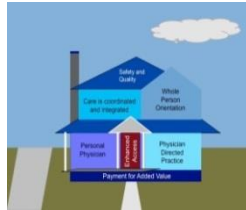


On a foundation of



Person-Centered Medical Homes



ASO-Based Intensive Care Management (ICM)



Pay-for-Performance (PCMH, OB)



Data Analytics/ Risk Stratification

we are building in



Community-based care coordination through expanded care team (health homes, PCMH+)



Supports for social determinants (ICM, transition/tenancy sustaining services, interventions for childhood trauma)



PCMH+ (launching 1/1/17)

with the desired structural result of creating



Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods/health enhancement communities



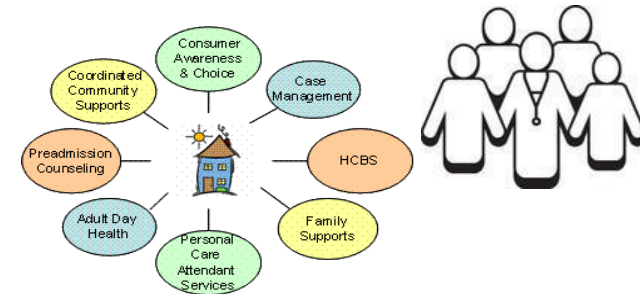
Federated ASO model that includes traditional MCO functions (member and provider supports, utilization management, grievances and appeals) and also new features (predictive modeling/risk stratification, data analytics, practice transformation support, Intensive Care Management).



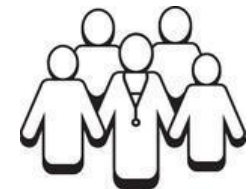
Prevention Agenda



Integration Agenda



LTSS Rebalancing Agenda

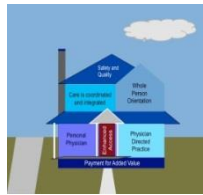




One or more ASOs that retain responsibility for member and provider support.



Data analytic contractor(s)



PCMH enhanced fees and performance payments



OB P4P

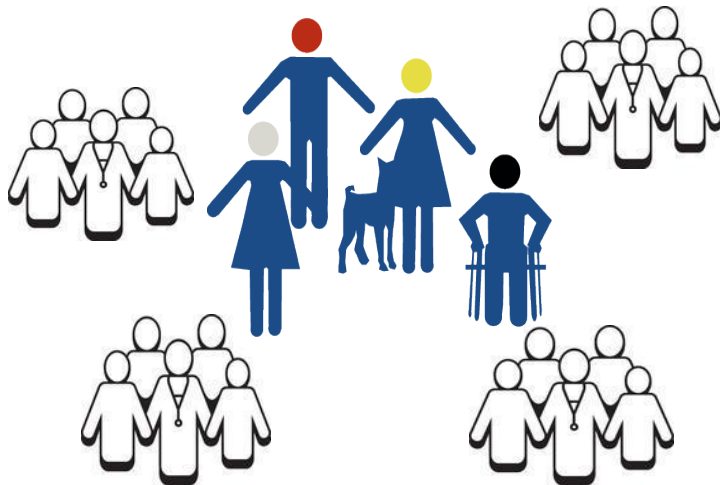


PCMH+

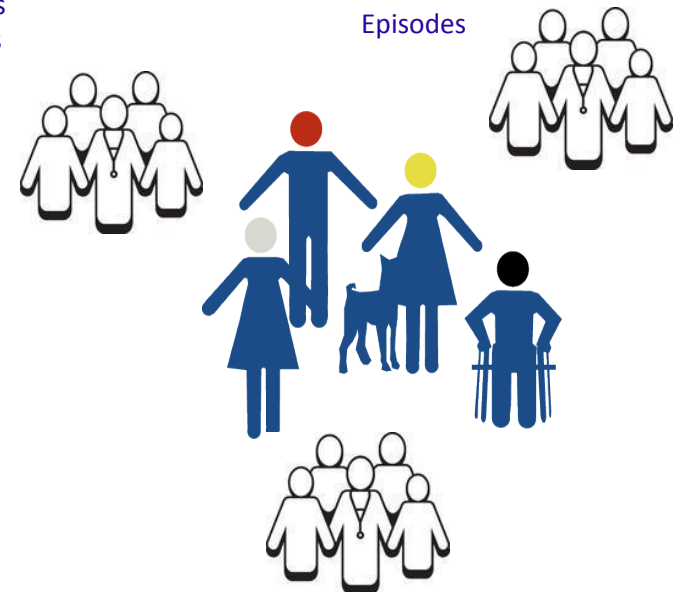


Shared savings arrangements

Episodes



Health neighborhoods composed of a range of medical, behavioral health, dental, long-term services and supports and transportation providers.



A stronger and healthier next generation that avoids preventable conditions and is economically secure, stably housed, food secure, and engaged with community.

Families that are intact, resilient, capable, and nurturing.

Choice, self-direction and integration of all individuals served by Medicaid in their chosen communities.

Empowered, local, multi-disciplinary health neighborhoods.

