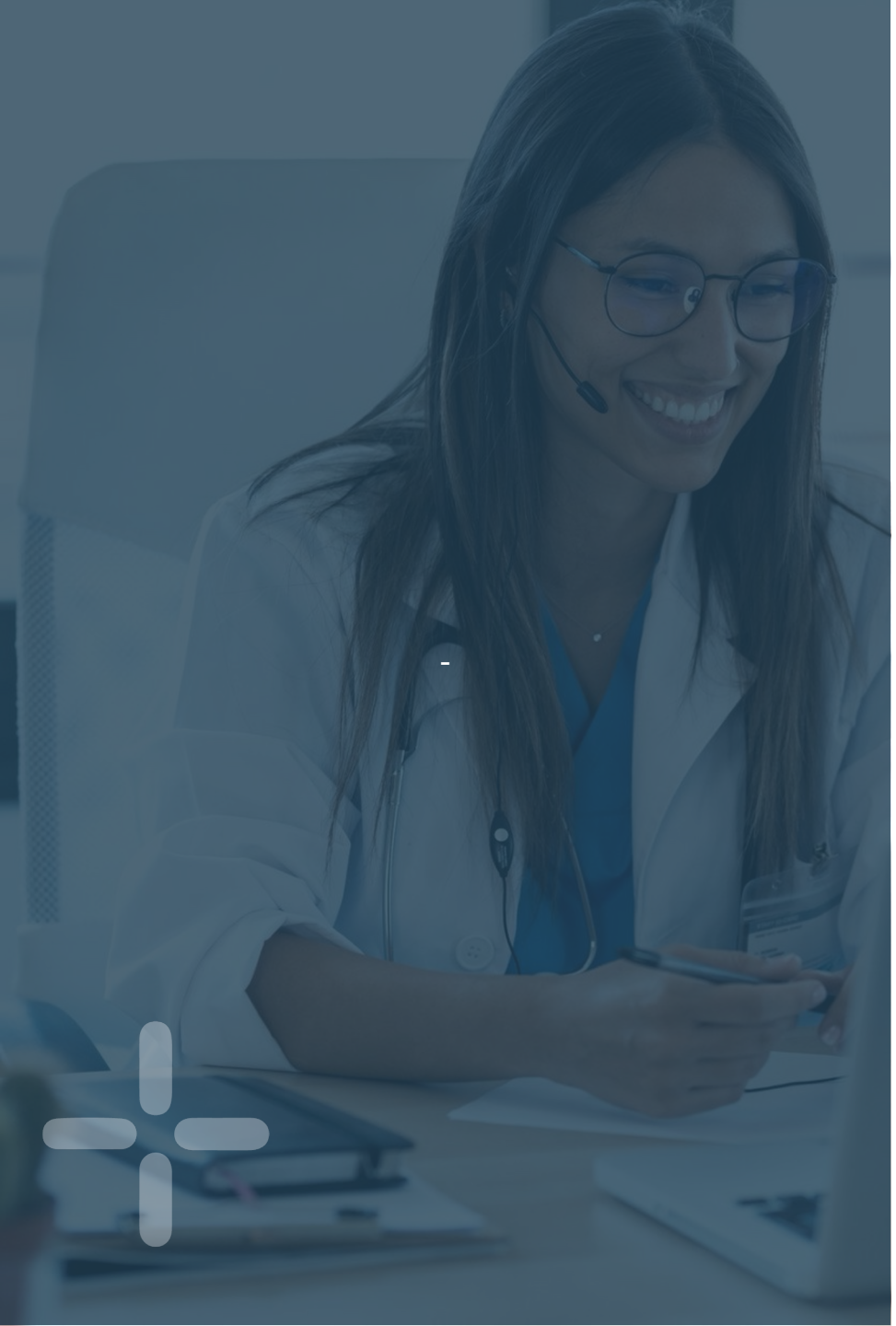
Leveraging Care Management Programs to Drive Quality Improvement

Speaker: Mike Paradiso, VP of Sales, ChartSpan



Agenda

01 Overview of Care Management Programs

Learn how CCM and APCM strengthen care and support value-based care goals.

02 Aligning Care Management with Quality Goals

See how program data and workflows directly enhance Star Ratings, MVP/MIPS, MSSP, and ACO outcomes.

03 Identifying and Addressing Care Gaps

Discover how remote care management programs help uncover and drive closures for critical care gaps.

04 Strategies for Quality Improvement

Explore practical ways to improve coordination, connect resources, and engage patients.

CHARTSPAN EXPERIENCE

1.4 in every 10 Medicare patients enrolled in a Care Management program is cared for by ChartSpan

- Largest Medicare care management provider in the U.S.
- ChartSpan will deliver nearly 1,000,000 unique, monthly care management patient encounters in 2025
- Invested $145,000,000 into APCM & CCM infrastructure, technology, people and processes

*Based on LexisNexis - 12 months of Medicare claims data

CHARTSPAN PARTNERSHIPS

The Preferred Care Management Provider for State Hospital & Medical Associations

Iowa Hospital Association Conference Center

Kansas Hospital Association

Community Health Center Association of Mississippi

Texas Hospital Association Endorsed Partner

Nebraska Hospital Association

Arkansas Hospital Association

Arizona Alliance for Community Health Centers
Primary Healthcare for All

Kentucky Hospital Association

cha Colorado Hospital Association

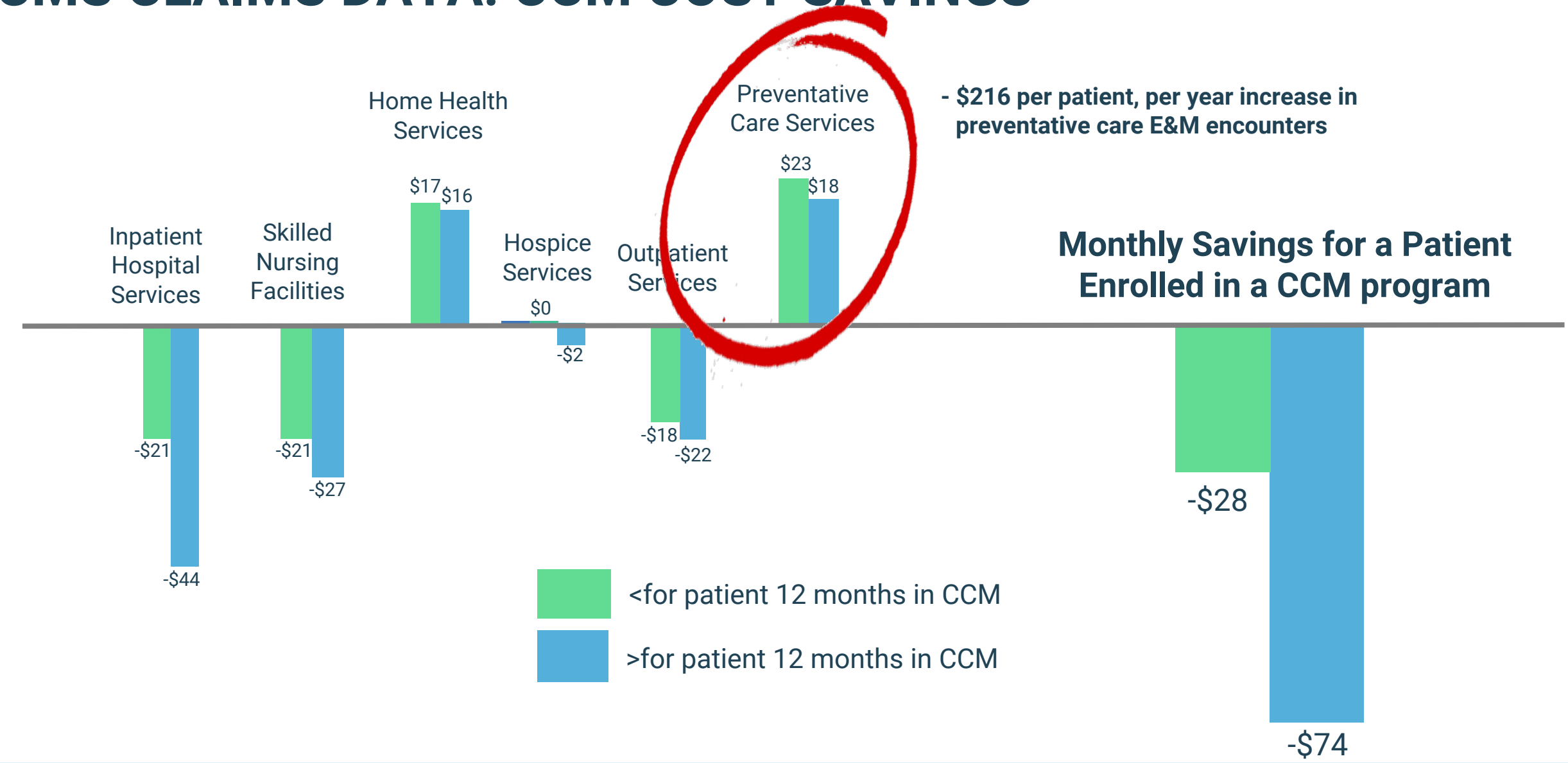
MORE RHCS THAN ANY OTHER U.S. CCM PROVIDER

National Claims Data

CMS DATA: CCM CLAIMS ANALYSIS

24 MONTHS: ALL CCM PATIENTS IN U.S.

CMS CLAIMS DATA: CCM COST SAVINGS



*59% of savings was paid in FFS reimbursements

Care Management

CCM & APCM

CHRONIC CARE MANAGEMENT

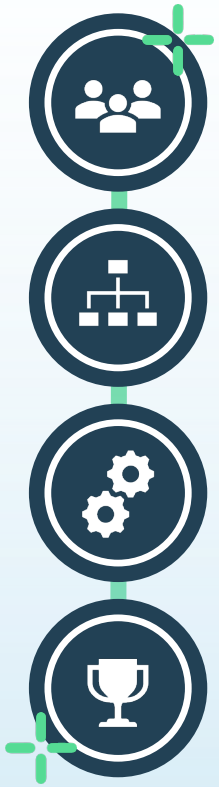
PREVENTATIVE CARE PROGRAM FOR MEDICARE PATIENTS

Patient must have **TWO** or more chronic conditions

Patient must have **24/7** access to care management

ENHANCED CARE MANAGEMENT (APCM)

Advanced Primary Care Management



Enhanced care management for **EVERY** Medicare patient, not just those with chronic conditions

Three stratified patient "**levels**" that determine the level of care and reimbursements, inclusive of both prevention and tertiary prevention

Program rooted in the ability to offer **complex service capabilities** and bundling of elements from multiple value-based care programs (CCM, PCM, TCM, etc.)

Qualitative APCM performance determined by **quality measure performance**, not quantitative time benchmarks

CARE MANAGEMENT : DIFFERENTIATORS

CHOOSE THE PROGRAM THAT WORKS BEST FOR YOU

Standard
Chronic Care Management (CCM)

No Stratification

- 99490 & 99439
- 2 or more chronic conditions
- Seen in past 12 months
- $60.49 pppm/ $45.93 pppm
- 82% of Medicare cohort

Enhanced
Advanced Primary Care Management (APCM)

Stratification (and Re-Stratification)

Level One
G0556

- 0-1 chronic conditions
- Seen in past three years
- $15.20 pppm
- 18% of Medicare cohort

Level Two
G0557

- 2 or more chronic conditions
- Seen in past three years
- $48.84 pppm
- 70% of Medicare cohort

Level Three
G0558

- QMB Patients - 2 or more chronic conditions
- Seen in past three years
- $107.07 pppm
- 12% of Medicare cohort

CARE MANAGEMENT: SERVICE REQUIREMENTS

CHOOSE THE PROGRAM THAT WORKS BEST FOR YOU

Standard
Chronic Care Management (CCM)

- Patient consent
- 24/7/365 access to clinical care
- Management of comprehensive care plan
- Care coordination **(Time-based thresholds)**

vs

Enhanced
Advanced Primary Care Management (APCM)

- Patient consent
- 24/7/365 access to clinical care
- Management of comprehensive care plan
- Comprehensive care management **(Performance-based)**
- **Eligibility stratification, including QMB confirmation**
- **Hospital discharge management**
- **Coordination of prescribed in-home & community-based resources**
- **Two-way, digital communication capability**
- **Risk stratification and population health analytics utilizing clinical data**

APCM COMPLIANCE: WHAT MANY WILL GET WRONG

SERVICE CAPABILITY CHALLENGES

- **QMB** eligibility validation
- Patient admissions/discharge **feeds**
- Compliant **digital patient engagement** platform
- Extensive network of **social and in-home health partners** and established clinical workflow
- Level One care plan **engagement requirement**
- Enhanced documentation of **psychosocial needs**
- **Value proposition** appeal by cohort

HOW APCM SERVES RHCS

HIGHER REIMBURSEMENT AND EMPHASIS ON SDOH

Care Tailored for Rural Patients

- ☑ Regular, remote communications
- ☑ Discharge management
- ☑ Community resources for the needs of rural patients:

Financial Benefits for Practices

Many RHC patients will qualify for APCM Level 3:

$110 reimbursement for QMBs with two or more chronic conditions

500 Level 3 patients
50% conversion* = 250 patients
x $110 pppm

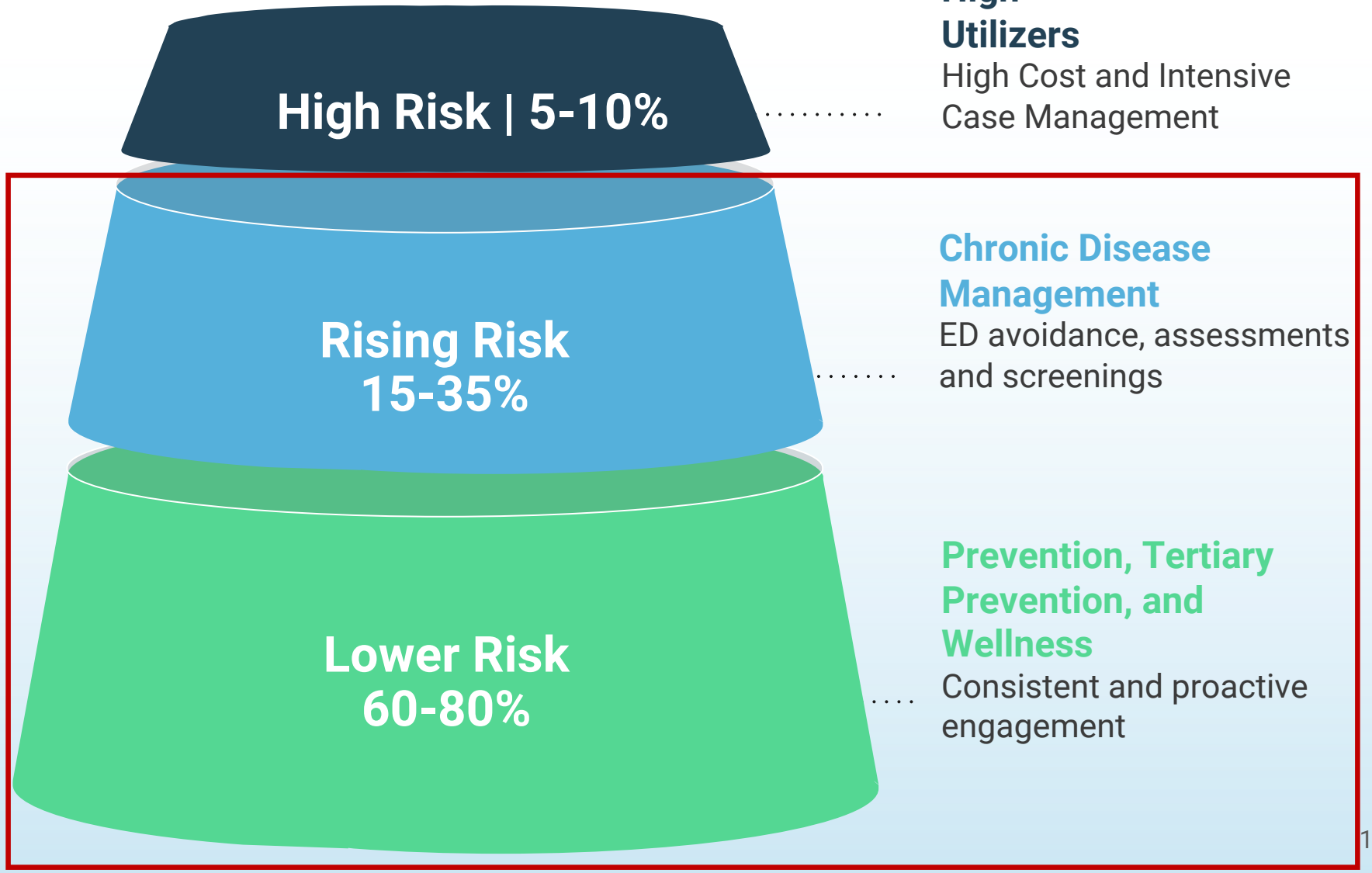
$27,500 in projected revenue*

**Results may vary by provider. APCM conversion rates are estimates.*

MEDICARE PATIENT COHORT COMPOSITION

TERTIARY PREVENTION CARE MANAGEMENT IS **NOT** CASE MANAGEMENT

Cost of care increases as illness burden increases



High Utilizers
High Cost and Intensive Case Management

Chronic Disease Management
ED avoidance, assessments and screenings

Prevention, Tertiary Prevention, and Wellness
Consistent and proactive engagement

Care Management Drives Quality Performance

CARE MANAGEMENT SERVICES

REINFORCE PROVIDER CARE INSTRUCTIONS

Medications

Medication Reviews

History

Patient Health History

Community

Center of Care Continuum

Records

Records Clearinghouse

Services

Health Services Inventory

Adherence

Appointment Adherence

Care Plan

Support Provider Instructions

Goals

Patient Focused Goals

24/7/365

Triage & Care Support

Assessments

Assessments & Screenings

Behavioral

Psychosocial Assessments

Social

Social Determinants of Health

SOCIAL DETERMINANTS OF HEALTH

CRITICAL COMPONENT OF CCM

SDOH Assessments

Proactively search for determinants instead of waiting for them to exacerbate a patient's condition.

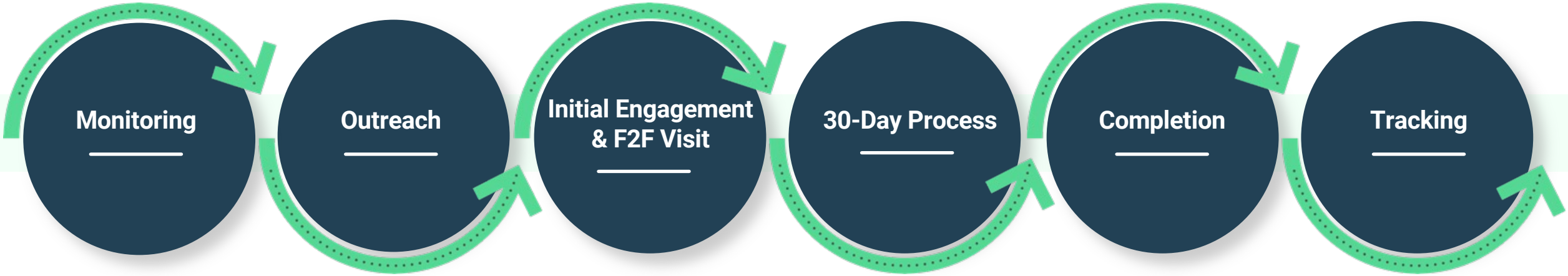
Core measures as well as a set of optional measures for **community priorities.**

Access to tens of thousands of **community based organizations** if existing community partnerships do not exist.

DISCHARGE FOLLOW-UP STANDARD WORKFLOW

THOROUGH, ORGANIZED PROCESS FOR EACH DISCHARGE

- Initiating patient capture post-discharge
- Following the patient through 30 days post-discharge, ensuring continuous outreach
- Driving smooth recoveries and improved patient outcomes



Real-time admission and discharge notifications

Capturing patients at discharge and initiating follow-up

Attempted within 2 business days. If successful, will attempt to schedule a F2F visit and provider notification

Attempted patient follow-up at 7, 15, and 30 day intervals

Follow up until patient is readmitted to the hospital or the 30-day post-discharge period is past

Tracking key statistics like patient volume, F2F scheduling and unavoidable readmissions

PATIENT POPULATION-LEVEL MANAGEMENT

CLOSING THE INFORMATION GAP: A 360° VIEW OF PATIENT HEALTH

APCM Pop Health pulls data from the continuum of patient providers and medication sources*

ChartSpan pop. health data offers a 360° view of patient health:

- ☑ Gather medical records from multiple providers, pharmacies, national and state databases
- ☑ Uncover missing and undocumented data

And actionable insights with synthesized data:

- ☑ Identify open care gaps: in-network, out-of-network, & pharmacies
- ☑ Care managers schedule screenings and perform assessments

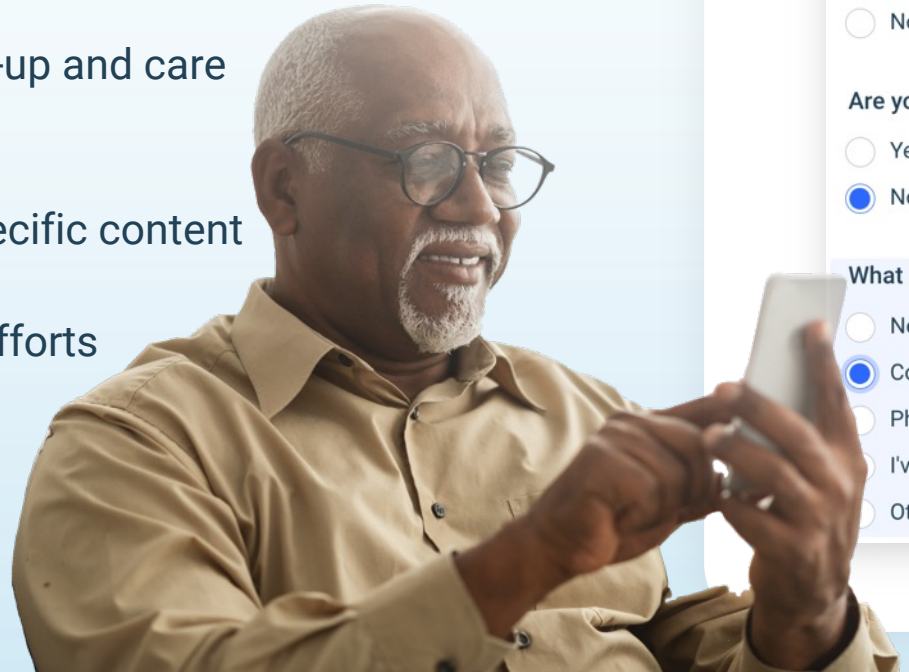
*Data is provided on an "as available" basis and in some areas may not be complete.

MEANINGFUL DIGITAL ENGAGEMENTS

HOW DIGITAL OUTREACH EXPANDS CARE

ChartSpan APCM's multimodal, digital-first approach leverages SMS, email, and electronic forms.

- Utilize digital surveys and forms to gather critical patient data
- Collect feedback on care goals, progress, vital screenings, and assessments
- Capture opportunities for follow-up and care gap closures
- Share educational, condition-specific content
- Document digital engagement efforts for each patient



Help your ChartSpan care team improve your hypertension care. Take our survey about your blood pressure readings, lifestyle, & meds. https://chartspan.com/pt/bloodpressure. Text STOP to opt out.

Are you currently prescribed medications to control your blood pressure? *

- (●) Yes
- ( ) No

Are you taking those medications as prescribed *

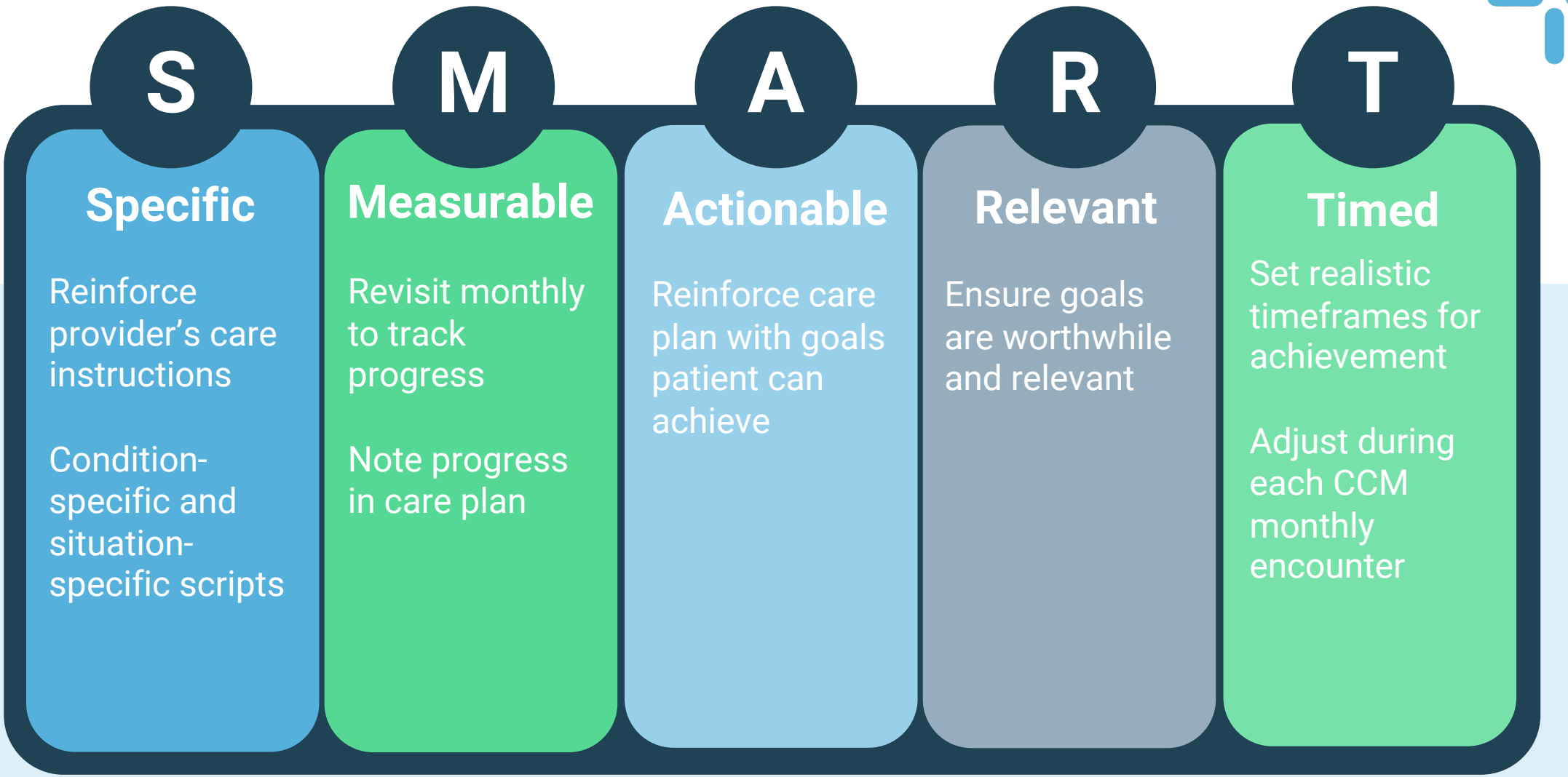
- ( ) Yes
- (●) No

What is preventing you from taking them as prescribed?

- ( ) Need Refill
- (●) Cost
- ( ) Pharmacy Access
- ( ) I've chosen not to take them
- ( ) Other

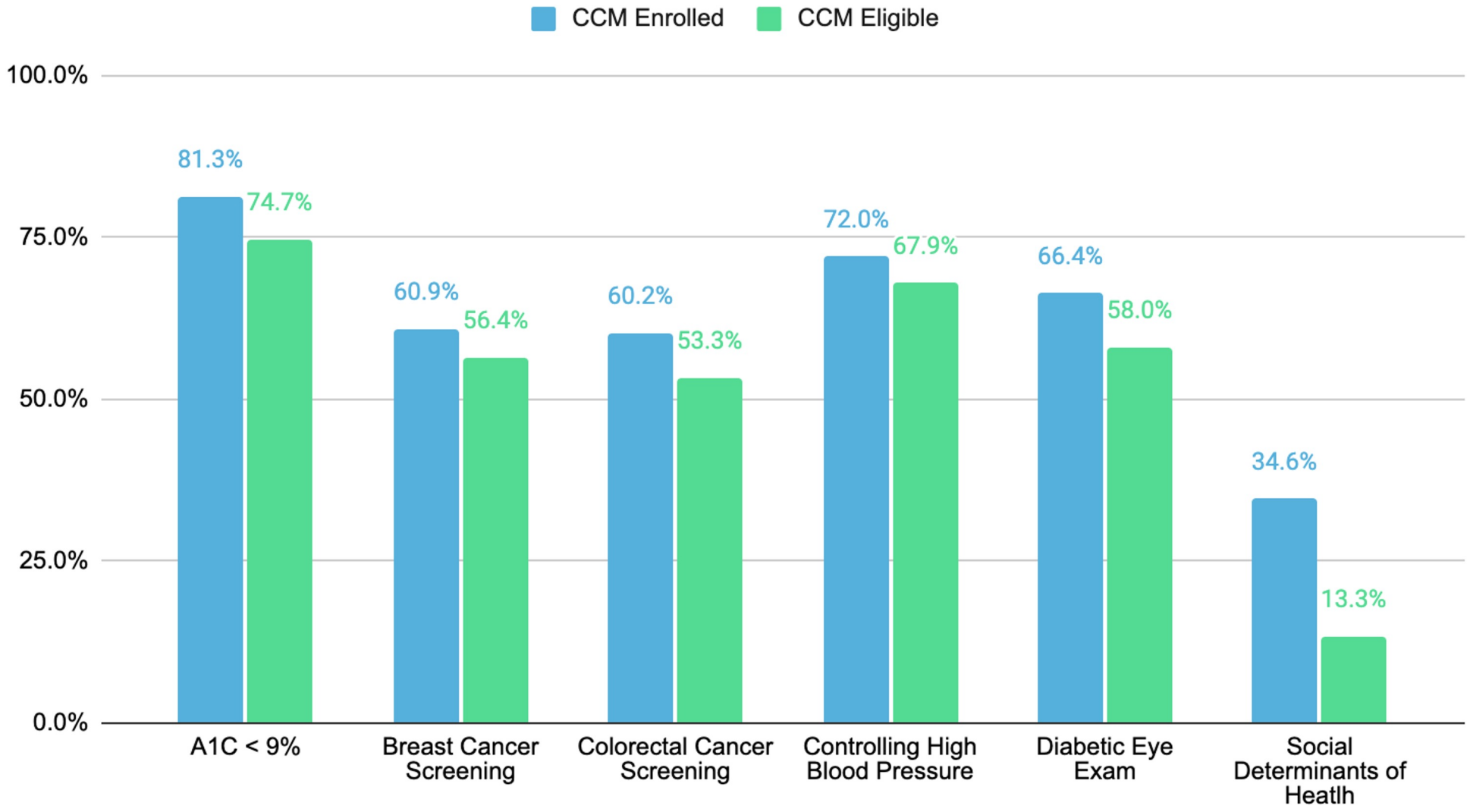
MEASURABLE CARE GOALS

FOUND IN THE PATIENT HEALTH SUMMARY (PHS)



QUALITY MEASURE PERFORMANCE

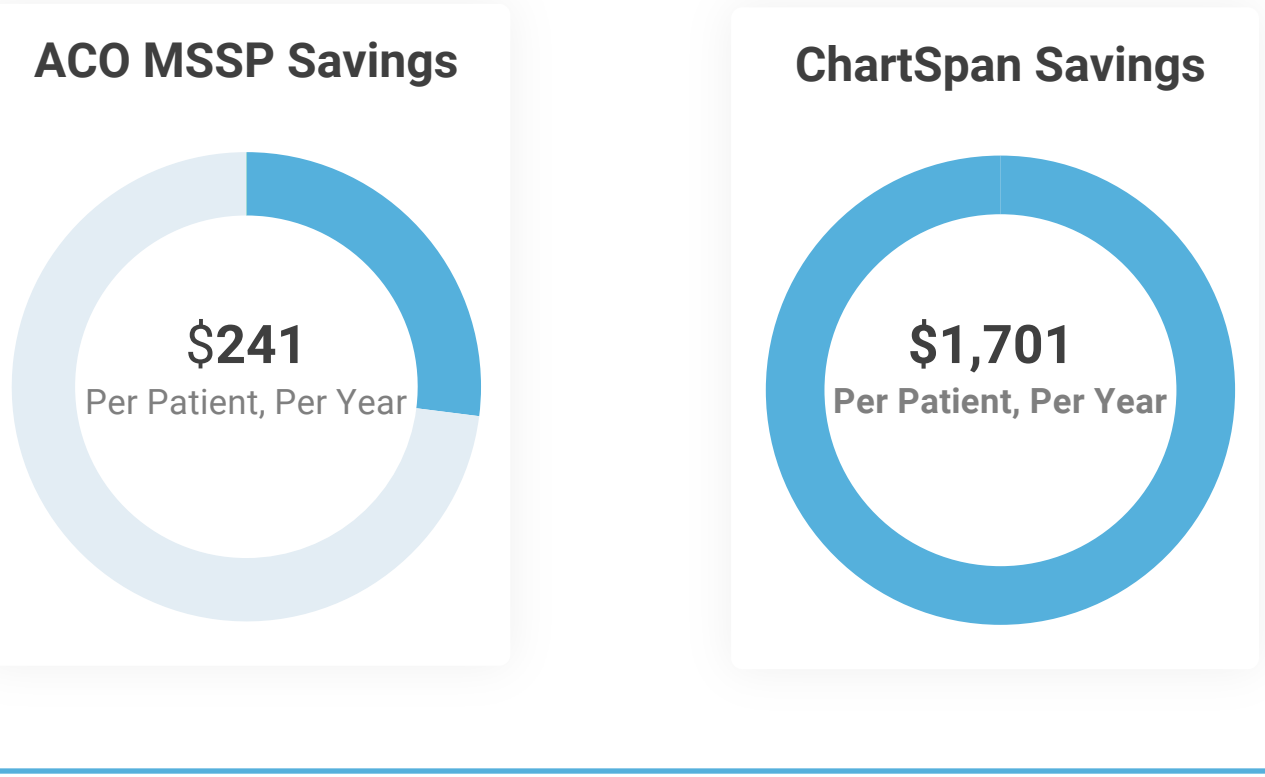
PRACTICES WITH CARE MANAGEMENT SCORE HIGHER ON THEIR QUALITY MEASURES



VALUE-BASED CARE PROGRAM PERFORMANCE

ANNUAL CLAIMS DATA

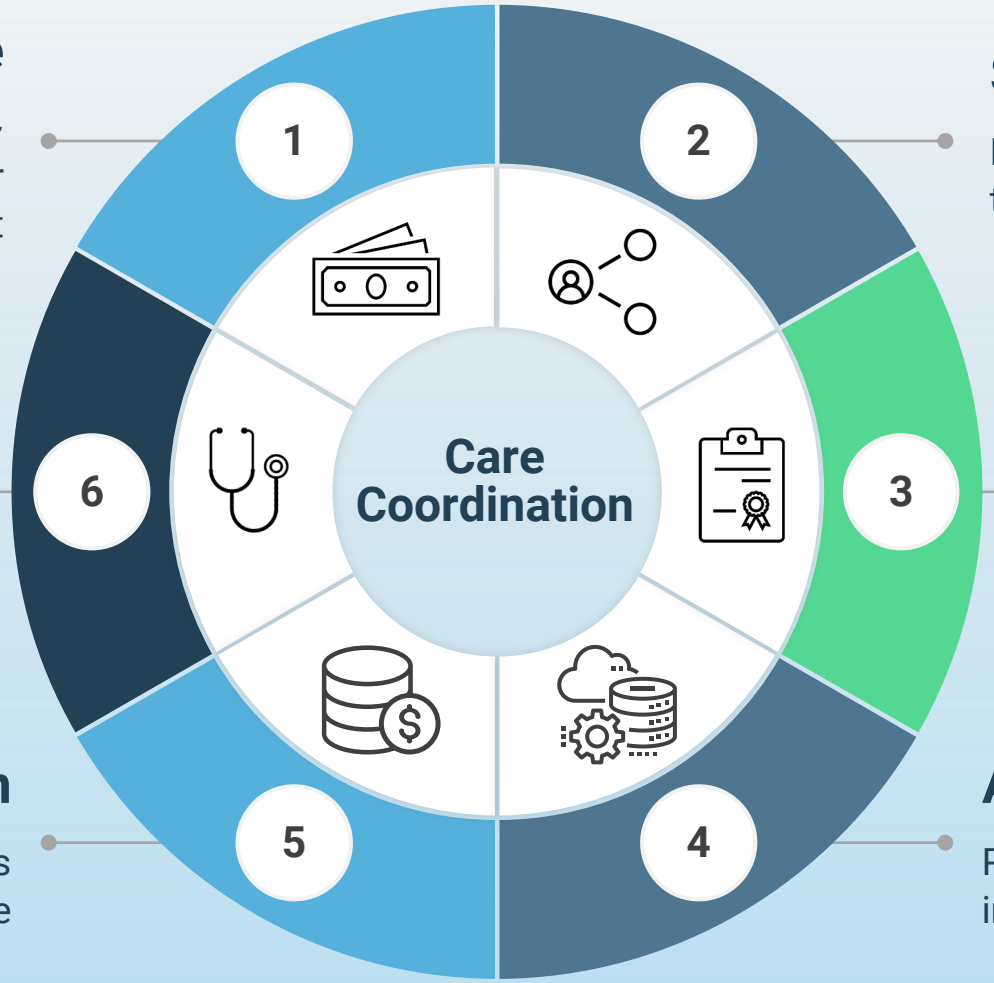
Net Savings



ChartSpan Care Management programs outperform the typical MSSP ACO in annual savings by nearly **700%** per year

THE POWER OF CARE MANAGEMENT PROGRAMS

PARALLEL RECURRING ANNUAL REVENUE STREAMS



Fee-For-Service

Net earnings of $250-$500 PPPY~ in recurring reimbursements for Part B & C patient

Shared Savings

Net earnings of $700 PPPY~ attributable to MSSP cost savings

E&M Encounters

$216 PPPY increase in annual preventative E&M encounters

MIPS/Quality

FFS increases and Bonus Pool earnings based on quality performance

Leakage Mitigation

Potential of thousands of dollars PPPY in-network revenue

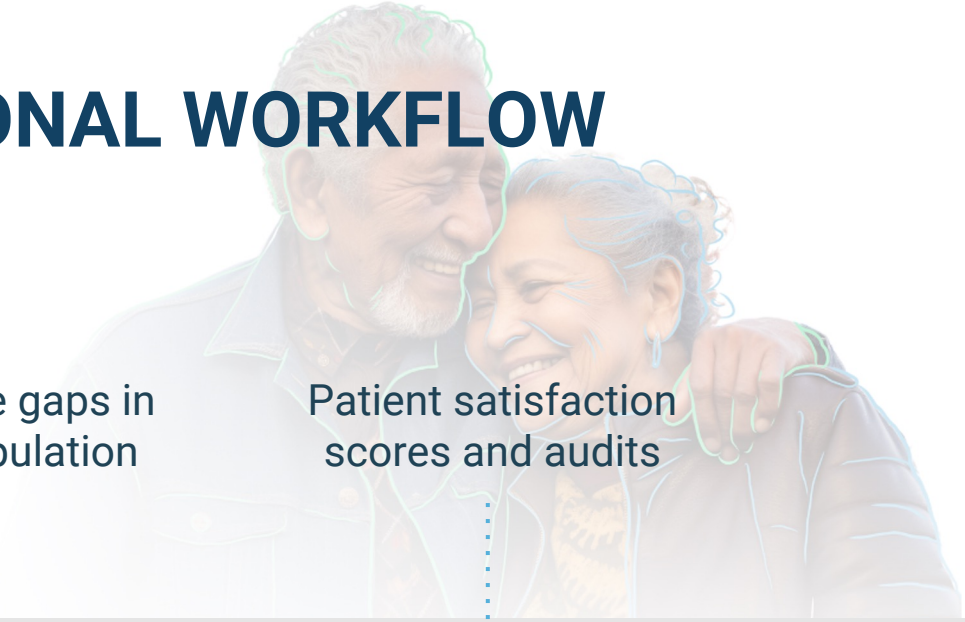
ACO & APM Models

Potential of thousands of dollar PPPY in increased beneficiary attribution

Care Management with ChartSpan

CARE MANAGEMENT PROGRAM OPERATIONAL WORKFLOW

TURN-KEY, FULLY MANAGED CCM SERVICE



Enrollment never ends

Eligible patient lists reviewed and approved

Patient consents recorded and archived

Address care gaps in enrolled population

Patient satisfaction scores and audits

Data Integration	Eligibility Verification	Education Campaigns	Enrollment Consent	Clinical Engagement	Population Health	Claims Billing	Quality Performance	Patient Services

Data extraction and processing

Ringless voicemails, digital and mail campaigns

24/7/365 Clinical patient support

Real time billing drives cash flow

Patient questions and support

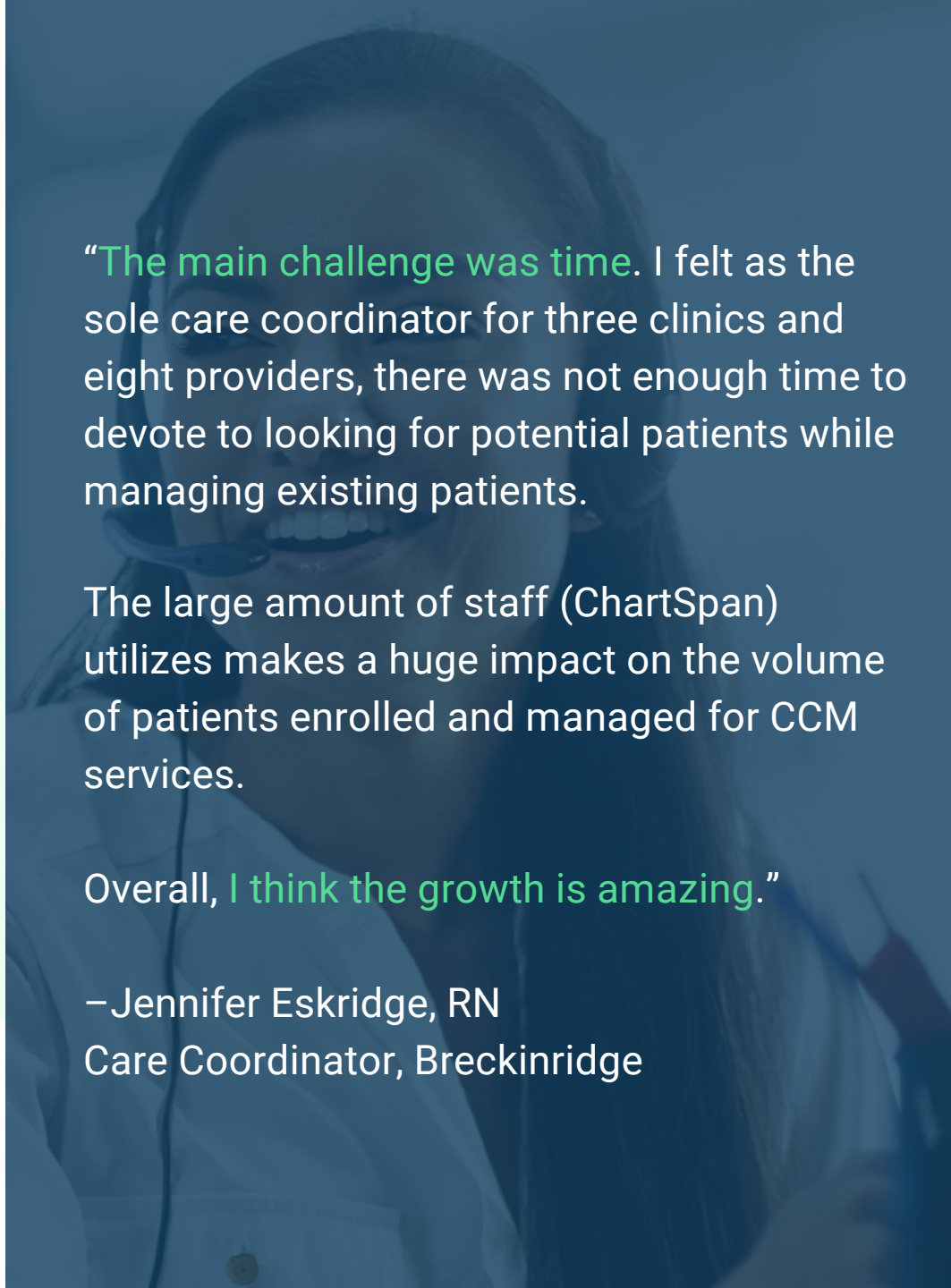
The most challenging part of running a Care Management program

THERE'S POWER IN NUMBERS

THE STORY OF BRECKINRIDGE HEALTH'S PROGRAM GROWTH

ChartSpan was able to consent **903%** more patients than Breckinridge Health could on their own

In-House Team		ChartSpan Enrollment Team
72	→	722



"The main challenge was time. I felt as the sole care coordinator for three clinics and eight providers, there was not enough time to devote to looking for potential patients while managing existing patients.

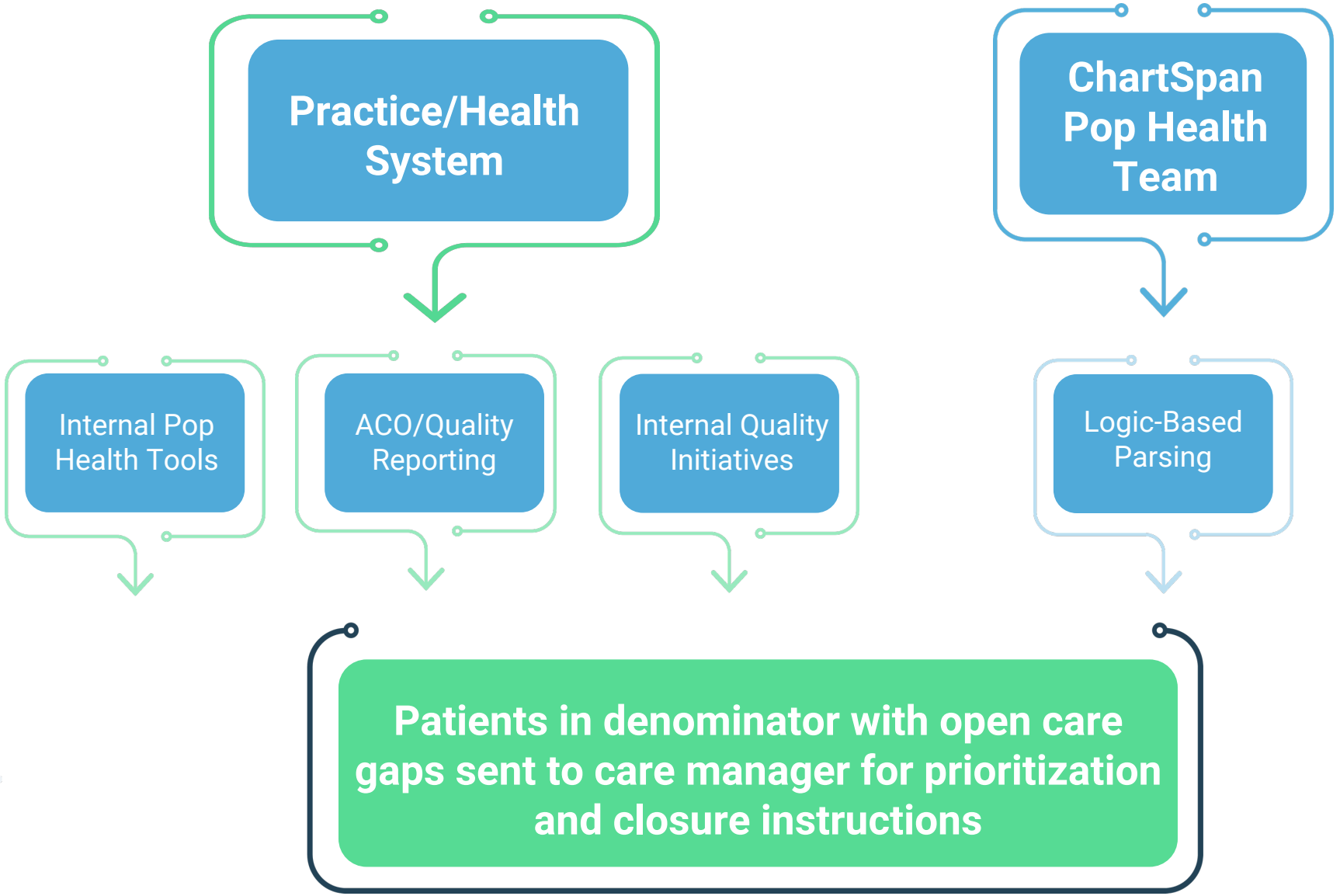
The large amount of staff (ChartSpan) utilizes makes a huge impact on the volume of patients enrolled and managed for CCM services.

Overall, I think the growth is amazing."

–Jennifer Eskridge, RN
Care Coordinator, Breckinridge

IDENTIFICATION OF CARE GAPS

NUMERATOR IDENTIFICATION



CHARTSPAN CARE MANAGEMENT ASSESSMENTS

- **Daily Health** Assessment
- **Technology** Assessment
- **Activities of Daily Living** Assessment
- **Medication Adherence** Assessment
- **Durable Medical Equipment** Assessment
- **Condition Awareness** Assessment
- **Fall Risk** Assessment

CHARTSPAN SUPPORTED QUALITY MEASURES

- Diabetic Eye Exam Screen
- Controlling Hypertension
- Smoking Cessation
- BMI Screening
- Breast Cancer Screening
- Colon Cancer Screening
- SDOH
- Uncontrolled DM HBA1C > 9%
- Depression Screening
- Cognitive Screening
- Flu Vaccination
- Pneumonia Vaccination
- Tetanus/Diphtheria Vaccination
- Herpes Zoster Vaccination

CARE MANAGEMENT SCORECARD

VIRGINIA HEALTH SYSTEM – 9-MONTH TIME FRAME

Quality Gaps in Care Addressed

BMI Screening
38 Assessments
Breast Cancer Screening
246 Assessments
Diabetes Hemoglobin
26 Assessments
Tdap Vaccination
243 Patient Assists
Controlling Hypertension
85 Assessments
Flu Vaccination
801 Patient Assessments
Pneumonia Vaccination
598 Assessments
Depression Screening
241 Assessments
Colon Cancer Screening
385 Assessments

CCM Assessments Completed

Activities of Daily Living
959 Assessments
Condition Awareness
1,183 Assessments
Cognitive Assessments
529 Assessments
Medication Adherence
194 Assessments
Fall Risk Screening
126 Screenings

Gaps in Care - Total
2,663 Patient Assists
Assessments
2,991
Social Determinants of Health
135
Patient Interventions
4,412

Patient Assists

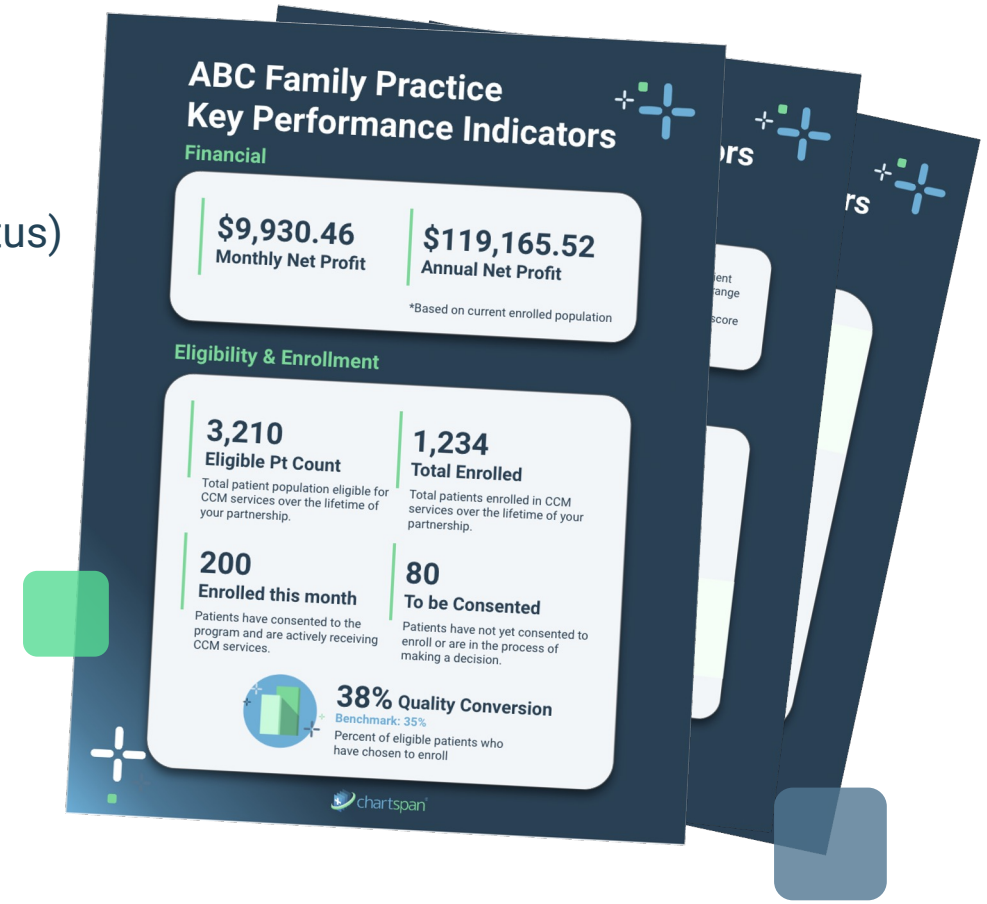
Clinical Support
933 Patient Assists
Patient Appointments
1,004 Appointments
Provider Communications
1,253 Patient Assists
Medication Refills
1,222 Patient Assists

METRICS OF SUCCESS

EMPOWERING OUR PARTNERSHIP

We focus on the below KPIs to demonstrate success:

- Patient satisfaction scores
- Number of patients currently enrolled and active (active + new status)
- Enrollment conversion %
- Clinical engagement % among enrolled patients
- Care gap assistance, including assessments and SDOH support
- Average program growth, month over month
- Financial metrics (profit margin, gross revenue, net revenue)



Contact us

Jack Van Norden

Regional Vice President- Nebraska

jack.vannorden@chartspan.com

(404) 822-4462

Mike Paradiso

Vice President, Sales

mike.paradiso@chartspan.com

(727) 967-1551

chartspan®