National Perspective on Managed Care Models

November 15, 2017

Overview

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National Perspective on IDD Models

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California Behavioral Health Treatment (BHT) Carve-In of Services

Medi-Cal[1,2]		
Objective	• Whole-Child Model Redesign to improve the coordination and continuity of care for children	
Stakeholders	• CMS • Managed Care Plan: Medi-Cal plans	• Department of Health Care Services • Department of Developmental Services
Enrollment	• January 2017 • Community-Based Adult Services • Multipurpose Senior Services Program • State Plan options 1915(j) and 195(k)	• State Plan benefit for Intermediate Care Facility and Skilled Nursing • 1115 California Bridge to reform Demonstration Waiver
Services	• Comprehensive treatment and focus of the whole-child rather than only their CCS-eligible condition(s)	• Care coordination through an organized delivery system
Approach	• Strengthen partnership among local Medical Therapy Program (MTP), health plan and providers, to promote improved outcomes and integrated care. Counties will remain responsible for MTPs.	
Funding	• Value based payment • State funded delivery system	• Counties responsible for MTPs
Outcomes	• Started January 2017 • In the 33 counties where the Whole-Child Model is not offered, DHCS proposes to extend the CCS carve-out to January 1, 2019	

[1]http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_22741.asp

[2]http://www.dhcs.ca.gov/services/ccs/Documents/WholeChildModel.pdf

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Outcomes: California BHT

Medi-Cal BHT Services (through March 2016)[3]		
Fee-for-Service BHT Services	Beneficiaries receiving BHT Services *after* transition	1,759
Managed Health Care Plan (MCP) BHT Services	Beneficiaries receiving BHT Service *before* transition	4,260
	Beneficiaries receiving BHT Service *after* transition	2,566 Total 6,826
	Increase since 2/1/2016 transition	+60%
MCP Continuity of Care (COC)	State percentage of transitioned beneficiaries receiving COC	90%
MCP BHT Providers Network	Statewide Total of MCP Provider Network	35,974
	Increase since 2/1/2016	+7%

[3]http://www.dhcs.ca.gov/services/medi-cal/Documents/BHT_Presentation2016_03-24.pdf

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New York: FIDA-IDD

New York State FIDA-IDD[4,5]		
Objective	• To test new model of care for Medicare-Medicaid IDD enrollees in New York State: New York City, Long Island, Rockland and Westchester • Increase quality and reduce cost • Enable self-direction of services in care planning and living independently	
Stakeholders	• Department of Health • Office for People with Developmental Disabilities	• CMS • Managed Care Plan: Partners Health Plan
Enrollment	• Anticipated eligible members: 20,000 • Voluntary	• Start-date: April 2016 • 21 and over
Services	• Person-centered • Comprehensive array of services • Interdisciplinary Team	• Care Manager • Life Plan
Approach	• Holistic approach towards care, addressing physical, behavioral health and social determinants of health	
Funding	• Blended Medicaid-Medicare capitated payment model • Paid prospectively to the contracted plan each month	
Outcomes	• Enrollment as of October 2017: 662 (3.3% of eligible population) • Outcome data unavailable based on start date	

[4]New York State Office for People with Developmental Disabilities
[5]New York State Department of Health

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Roadmap: New York Future State[6]

- New York's goal is to integrate the delivery of care for individuals with IDD
- Implementation of Health Homes for IDD population will begin the move towards integrated care delivery beginning in 2018
- Transition to managed care will initially be voluntary enrollment with the establishment of Specialized Intellectual and Developmental Disabilities Plans (SIPs)
- Timeline 2018-2024

[6]New York State Office for People with Developmental Disabilities

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Kansas

KanCare[7,8]		
Objective	• Physical and behavioral health service were integrated in 2013 through the KanCare program • Improved integration between physical and behavioral health lead to adding supports services in 2014 as a way to further enhance care provided, improving physical well-being and quality of life • Improve quality and reduce waiting list	
Stakeholders	• Department of Health and Environment • Department for Aging and Disability Services • CMS	• Managed Care Plans: Sunflower Health, Amerigroup and United Healthcare Community Plan
Enrollment	• Eligible Members: 8,500 (IDD population) • Managed Care Enrollment Required	• Implementation: February 2014
Services	• Person-centered integrated care • Comprehensive array of services, including LTSS and HCBS	• Additional Waiver programs for the following: Technology Assisted and Autism
Approach	• Integrated care model that increases expectation for improved outcomes and increased access to care	
Funding	• Pilot between 2013 and 2014 (500 Members and 25 providers to test billing and workflows) • Capitated Rates based on eligibility group and full risk for health plans • Percentage of savings to be reinvested in work-related programs	
Outcomes[9]	• 2016 CMS Annual Report 2016 representing claims data for calendar year 2015 • 9,346 enrolled in 2016	

[7]KanCare
[8]Kansas Department for Aging and Disability Services
[9]KanCare Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.16

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Outcomes: KanCare[10]

Population defined as individuals with the following: 1) severe mental illnesses, 2) IDD and 3) physical disabilities

Measure (Pay for Performance)	Population			Eligible KanCare Members		
Comprehensive Diabetes Care	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
HbA1c testing	84.40%	86.50%	87.60%	83.10%	84.80%	84.90%
HbA1c control <8.0%	84.40%	86.50%	87.60%	83.10%	84.80%	84.90%
Eye Exam	58.70%	63.70%	66.50%	50.10%	58.60%	62.50%

Population defined as the following: Individuals accessing HCBS Services:

Measure	Population			Eligible KanCare Members		
Applicable to Population receiving HCBS Waiver Services	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
Increase in the number of primary care visits (Annual preventative health visit)	92.00%	93.10%	94.00%	88.40%	87.50%	87.10%
Decrease in number of Emergency Department visits (per 1,000 members per month)	77.58%	78.06%	79.64%	65.17%	64.19%	66.31%
Increase in Annual Dental Visits	49.40%	49.00%	51.60%	60.30%	60.00%	60.90%

Coordination of Care (and Integration)	
Care Management for Members receiving HCBS Services	KDADS is working with the MCOs to improve documentation of assessments of member needs and updates of service plans as needs change

[10]KanCare Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.16

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Key Trends and Takeaways

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Looking Forward

In addition to the move to managed care, states are increasingly looking to move away from volume-driven care to value based payment arrangements. This move can do the following:

- Support population health
- Improve integration of care for populations that have significant comorbidities
- Increase opportunities to provide whole-person care

As more states move from fee-for-service and consider value-based payment arrangements providers and advocates should do the following:

Seek guidance in understanding the process of moving to managed care and value-based payment arrangements
Examine the benefits offered to ensure they reflect what individuals need for improved quality of life
Ensure that continuity of care and the implementation cycle is adequate so there is not disruption in care
Shape quality measures to reflect the needs of individuals
Identify technology needs and interoperability that supports integrated physical and behavioral health care as well as social supports

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Understanding the Need

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Intellectual Developmental Disability (IDD)

A group of disorders with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains[11]

Statistics reflect that individuals with IDD are at significantly higher risk of mental illness

- It is conservatively estimated the prevalence is 33%[12]

Statistics reflect individuals with cerebral palsy (CP) have a higher rate of co-occurring conditions[13]

- 41% had co-occurring epilepsy
- Co-occurring epilepsy was more common among children with CP who had limited or no walking ability
- Almost 7% had co-occurring autism spectrum disorder (ASD)
- Co-occurring ASD was more common among children with non-spastic CP than spastic CP compared to peers rate of 1%

Comorbid conditions, regardless of the conditions, does not simply mean the addition of two diseases that follow usual course of care independently[12]

- The prognoses of all diseases are impacted by the presence of the comorbid condition
- Providers are usually focused on the disease they are most familiar with

[11]American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
[12]Sartorious, N. (2013). Comorbidity of Mental and Physical Diseases: A Main Challenge for Medicine of the 21st century. *Shanghai Archives of Psychiatry*, *25*(2), 68–69.
[13]Center for Disease Control and Prevention

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Understanding the Need

Medical costs to treat patients with IDD, mental health and substance use disorders is significantly increased, and mortality rates in this population are increasingly high

Autism Spectrum Disorder[14]	The lifetime cost for an individual averages $2.4 million when Autism Spectrum Disorder (ASD) involves intellectual disability and $1.4 million when it does not
	An estimated 40 percent of individuals with ASD also have intellectual disability
	ASD yearly cost to the United States is an estimated $236 billion a year
Mental & Behavioral Health	Estimated medical cost for treating patients with chronic medical and comorbid mental health and substance use disorders can be two to three times higher[15]
	Most of the increased costs for comorbid conditions is contributed to medical care[15]
	It is well recognized that psychiatric disorders have a higher mortality risk and may be worsening over time[16]

[14]Buescher, Ariane V.S. et.al (2014 June). Costs of Autism Spectrum Disorders in the United Kingdom and the United States. *JAMA Pediatrics*, Vol 168, 8: 628-728.
[15]Melek, S.P., Norris, D.T., and Paulus, J.(2014 April). *Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry*, Millman, Inc.
[16]Chesney, E., Goodwin, G. M. and Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*, 13: 153–160.

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COPE Health Solutions' Approach

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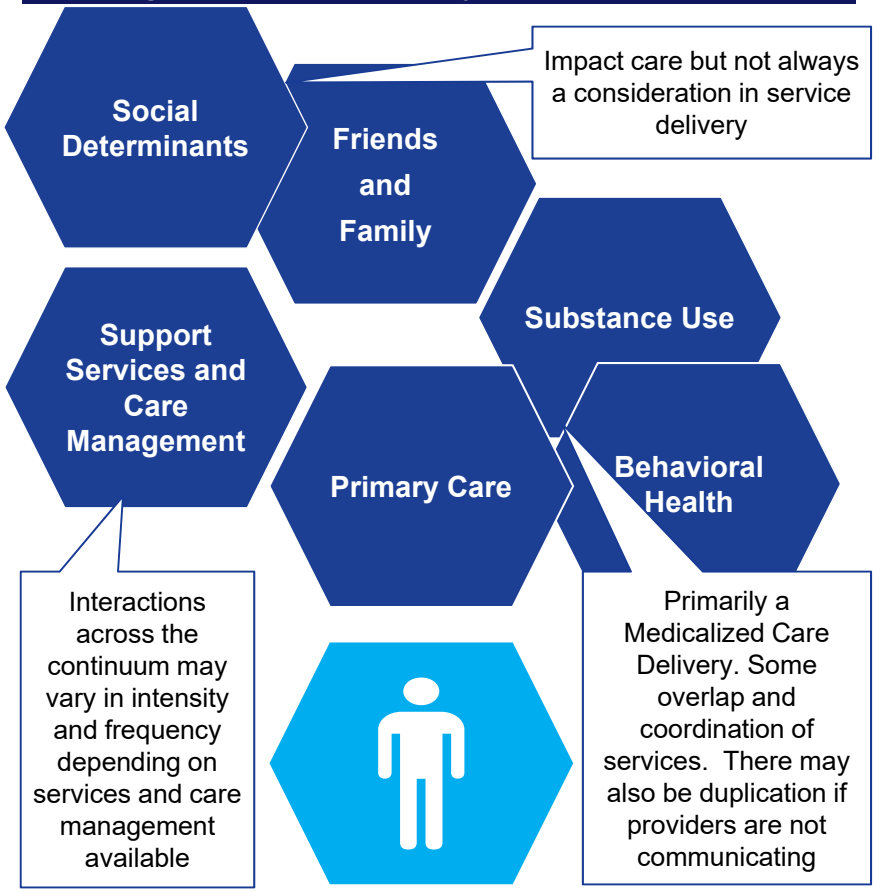
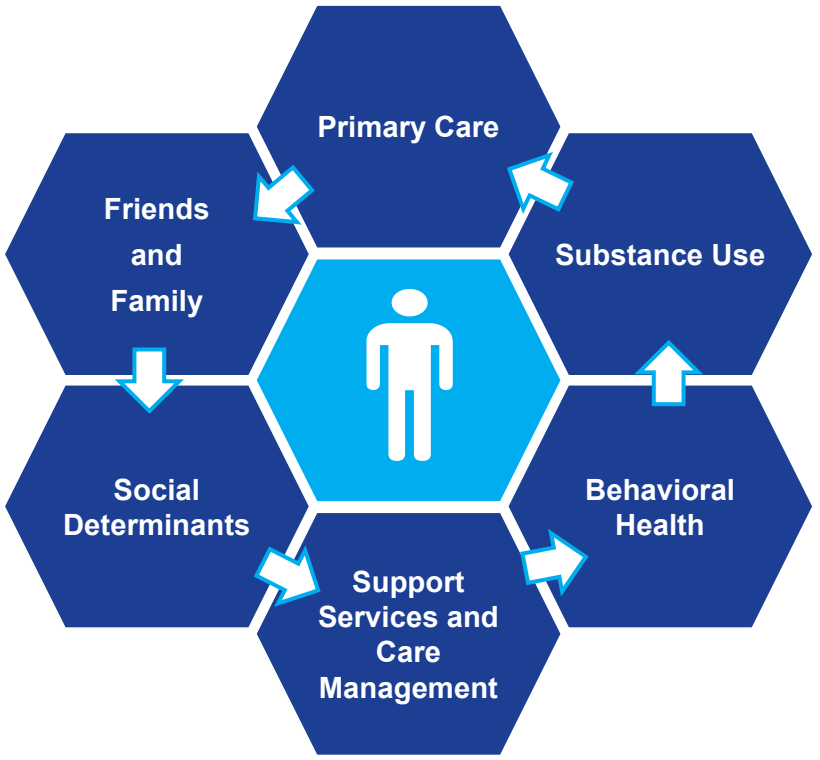
Integrated Holistic Care

Integration of services improves quality of care for individuals with multiple health conditions by treating the whole person in a comprehensive, holistic approach

Fragmented Pathways to Access Care



Person Driven Integrated Care



- Person-centered delivery of service
- Everyone is working together to achieve improved quality of life

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Managed Care Models

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Understanding Managed Care

Managed Care is more than a financing mechanism

Managed Care can be the vehicle to support holistic, service delivery through:

Integrated care

Improved care coordination

Increased access to care

Improved independence and self-determination

Managed Care is positioned to impact quality outcomes

- Fee-for-Service (FFS) does not present as many opportunities for data collection and analysis
- Managed Care often has rigorous reporting requirements to State and Federal entities that may not exist in a FFS environment
- Through managed care and stakeholder engagement measures can be identified that support quality of life measures

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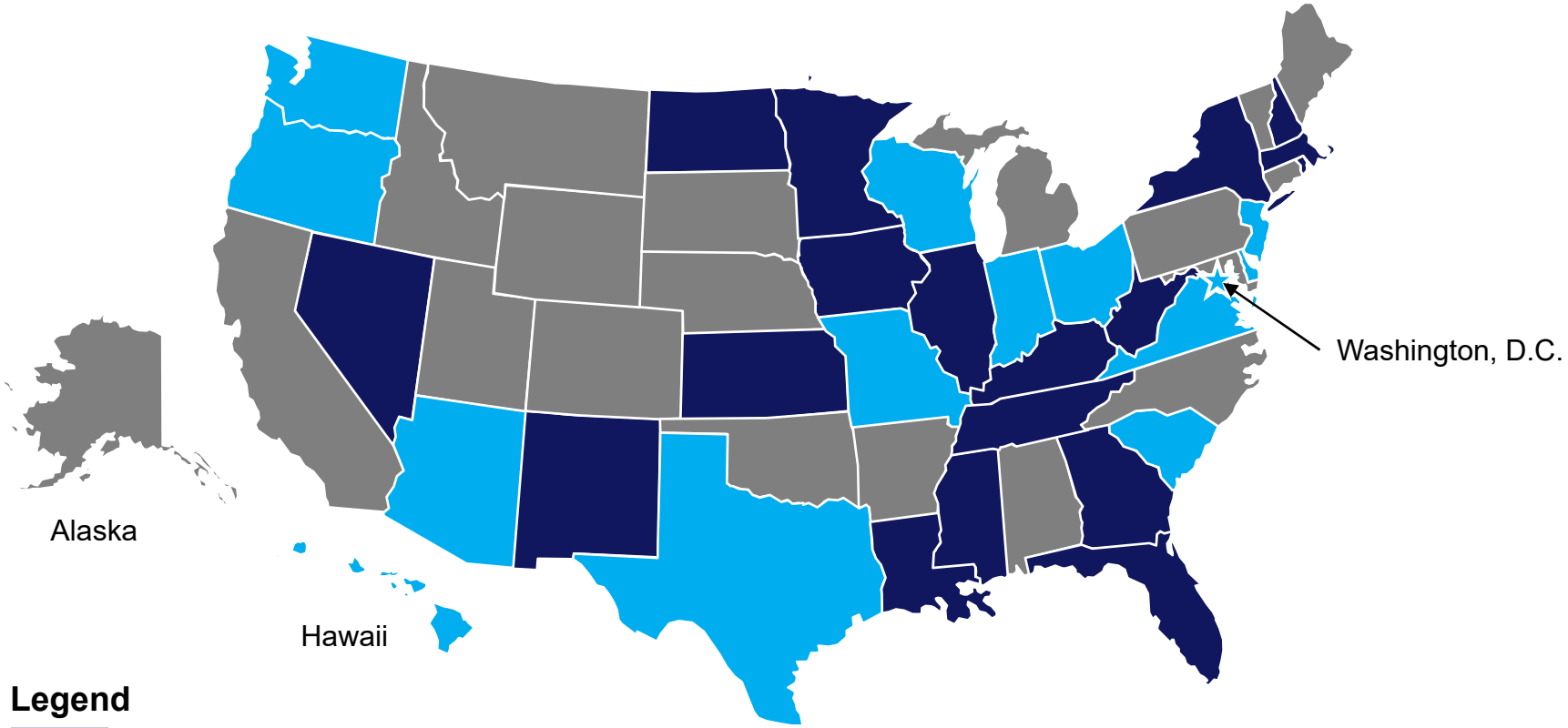
Fiscal Year 2016 and 2017 Carved-In Benefits

18 states have fully carved-in behavioral health and substance use services; 14 states have variation of carved-in behavioral health and substance use services[17]



[17]Antonisse, L., Edwards, B., Ellis, E., Hinton, E., Gifford, K., Rudowitz, R., Smith, V.K., and Valentine, A. (2016, October 13). *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. Kaiser Family Foundation

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Transition to Managed Care

Key considerations for preparing for a managed care environment

	Ample planning
	Stakeholder engagement and ongoing involvement in implementation and oversight
	Alignment of payment structures and goals
	Whole Person approach from policies to workflows to service delivery
	Ensure there is availability and access to a network of qualified providers
	Quality strategies that are transparent and appropriately tailored to address the needs of the population including quality of life measures
	Provider preparation and support throughout the transition

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Appendix A

Additional Facts

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Carved-In Benefits Detail

Fiscal Year 2016 and 2017
18 States have fully carved-in behavioral health and substance use services[18]

State	Outpatient Behavioral Health	Inpatient Behavioral Health	Outpatient Substance Use	Inpatient Substance Use
Florida	Y	Y	Y	Y
Georgia	Y	Y	Y	Y
Illinois	Y	Y	Y	Y
Iowa	Y	Y	Y	Y
Kansas	Y	Y	Y	Y
Kentucky	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y
Minnesota	Y	Y	Y	Y
Mississippi	Y	Y	Y	Y
Nevada	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y
New Mexico	Y	Y	Y	Y
New York	Y	Y	Y	Y
North Dakota	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y
Tennessee	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y

Fiscal Year 2016 and 2017
14 States have variation of carved-in behavioral health and substance use services[18]

State	Outpatient Behavioral Health	Inpatient Behavioral Health	Outpatient Substance Use	Inpatient Substance Use
Arizona	Varies	Varies	Varies	Varies
Delaware	N	Y	Y	Y
DC	Y	Y	N	Y
Hawaii	N	N	Y	Y
Indiana	N	Y	Y	Y
Missouri	N	Varies	Varies	Varies
New Jersey	N	N	N	Varies
Ohio	Varies	Y	Varies	Y
Oregon	Y	N	Y	N
South Carolina	Varies	Varies	Y	Y
Texas	Varies	Varies	Varies	Varies
Virginia	Varies	Y	Varies	Y
Washington	Varies	Varies	Varies	Varies
Wisconsin	Varies	Y	Y	Y

[18]Antonisse, L., Edwards, B., Ellis, E., Hinton, E., Gifford, K., Rudowitz, R., Smith, V.K., and Valentine, A. (2016, October 13). *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. Kaiser Family Foundation

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California Whole-Person Care Pilot

Whole-Person Care (WPC) Pilot[19]		
Objective	Coordination of health, behavioral health, and social services, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources	
Stakeholders	• CMS – Section 1115 Waiver authorized • Managed Care Plan: Medi-Cal 2020 • Department of Health Care Services (DHCS) • Health and Hospital Authority	• County or Regional agency • Designated public hospital • District municipal public hospital • Consortium of any of the above
Enrollment	• 5 year demonstration 1/1/16-12/31/20 • Avoidable or repeated emergency use, hospital admissions or nursing facility placement	• 2 or more chronic conditions • Mental health and/or substance use disorders • Currently experiencing homelessness/high risk for homelessness
Services	• Integration among county agencies, health plans and providers • Increased coordination and appropriate access to care • County based initiatives that coordinate health, behavioral health and social services	• Achieve targeted quality and administrative improvement benchmarks • Increase access to housing support/services (optional) • Improve health outcome for the WPC population
Approach	• County or regional approach to holistically improve the care for high utilizers and those at risk	
Funding	• 5 Year up to $1.5 billion federally funded pilot program • Permissible source of intergovernmental transfers (GTs)	
Outcomes	• Pending - Program Y1: 1/1/17-6/30/17 payment 75% for application and 25% for baseline data	

[19]http://www.dhcs.ca.gov/provgovpart/Documents/DHCSStateInitiativesCrosswalk3-16-16.pdf

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New York: Health and Recovery Plan

Health and Recovery Plan (HARP)[20]		
Objectives	• Establish a special needs plan that integrates physical health, mental health and substance use services specializing in serving individuals with severe behavioral health conditions • Better health, better care, greater access, lower cost and improve quality of life	
Stakeholders	• Department of Health • Office of Alcoholism and Substance Abuse Services	• Office of Mental Health • CMS • Managed Care Plans (13)
Enrollment	• Eligible individuals identified for enrollment based on risk factors and Medicaid use • Passive enrollment	• Anticipated eligible population: 117,973 • Start-date: October 2015 • 21 and over
Services	• Person-centered, integrated care • Enhanced benefit package • HCBS services, including peer support	• Health Home Enrollment • Health Plan Care Management
Approach	• Holistic approach towards care, addressing physical health, behavioral health and social determinants	
Funding	• Capitated Payment	• Value-based Payment Pilots in 2017
Outcomes	• Enrollment as of October 2017: 94,725 (80% of eligible individuals) • Health Plans will report outcomes by product line for 2016	

[20]New York State Department of Health

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Washington Model

Apple Health[21]		
Objective	Provide high quality health care through innovative health policies and purchasing strategies	
Stakeholders	• Health Care Authority • Department of Public Health • Housing and Supported Employment	• CMS • Apple Health MCOs (5) • Tribal Governments
Enrollment	• Eligible individuals identified for enrollment based on risk factors and Medicaid use	• 1.8 million are covered by Apple Health • Passive enrollment
Services	• Stable housing and employment • Assist unpaid caregivers with training education, specialize medical equipment and assistance • Bi-directional integration of physical and behavioral health through care transformation • Access to oral health services	• Personal care benefit • Community Based Care Coordination • Transitional Care • Diversion Interventions • Address Opioid Public Health crisis • Reproductive Maternal and Child Health • Chronic Disease Prevention and Control
Approach	• Integrate behavioral and physical health • Convert 90% of Medicaid provider payment to reward quality of care • Foundation Community Support Services (FCS)	• Transformation through Accountable Communities of Health (ACH) • Long-term Services and Supports (LTSS) for the aging population
Funding	• VBP	• $1.5 billion federal investment
Outcomes	• All 9 ACHs have completed Phase II certification and project selection is being finalized	

[21]Washington State Health Care Authority

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Appendix B

About COPE Health Solutions

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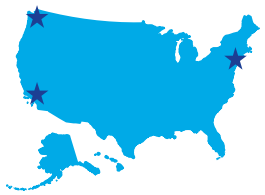
Organizational Overview

We are the partner of choice for providers and payors across the United States who are committed to success in the new value-based payment environment and developing the diverse talent needed to fill future health care roles



Offices in Downtown Los Angeles, Manhattan and Seattle, with teams across the country in major markets including Texas, the Northwest, Florida and the Northeast

COPE Health Solutions currently has over 120 employees partnering with health systems and health plans across several states and enrolls over 4,500 students annually in our courses, with a growing national and global presence

COPE Health Solutions has a proven track record in all aspects of strategy, population health management, Medicare/Medicaid transformation and workforce training across the continuum

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Thought Leadership, Visionary Transformation

COPE Health Solutions' purpose and core beliefs are defined by our mission and vision statements and enabled through a set of shared firm values

Mission

To help our clients achieve visionary, market-relevant health care solutions

Vision

Our clients are leaders in adding value for consumers through innovations in population health management, talent development and alignment of financial incentives

Values

- Live and work honestly and with **integrity**
- Foster **access** to health care for diverse communities
- Assure the highest **quality** outcomes
- Support the organization and other members through **teamwork**
- Find solutions and generate positive change through **innovation**
- Succeed by taking **initiative** to improvise, adapt to and overcome challenges

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Calculated Risks for Transformational Change

Our team of health care experts provides clients with tools, services and implementation support, ensuring success in a challenging and rapidly evolving health care environment

	COPE Health Solutions	Competitor Firms*
Strategic Planning and Operational Competencies	✓ Delivers practical strategy for all lines of business to gain market share ✓ Not inhibited by risk-aversion ✓ Created a transformational space where others continue to fail and leave all-payer (safety net) clients without an effective approach for long-term viability ✓ Proven track record directly supporting clients with implementation, not simply strategic planning ✓ Proven success with Medicaid (before ACA legislation and national push for value-based payments)	– Risk-averse – Focus on commercial and Medicare lines of business – Projects generally geared towards short-term wins to the bottom line: • Revenue cycle • Process improvement • Non-integrated implementation • High-margin markets/clients
Organizational and Workforce Competencies	✓ Developed unique model through Health Care Talent Innovations that leads to a loyal, long-standing client base eager to share their success ✓ Built largest health care talent pipeline in the country (over 20,000 resources)	– Lack competencies in this area

** PwC, Deloitte, KPMG, E&Y, Manatt, Accenture, ECG, The Advisory Board, GE Healthcare, The Camden Group and McKinsey*

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Appendix C

COPE Health Solutions Team Biographies

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Allen Miller
Chief Executive Officer

Allen Miller is the CEO of COPE Health Solutions. He has over 20 years of experience providing strategic planning, business development, operations analysis/improvement consulting services and leading assessments, planning, development and implementation of integrated delivery networks throughout the United States. Under Allen's leadership, COPE Health Solutions has become the pre-eminent go-to solutions company for health systems and health plans looking to take on a leadership role in population health for Medicaid and the Exchange.

COPE Health Solutions complements its consulting services with the largest health care talent pipeline in the country, known as Health Scholars, providing a unique health care training experience to over 3,500 students annually receiving eight units of University of California course credit in over 20 hospital and ambulatory sites throughout California and Washington State. Recently, a care navigator, health coach and complex care management training program was developed to train graduates of the program for some of the new roles being created as health system clients develop population health management capabilities and capacity.

A hallmark of COPE Health Solutions' consulting services is engagement in transformative strategic planning, design and implementation work with large health systems, health plans and others to develop clinically integrated delivery networks, re-design financial incentives and to learn to leverage financial risk to improve quality and reduce costs. Allen and his team are consistently on the cutting edge of work to implement new health care policy, including federal demonstrations and state waivers across the country, by partnering with providers and payers to transform fragmented, acute care "un-systems" of delivery into coordinated systems of care focused on improving the health of populations, while enhancing efficiency and aligning financial incentives.

A graduate of UCLA, both for his Bachelors of Science and his Masters of Public Health in Health Services, Mr. Miller also completed an intensive on International Business at Oxford University in England. Mr. Miller also has extensive teaching and lecturing experience, most notably as a former faculty member teaching orthopedics for the American Academy of Family Physicians and the California Academy of Family Physicians.

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Wendy Smith
Executive Vice President

Wendy Smith is a proven health care leader possessing over 25 years of health plan experience in all populations including Commercial, Medicaid, Medicare Advantage/Duals, Exchange, Direct to employer and indigent populations. She has worked with many of the nation's largest health care companies including Aetna, UnitedHealthcare, PacifiCare and Ascension Health as well as several health insurance start-ups that went on to successful exits.

Ms. Smith is focused on enhancing strategy and operations, aligning innovation, and is a subject matter expert in network expansion and contract negotiations from fee-for-service to global capitation and value-based agreements.

In addition to her corporate background, Ms. Smith has a passion for advising health technology companies with a goal of improving efficiency and health care delivery.

She is on the board of visitors at her alma mater Southwestern University and serves on several health technology advisory boards.

Ms. Smith has an undergraduate degree from Southwestern University and Masters in Healthcare Administration from Texas State University.

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Dawn Johnson
Executive Vice President

Dawn Johnson is a masters-prepared registered nurse with a diverse background in clinical care, health policy and consulting. With more than 20 years of professional healthcare industry experience spanning both the public and private sectors, Ms. Johnson has worked with multiple federal agencies, state governments, private organizations and vendors. Dawn comes to COPE Health Solutions with a background in care management, care coordination, government relations, health policy and business development. Her focus is on healthcare system transformation that improves the care delivery system for vulnerable populations, improves clinical outcomes and empowers consumers to become more accountable for their healthcare.

Prior to joining COPE Health Solutions, Dawn's private sector leadership roles allowed her to use a clinician's approach to develop strategies, mitigate risk and collaborate on solutions for payers, providers, vendors and consumers. During her federal tenure she served as a nurse case manager for the Veterans Affairs and successfully reduced recidivism in her chronically ill populations. At the Centers for Medicare and Medicaid Services (CMS), Dawn served in both the region and central offices, across both Medicaid and Medicare. At the end of her tenure she was responsible for managing the largest pilot program for Medicare fee-for-service beneficiaries that tested disease management strategies, which included multiple public-private cooperative agreements and partnerships, $350 million in program fees and more than $10 million in support contracts.

Dawn earned her BSN and MSN from the University of Maryland at Baltimore, School of Nursing.

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Tom Dougherty, MBA, FACHE
Executive Vice President

Tom Dougherty, MBA, FACHE, is an Executive President at COPE Health Solutions with more than 25 years of broad-based experience in senior leadership roles for health care systems, hospitals, health plans, post-acute care, home health and hospice. He has extensive experience in operations and integration, strategic planning, care delivery redesign, contracting, reimbursement, capitation, financial management, revenue cycle and business development. He has led turnarounds, transformations, reengineered operations to achieve efficiencies and large-scale network development. Mr. Dougherty works with clients to transition to risk and value-based reimbursement models, maximize their operational efficiencies and revenues, create new opportunities, expand the benefit of their services, implement appropriate strategies and pursue the right innovations that lead to success as health care faces extraordinary changes.

Prior to joining COPE Health Solutions, Mr. Dougherty served as President of his own consulting practice, Healthcare Innovators. In this role, Mr. Dougherty guided his clients in strategic planning, transforming business models from fee-for-service to services that complement coordinated care risk models such as capitation or bundled payments. He provided assessments and evaluations for mergers and acquisitions, service line redesign and innovations and identification of opportunities for performance improvement. Mr. Dougherty has served as an executive in many health care systems, including Downey Regional Medical Center, Valley Health System, Inter Valley Health Plan, PPO Alliance and others.

Mr. Dougherty is a Fellow of the American College of Healthcare Executives (FACHE) and serves on the Board, and is a Past President, of Health Care Executives of Southern California (HCE), the greater Los Angeles chapter of the American College of Healthcare Executives (ACHE). He enjoys mentoring early careerists. He is a past member of the Advisory Committee for the Healthcare Administration Program of California Baptist University.

Mr. Dougherty earned his Bachelor of Science in business administration degree from Xavier University in Cincinnati, Ohio and his Master of Business Administration degree from the University of Phoenix.

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Carla D'Angelo, MPH
Vice President

Carla D'Angelo joined COPE Health Solutions as a vice president in 2016. She has more than 10 years of leadership experience in the health care industry with a primary focus on health plan and provider collaboration. Prior to joining COPE Health Solutions, Carla served as the senior vice president at YourCare Health Plan, a low-income health insurer in Western New York. In this role, Carla led the New York State Medicaid Delivery System Reform Incentive Payment (DSRIP), value-based contracting, marketing and quality efforts. Carla also served as the senior vice president of administration at Trillium Health, a Federally Qualified Health Center (FQHC) Look-a-Like in Rochester, NY where she led the health center through their FQHC application process.

Additionally, Ms. D'Angelo ran the 340B pharmacy, marketing and organizational advancement departments, human resources and organizational strategy and board relations. Carla also served as the interim CEO for the organization. Carla spent seven years at Excellus BlueCross BlueShield, most recently as the Director of Financial Services, Consulting.

Carla's expertise is in value-based contracting, accountable care organization development, provider contracting and health care reimbursement. In her senior leadership roles, Carla has gained expertise in board relations, strategic planning, executive coaching and leadership development. Her passion is around eliminating health disparities for low income and vulnerable populations.

Carla received her Master's in Public Health from SUNY Albany. She has served on numerous local non-profit boards and currently serves as the president of the Healthcare Financial Management Association (HFMA) in her local chapter. Carla is a 40 under 40 awardee and has won numerous awards for her volunteerism. Carla enjoys scuba diving, traveling the globe, yoga and golfing.

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Nanette McLain, Manager

- Ms. McLain supports organizations in building care management capabilities, enhancing clinical integration and establishing population health interventions to address risk and improve clinical outcomes. As a licensed clinical social worker Ms. McLain is a subject matter expert for the integration of behavioral and physical health care, applying a person-centered, holistic approach.

Erin Torrens, Consultant

- Ms. Torrens brings a background in behavioral intervention and developmental disability case management. She previously worked as a Clinical Supervisor for an Applied Behavior Analysis vendor. Ms. Torrens has successfully managed care teams, designed individualized patient centered programs, developed effective and practical behavior intervention plans and partnered with school districts to develop cross-sector comprehensive behavioral care models.

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