From:	Jennifer Baron
To:	solicitation.questions
Subject:	AHCA RFI response / Cityblock Health
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Attachments:	Cityblock Health Response to AHCA RFI.docx

Good evening, Cody -

Thank you for the opportunity to respond to the AHCA Request for Information / RFI 014-21/22 on the re-procurement of the Statewide Medicaid Managed Care program. Please accept the attached submission from Cityblock Health.

We are comfortable with our full submission being released to the public, and have not included a redacted version - though we appreciated the option to do so!

We would be pleased to discuss any part of this response.

Thank you,
Jennifer Baron

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Want to join our team?

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June 2, 2022

Cody Massa
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2727 Mahan Drive
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Thank you for the opportunity to respond to the Florida Agency for Health Care Administration (AHCA) Request for Information / RFI 014-21/22 on the re-procurement of the Statewide Medicaid Managed Care (SMMC) Program. Please accept the following submission from Cityblock Health, Inc. (Cityblock). Cityblock is a provider organization delivering integrated physical, behavioral, and social care to Medicaid, dually eligible, and other members living in lower-income neighborhoods that have historically had poor access to health care services.

We partner on an at-risk basis with a number of Medicaid and Medicare Advantage plans, including Dual Eligible Special Needs Plans (D-SNPs) and Medicare-Medicaid Plans (MMPs). Value-based payment (VBP) arrangements in which Cityblock partners with a health plan on an at-risk basis, with both partners at risk and accountable for the full set of services available to our members, are at the core of our care model. Aligning member, plan, and provider interests in this way allows for a better member experience and whole-person care, and drives improved outcomes and lower costs. While Cityblock does not currently operate in Florida, we are growing quickly and are committed to promoting equitable access to coverage and care for individuals in underserved communities nationwide.

Responses

AHCA has expressed interest in hearing from stakeholders with experience in the managed health and long-term care industries regarding best practices and innovations in business models as well as service delivery for Medicaid managed care. We respectfully share our thoughts on how we partner with Medicaid managed care plans and other health plan partners to:

- Leverage the managed care delivery system, either through expanded benefits or other mechanisms, to promote sustainable economic self-sufficiency among Medicaid recipients in the short and long term.

Empowering our members to achieve their employment goals is an important step in addressing their physical, behavioral, and social needs. Engagement in meaningful work can not only reduce financial stress, but also improve an individual's notion of self-worth and self-efficacy. Our model includes a number of touchpoints and opportunities to support members' employment goals:

- **Assessment**: Our members' Community Health Partners (CHPs), hired from the communities in which our members live, prioritize learning up front about our members' employment status and goals. Through our member assessment process, CHPs discuss and document members' work-related goals - including interests, values, and desired work environments - as well as any current barriers and member concerns.
- **Education**: As needed, CHPs provide education to members on hard versus soft skills, and assist members - directly or by connecting them with formal programs - with developing soft skills like networking and resume writing. We work with members who use public assistance programs (e.g., SSI, SNAP) to understand how paid employment can improve their financial health while maintaining access to health coverage and care, as well as other needs.
- **Social services**: CHPs are familiar with and connect members to local social services and other resources to support their employment goals. For example, as appropriate, CHPs will assess member eligibility for and interest in vocational and training programs (e.g., nursing, culinary, automotive, mechanical) - including programs serving individuals with relevant diagnoses or circumstances (e.g., behavioral health, criminal justice re-entry, seniors, people with disabilities, women). CHPs also work with members to explore paid employment and volunteer opportunities outside of vocational and training programs. For both vocational and other options, CHPs assist members with accessing and applying to online job postings, and collaborate with other parties as needed to facilitate any referrals.

We find that many members we engage who are unable to work due to their health conditions would like to return to paid employment. For some, this may be a relatively short journey, while for others it may require months of medical, behavioral and social engagement. We work with the members in the latter population to put the right supports in place to manage chronic conditions and address other barriers to employment wherever possible. Recognizing that workforce readiness for an at-risk population is not a one-size-fits-all endeavor has been critical to laying the foundation for meaningful and sustainable employment for Medicaid and other low-income members.

- Utilize value-based payment designs to simultaneously increase quality and reduce costs.

In our experience, the financial flexibility conferred by value-based agreements with our health plan partners is the foundation for member-centered care - particularly for members with complex health and social needs. Through payment arrangements aligned with member outcomes and value rather than volume, we are able to invest in an integrated, whole-person approach that emphasizes preventive health services and encompasses social needs, including housing instability, unemployment, food scarcity, transportation limitations, and lack of social support at both the individual and community level.

We enter into total cost of care, risk-based arrangements with innovative Medicaid managed care plan partners that include a per member per month (PMPM) capitation payment for the set of comprehensive primary, behavioral and social care services Cityblock provides. Within this value-based model, we align with our plan partners around quality metrics that advance the goals of the applicable state Medicaid program, and promote improved member outcomes and health equity.

Our results underscore the power of value-based payment designs to reduce unnecessary utilization and drive down total cost of care. Among our early high-cost cohorts, we have seen a 20% reduction in inpatient admissions and a 15% reduction in emergency department (ED) visits.

We understand Florida has been an early adopter in this area, and that AHCA includes VBP targets for health plans participating in the SMMC Program. As AHCA contemplates how to continue to promote a transition from volume to value, we would encourage continuing to offer flexibility to SMMC plans for how they deploy value-based models. Our experience, coupled with our interactions in other markets with a number of Florida's leading managed care organizations, suggests a handful of best practices for consideration:

- Clear articulation of VBP contract structures (e.g., performance incentives, one-sided risk, two-sided risk, full risk, etc.).
- Favorable consideration in the SMMC plan selection process for:
    1. higher-risk VBP approaches with advanced primary care provider groups offering greater opportunity for meaningful cost savings
    2. other desirable arrangements that expand the scope of VBP to include individuals with complex social needs (e.g., based on our experience, arrangements involving care management for high-risk populations).
- Progressive targets and/or financial incentives for SMMC plans to move toward more impactful risk arrangements.
- Quality measures that focus not only on effectiveness of care, but also on timeliness, ease of access, member experience/engagement, and equity. In contrast, unadjusted measurement of screening or health risk assessment rates across demographics or acuity cohorts can penalize providers serving members with complex health and social needs.

- Explicit inclusion of risk-based fees, quality or total cost of care bonuses, or similar compensation to providers in the calculation of plan income subject to current or future Achieved Savings Rebate caps, or included in the numerator of medical loss ratio (MLR) calculations. Here, however, AHCA may wish to consider excluding quality or total cost of care bonus payments from an SMMC plan to a related party (i.e., an entity owned by or affiliated with that plan), to encourage VBP arrangements between independent entities that both have a clear incentive to improve outcomes and lower costs.
- During the Medicaid rate setting process, inclusion of quality payments made by SMMC plans to providers under VBP approaches. If such payments are not factored into the baseline, MCOs could essentially see a financial penalty for effective, cost saving VBP arrangements.

- Maximize home and community-based placement and services through proactive aging-in-place strategies.

One innovation that may now be available to states to support members in the community and avoid facility residence, allowing them to age in place, is use of "in lieu of" services (ILOS) that extend to social determinants of health (SDOH).

CMS recently approved an ILOS arrangement with California that defined the scope of ILOS to include preventive services, and also allowed for the assessment of cost effectiveness in aggregate across members, and not for each individual member. The California program includes various services likely to support community residence (e.g., nursing facility transition/diversion to assisted living facility, day habilitation, personal care and homemaker services, and home modifications).

We understand that AHCA includes ILOS in its contracts with SMMC plans, allowing the plans to substitute services from a defined list for comparable services. We applaud AHCA for pursuing ILOS that not only enable community residence, such as the long-term care benefit for structured family caregiving, but also a number of behavioral health diversionary services that support lower acuity, outpatient care for individuals with behavioral health needs.

- Align quality metrics and outcomes with the Florida State Health Improvement Plan (SHIP).

Cityblock Health was founded on many of the same notions that underpin the Florida SHIP: that support for health and wellness must go beyond the walls of the clinic; that community- and individual-level focus and solutions are required to control spending that is out of proportion to outcomes; that health inequity is as pernicious and malignant a force as disease itself. As such, the work we do today and the work we aspire to do tomorrow is well aligned to the goals of Florida's SHIP – particularly those goals related to health equity, child and maternal health, preventative medicine, serious mental illness, and substance use disorder. We would support

inclusion of performance metrics aligning with Florida's SHIP that hold program participants financially accountable for delivering improvements in measurable areas. For example:

- **Health Equity**: Disparities are assumed to be rooted in subpopulations of the historically underserved. The ability to measure and stratify data to uncover these inequities in a concrete way is critical to eliminating the inequities. Programming can then be targeted more effectively to address the needs of specific subpopulations, and tracking stratified data can help elucidate what tailored interventions have impact.
- **Maternal Care**: Historically underserved populations often experience barriers to access to prenatal care. Measuring access to prenatal care provides a guide to efforts intending to engage hard-to-reach members. Utilizing multidisciplinary care teams is an effective way to support these members in continued engagement, throughout and beyond their pregnancy; measurement will ensure that interventions to remove barriers to access are effective.
- **Access to Immunizations**: Measuring adherence to recommended immunization schedules across key subpopulations (children, adolescents, and more) is a critical driver to implementing tailored interventions (particularly around social resource barriers) to improve adherence.
- **Healthy Weight, Nutrition, and Physical Activity**: Screening members for these healthy behaviors and then removing barriers to accessing needed supports in the community for healthy eating and activity are an important foundational approach to chronic disease management. Screening members across subpopulations and placing additional emphasis on screening and care planning for those at risk of chronic disease can manifest in improvements specifically in performance on diabetes and hypertension outcome measures.
- **Behavioral Health and Substance Use Disorder (BH/SUD)**: Cornerstones of improving health related to BH/SUD include identifying BH/SUD needs, facilitating access to services, and removing barriers to treatment adherence. Individuals with serious mental illness and SUD may benefit from innovative interventions to support their engagement – including interventions not historically used by traditional physical health delivery systems. Quality metrics that examine members' connection to BH/SUD services and adherence to medication can help drive improvement efforts with new, innovative, integrated approaches to BH/SUD care.
- **Chronic Disease Management**: The industry is learning that effective chronic disease management requires efforts that go well beyond traditional physical health approaches and require cross sector collaboration. In addition, an intentional focus on screening for SDOH-related needs and connection to resources is an important aspect of removing barriers to successful chronic disease management. Linking improvement programs in cross-sector collaboration and SDOH with outcome measurement for chronic diseases (including but not limited to diabetes and its comorbidities, hypertension, asthma) can be a powerful indicator of whether novel approaches in biopsychosocial care delivery have been successful in preventing comorbidities of chronic disease.

As with any measurement and reporting schema, it is important to ensure that what is being measured are indeed the types of behaviors, interventions and outcomes sought. We also find that combining more readily measurable behavioral/process measures (e.g., screenings, outreach) with financial or clinical outcomes (e.g., cost savings, reduction in disease burden) help to track progress in the initial years of a health equity/SDOH program, to ensure we are pointing toward improved longer-term outcomes that can take months or even years to manifest.

- Enhance specialty health plan services to improve outcomes for recipients. Increase the number of plans to address target populations with specific health conditions or needs.

Cityblock has experience developing tailored care plans that enhance specialty health plan services to improve member outcomes, augmented by specialized, integrated care teams. Our model enhancements for targeted chronic conditions focus on high and rising risk members, especially individuals with chronic conditions and comorbidities that are unaddressed or undermanaged (e.g., diabetes and kidney care, including chronic kidney disease and end-stage renal disease).

We have taken this approach for a range of chronic conditions, including SMI, which we understand to be a focus area for the SMMC Specialty Plan model. For Cityblock members with SMI, we offer a multi-modal, member-specific care team that includes psychiatrists and behavioral health specialists and focuses on needs and vulnerabilities commonly experienced by the SMI population. For example, for individuals with schizophrenia, our Mobile Integrated Care teams are capable of providing — in the home — evidenced-based treatments, such as Long-Acting Injectable Antipsychotics or Clozapine. For members who are also frequently admitted to inpatient hospitals or emergency rooms, we focus on transitions of care to better integrate with long-term providers in the community, with the goal of reducing readmissions. Additionally, we connect members with available social support services, such as day programs and supported employment; ensure that members understand their underlying behavioral health conditions; and equip members with thoughtful, strength-based, member-centric plans that they can draw upon should they experience acute psychiatric symptoms. This comprehensive approach – inclusive of behavioral health, substance use disorder, medical and social care – aims to lower total cost of care by improving member engagement and reducing unnecessary inpatient admissions and emergency room visits.

- Improve coordination of care for individuals enrolled in both the Medicare and Medicaid programs.

Care coordination for individuals dually eligible for Medicare and Medicaid is at the heart of Cityblock's high-touch, member-centric care model. In our experience, Medicare-Medicaid integration is key to addressing the fragmented care and poor health outcomes that can result when benefits are not coordinated. We are encouraged by a number of new and potential flexibilities and funding opportunities for states to develop and refine their approaches to integration for dually eligible individuals. For AHCA's consideration, we are sharing our thoughts

and experience with 1) integrated care delivery, 2) current state policy levers and opportunities, and 3) resources and potential funding opportunities for states.

1. Integrated care delivery and coordination

We have experience serving dually eligible individuals enrolled in plans across the Medicare-Medicaid integration continuum. We currently serve dually eligible individuals through partnerships with Medicaid managed care organizations in multiple states, including North Carolina and Washington, DC. We also partner with D-SNPs in New York and Connecticut to serve over 13,000 members, a Medicare-Medicaid Plan (MMP) in Massachusetts, and other Medicare Advantage plans in North Carolina and Connecticut. We plan to launch a new partnership in Ohio later this year, serving Medicaid managed care and MMP members.

We have demonstrated success serving dually eligible and low-income, underserved Medicaid members, with outcomes including:

- 70% member engagement for this hard-to-reach population, compared to a health plan average of 15%.
- Overwhelmingly positive member experience, as evidenced by an average Cityblock Net Promoter Score of 90.
- Among our early high-cost cohorts, we have seen a 20% reduction in inpatient admissions and a 15% reduction in ED visits.

Our care model emphasizes a local team-based approach, with care teams hired for their ability to empathize and exhibit compassion, in addition to delivering high quality care. Community Health Partners - a non-clinical role hired from the local community - coordinate the Cityblock care team, support the member in coordinating care from external providers across both Medicare and Medicaid (e.g., specialists, dental care, vision), and work directly with the member to close social gaps.

Our care teams co-create and personalize care plans in partnership with our members that encompass both Medicare and Medicaid services, reflecting each member's needs, goals, and priorities - as well as potential obstacles to achieving them, particularly any challenges related to SDOH. We use the care plan as the foundation to structure each member-specific care team. For example, the team might include a dietician for a member with diabetes, a behavioral health specialist for a member with depression, or a doula for a member in their second trimester. The care team also includes a community engagement manager responsible for relationships with social services and community-based organizations. Members can choose where their care is delivered, with options including physical neighborhood clinics known as hubs, through telehealth, or through in-home clinical visits and community paramedic-led acute interventions as appropriate.

Underlying the care team is Commons, our robust care coordination system. This proprietary technology enables team-based, whole-person care delivery by incorporating member feedback and integrating social needs data with clinical and claims data.

As AHCA thinks about how best to enhance access to high quality care for dually eligible individuals, we would encourage efforts to increase both the availability of integrated care and the number of people enrolled in integrated models. Our care model also uses innovative technology to create a member-centered experience that works across both Medicare and Medicaid to empower members to identify and address health and social needs.

2. Current state policy levers and opportunities

Florida already offers a number of D-SNPs, including Highly Integrated D-SNPs (HIDE-SNPs) and Fully Integrated D-SNPs (FIDE-SNPs), laying a strong foundation for further integration. Some policy levers that AHCA might consider as a next step to increase the level of D-SNP integration, as well as the proportion of dually eligible individuals enrolled in integrated plans:

- **Default enrollment:** D-SNPs may apply for Centers for Medicare & Medicaid Services (CMS) approval of default enrollment, which allows Medicaid-only enrollees who are enrolled in Medicaid managed care plans to be automatically enrolled into a D-SNP offered by the same organization when they become eligible for Medicare (i.e., become newly dually eligible). Default enrollment occurs on an opt-out basis, and members can choose not to enroll in the D-SNP. However, the "default" is integrated care, with Medicare and Medicaid benefits covered by the same organization.

  We understand that in Florida, individuals enrolled in a D-SNP also receive their Medicaid benefits, exclusive of long-term care, through the D-SNP as most Medicaid benefits are capitated into the State Medicaid Agency Contract (SMAC). Default enrollment could help members who are currently enrolled in an SMMC plan begin their coverage experience as dually eligible individuals in an integrated plan with the same managed care organization that provides their Medicaid coverage. This change could minimize the confusion that members face when trying to decide between various D-SNPs, other Medicare Advantage plans, and Original Medicare fee-for-service. AHCA could support default enrollment by:
    - Ensuring plans have access to the data they need. At least 60 days before their enrollment takes effect, CMS requires each D-SNP to send a notice to the individuals who will be default enrolled into their plan. Plans need data from the state in order to identify the individuals who are gaining Medicare eligibility.
    - Encouraging D-SNPs to pursue default enrollment, or requiring it (e.g., by a certain date) in the SMACs between D-SNPs and the state.

- **Limit D-SNP enrollment to full-benefit dually eligible individuals**: Reserving D-SNP enrollment for full-benefit dually eligible individuals lets plans focus on designing care coordination, benefits, and cost sharing arrangements to serve a member population that qualifies for full Medicaid benefits. In contrast, partial-benefit dually eligible individuals receive Medicaid assistance with certain Medicare costs, but do not actually receive Medicaid services. One downside to this approach would be disruption due to

disenrolling partial benefit dually eligible individuals from their current D-SNPs. Two alternatives AHCA might consider:

- AHCA could limit enrollment to full-benefit dually eligible individuals only for new D-SNPs, perhaps with incentives for existing D-SNPs to transition in the future, over time.
- Rather than preclude D-SNPs from enrolling partial-benefit dually eligible individuals, AHCA could require D-SNPs to use separate plan benefit packages (PBPs) for full- and partial-benefit dually eligible individuals. AHCA could require current D-SNPs to offer separate PBPs if they choose to continue to enroll partial-benefit dually eligible individuals, while requiring new D-SNPs to enroll only full-benefit dually eligible individuals.

- **Exclusively aligned enrollment**: our understanding is that Florida already requires its FIDE SNPs to have exclusively aligned enrollment, where FIDE SNP enrollment is limited to full-benefit dually eligible individuals who get their Medicaid benefits from the FIDE SNP or an affiliated Medicaid managed care plan. We believe that Florida also already prioritizes aligning dually eligible individuals enrolled in other types of D-SNPs with the same plan for Medicare and Medicaid benefits. Florida could consider using its SMACs to require exclusively aligned enrollment for HIDE SNPs, or for all D-SNPs (or for all new D-SNPs) operating in the state. Exclusively aligned enrollment simplifies how members experience their Medicare and Medicaid benefits, which are covered by the same (or an affiliated) organization.

- **Integrated member materials**: AHCA could work with CMS to develop integrated member materials that cover both Medicare and Medicaid benefits for its current FIDE SNPs and any other plans with exclusively aligned enrollment. We have found integrated materials to be significantly more understandable to members, who no longer need to reconcile separate sets of Medicare and Medicaid documents.

3. <u>Resources and potential funding opportunities</u>

Increasing access to integrated care for dually eligible individuals can be complex and time-intensive. A number of resources are available to assist states interested in pursuing integration efforts ranging from incremental steps to larger overhauls, including:

- **Medicare-Medicaid Coordination Office (MMCO)**: the CMS MMCO works directly with states interested in exploring options to integrate care for dually eligible individuals. The Bipartisan Budget Act of 2018 also designated MMCO as a D-SNP point of contact for states.
- **Integrated Care Resource Center (ICRC)**: CMS has contracted with Mathematica Policy Research to lead ICRC, a technical assistance resource center available to work with all states on the design and delivery of integrated care for dually eligible individuals.
- **Arnold Ventures Funding Opportunity**: Arnold Ventures is supporting a funding opportunity for states seeking to transform care and increase Medicare-Medicaid

integration for dually eligible individuals. This initiative, coordinated by the Center for Health Care Strategies, accepts applications on a rolling basis.
- **State funding bill**: US Senator Casey (D-PA) recently introduced a bill (SB4273) that, if passed, would provide states with resources to support Medicare-Medicaid integration efforts.

In addition, US Senators Scott (R-SC), Casey (D-PA), and Cassidy (R-LA) recently introduced a bill (SB4264) that would require states to develop, and submit to the US Department of Health and Human Services, strategies to integrate care for dually eligible individuals. Passage of that bill may yield further resources to assist states with developing plans that will best serve their local populations.

- Improve recipients' experience with the SMMC Program.

We view member satisfaction as critical not only in its own right, but as a prerequisite for a successful care delivery model where members are engaged in their health and health care. At its foundation, our approach to member satisfaction and experience is based on trust, placing members at the heart of our care teams, and getting to know each individual's unique needs, wants, and goals.

Our CHPs and outreach specialists are hired locally from the communities in which our members live, and share a level of cultural resonance with the members they serve. Prior to engaging new members, we conduct detailed analyses to understand the cultural sensitivities and needs of the local member population. For example, if we identify a number of high and rising risk members who are most comfortable speaking a language other than English, we will hire multilingual care teams and validate our staff's language proficiency through comprehensive fluency exams and interviews.

CHPs are available to answer any questions members may have, and work with members to coordinate access to primary, specialty, and behavioral health services, as well as resources from community-based organizations.

We also improve member experience of care - as well as the experience of other providers serving our members - by reducing delays in transitions of care and better supporting members during hospital discharge. When a member is admitted into the hospital, our Commons platform receives an admission, discharge, and transfer (ADT) notification and alerts the member's personalized care team. The member's CHP conducts facility rounding and visits the member in the hospital, seeking to understand the various clinical and non-clinical factors that led to admission. We then facilitate a transition of care out of the hospital and into an appropriate location of the member's choice. The CHP and care team provide 24/7 access and support to the member throughout the transition to avoid readmission into the hospital.

If a member is admitted to the hospital for a condition that can be treated in an outpatient or home setting, our ED@Home team supports the member's transition of care away from the

hospital and provides continuity of services (e.g., testing, IV fluids, at-home monitoring). Our community paramedics connect directly with a physician via telehealth to administer the appropriate testing and interventions in a member's home or at a community location to ensure member stability during the transition.

- Increase timely access to providers and services.

Integration, coordination, and a focus on the holistic needs of the individual are critical to achieving the aims and promise of value-based care and payment arrangements – but it starts with members getting care when they need it. That's why the Cityblock care model offers traditional brick-and-mortar care delivery together with virtual care and mobile care, augmented by care teams that span the breadth of the provider continuum. These teams help to fill gaps in members' care, including those resulting from provider capacity constraints. Our teams include physicians, nurses (nurse practitioners, registered nurses), behavioral health specialists, licensed certified social workers (LCSWs), pharmacists, and Community Health Partners – a full complement of what is needed in a community setting, to ensure we can deliver integrated comprehensive primary care, community-based mental health services, and social care in addition to connections to community-based organizations in the network.

For members with an established primary care relationship that is working well for them, Cityblock enhances that relationship with a number of services, including off-hours access for questions or issues that arise outside of traditional clinic hours. And when a member lacks a meaningful relationship with a primary care physician (PCP) that gives them the access to care at a time and place that works for them, a Cityblock physician can serve as the member's PCP.

- Achieve cost savings throughout the SMMC Program.

Our model has achieved utilization shifts and associated cost savings through:

- Improving member engagement by fostering a caring and trusting relationship.
- Identifying which members are likely to be or become high risk using a proprietary acuity and utilization predictive scoring methodology, with intensified monitoring of members predicted to be at high or rising risk.
- Identifying potential challenges to medication adherence and proactively problem solving barriers to adherence in partnership with the member.
- Addressing gaps related to SDOH, to support members' overall health and well-being.
- Improving access to care provided whenever and wherever desired by members.

To implement these practices, we rely deeply on being accessible to members 24/7, either in person or via our Virtual Hub. We train our care teams on clear, evidence-based clinical escalation workflows, and can deploy our clinical teams over the phone, in person at Cityblock clinics (hubs), or in members' homes or other preferred locations.

Around-the-clock availability is especially important for serving members with urgent clinical and

behavioral health needs. We offer Mobile Integrated Care services to meet members whenever and wherever they are, including:

- **ED@Home**: our ED@Home teams, staffed by paramedics working in partnership with virtual clinicians, can be deployed within 90 minutes to meet members in their homes or other preferred locations for hospital-level concerns. Through this hybrid digital and physical engagement, a virtual Cityblock clinician uses telehealth to deliver personalized, live guidance to the in-person paramedic. ED@Home teams conduct diagnostic tests, labs, and other higher-intensity services aimed at emergency department diversion.
- **Virtual Urgent Care**: our members engage virtually with a physician for diagnosis and treatment of urgent clinical and behavioral health needs. Our clinicians deliver virtual urgent care over text, phone, mobile app chat, or video. All virtual services are compliant with the Health Insurance Portability and Accountability Act (HIPAA) and are available 24/7.

We would be pleased to discuss any part of this response, and appreciate the opportunity to share it.

Sincerely,

Toyin Ajayi

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