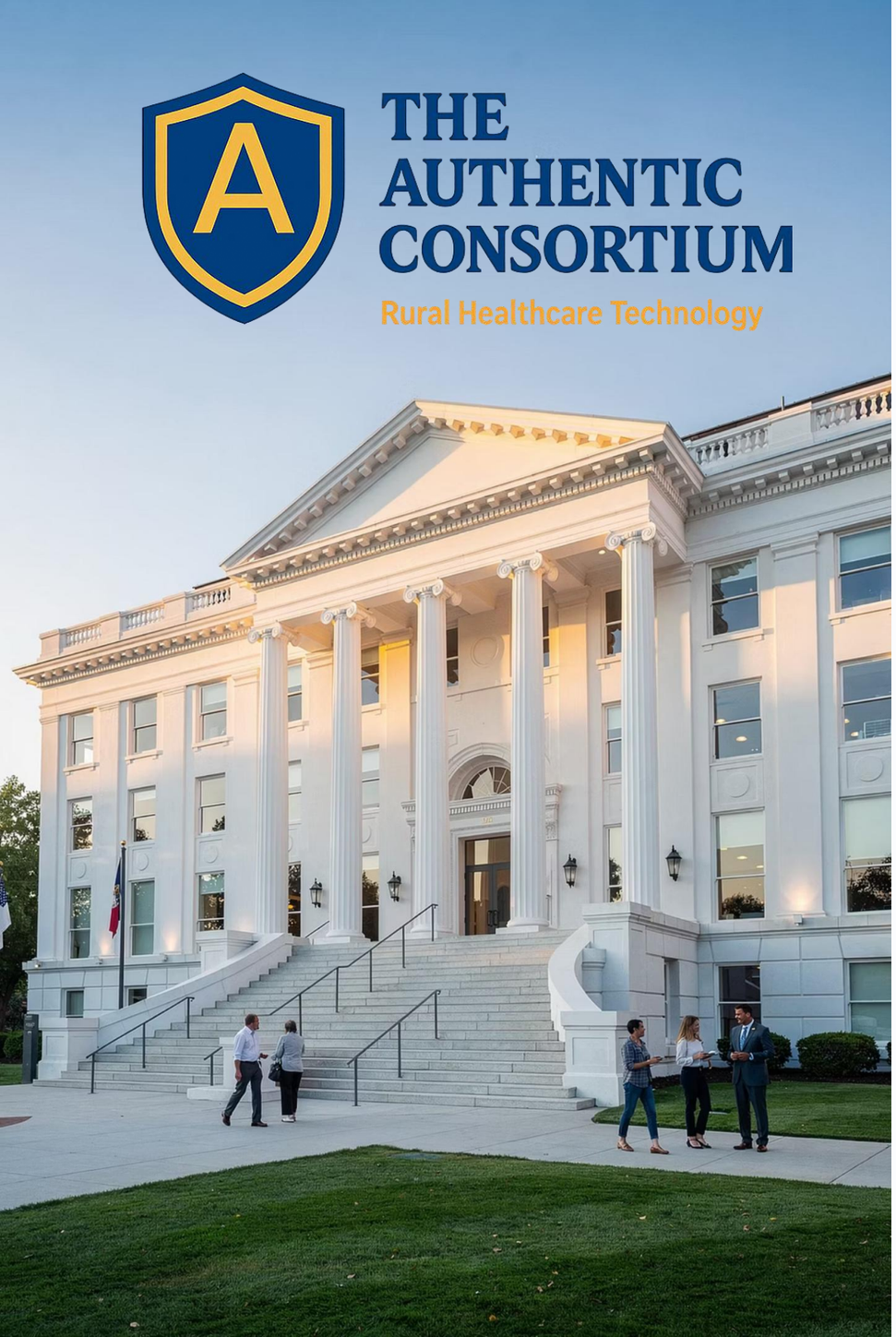


The Authentic Consortium (ACT): Ultimate Clinic “3C” Saving Virginia RHCs Time, Money and Potentially LIves

1. Compliance

Automated regulatory adherence protecting state and federal dollars

2. Care

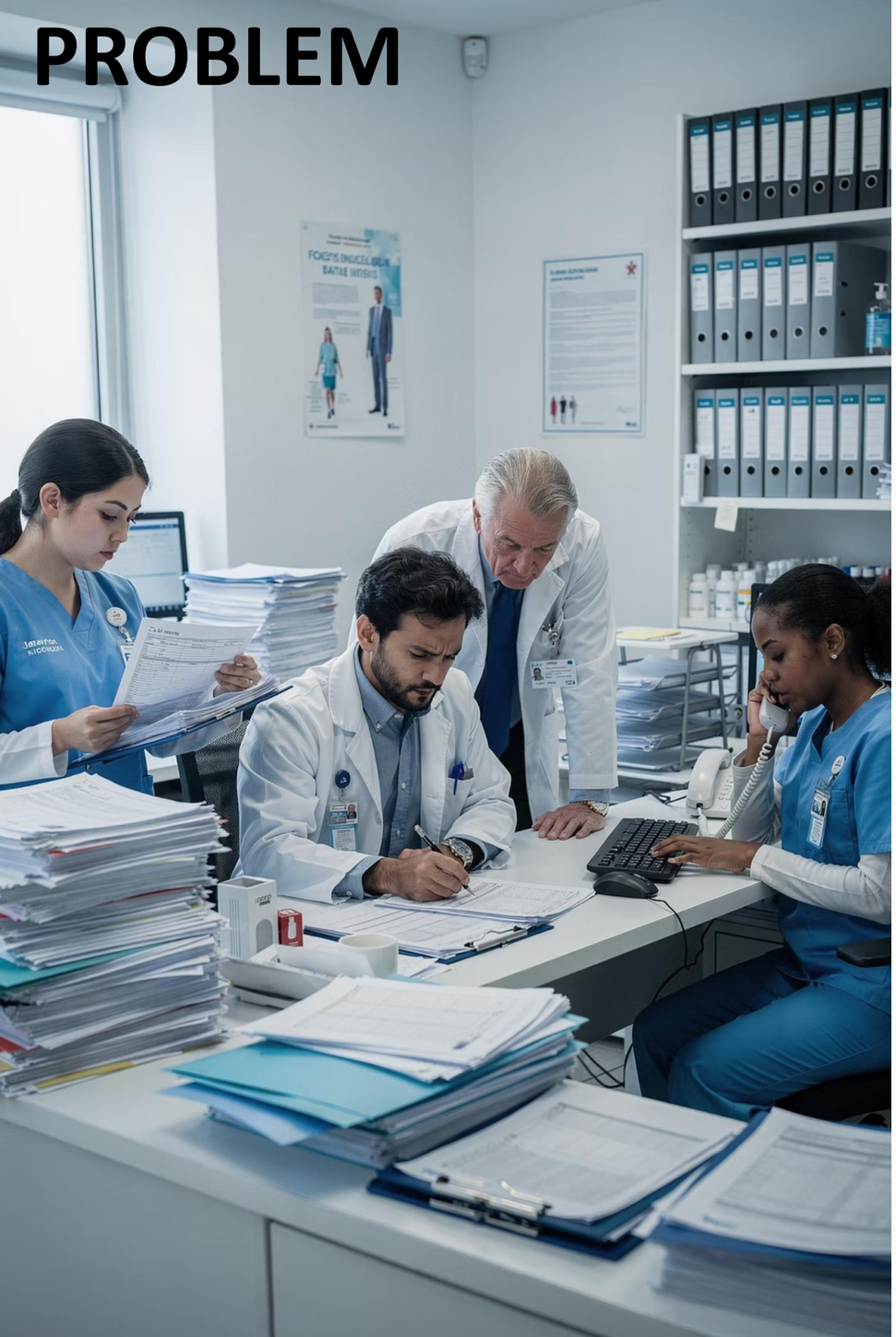
24/7 virtual support extending access across rural communities

3. Collect Cash

Error-free billing ensuring financial sustainability for rural clinics

Virginia-Based Service Disabled Veteran Owned Small Business (SDVOSB)

PROBLEM



The Problem C1 Solves: Compliance Costs Time

C1 fixes the gap between what CMS expects today and what overworked rural staff can realistically remember and apply at the point of care and billing.

Why This Is Important Now

- **2025–2026 rule changes are big and ongoing.** CMS's 2025 Final Rule for RHCs brings new care-management billing codes, changed vaccine billing, and clarified primary-care definitions; telehealth flexibilities run through at least the end of 2025, all of which alter what is "compliant" and "billable" day-to-day.
- **Real-time compliance tech is becoming the standard.** Organizations using real-time compliance tracking and analytics reduce discrepancies and penalties by up to ~30%, compared with manual, retrospective methods—exactly the kind of improvement rural sites need as enforcement and documentation expectations tighten.

PROBLEM

The Problem C2 Solves: Distance and Duration

- Virginia rural patients often travel ***30–50+ miles***
- ***Only 4 in 10 rural adults*** Virginians get same or next-day appointments

Why This Is Important Now

- ***Rural access gaps are deepening***. Rural communities face persistent clinician shortages, higher unmet need, and increasing reliance on ED care for primary-care-sensitive conditions.
- ***Virtual care has become a lifeline***. Telehealth and virtual care are now recognized as essential to bridging distance and specialty gaps in rural areas, improving access and reducing travel burdens.
- ***Policy and payment are shifting in favor of virtual models***. States and payers are expanding telehealth coverage and virtual-care strategies for rural populations.

PROBLEM

Healthcare Dilemma

1. Compliance, Care and Cash errors and inefficiencies suck precious time

2. Time lost leads to burnt our RHC workers

"We are all just about to burnout with no end in sight."

~RHC Nurse

3. Burnt Out workers leads to errors

"I'm on light-duty, so they stuck me in billing with no training…and now 18% of my billing is incorrect."

4. RHC risk closing, impacting all Commonwealth

Rural and national data show **burnout affects up to ~50% of rural clinicians a nd is strongly correlated with risk of clinic closing**

PROBLEM

The Problem C3 Solves: Revenue Leakage from Billing Errors

- Rural clinics routinely miss ***10–20% of potential revenue*** because of registration errors, missed charges, coding mistakes, and denials that are never fully worked.
- Studies show ***RHCs can lose up to 20% of income*** to revenue leakage, and inefficient RCM practices can lower net patient revenue by **3–5%** annually—huge numbers for clinics already on the edge.
- Many rural facilities lack experienced RCM staff and modern technology, so billing is reactive and manual, and a single misstep with Medicare or Medicaid can threaten sustainability.

Why This Is Important Now

- ***More than a third of rural hospitals are losing money;***
- ***nearly 75% of unpaid claims are tied to fixable errors***
- ***Rural experts emphasize that "hidden dollars" in charge capture*** and denial management are now essential to keep doors open, not just to pad margins.

SOLUTION

3C Solution

1

Three critical functions, one platform:

COMPLIANCE, CARE, and COLLECT CASH are fully integrated, so every staff action is simultaneously compliant, clinically appropriate, and revenue-sound.

2

Proactive compliance guardrails:

Real-time rule updates and "hard stops" prevent CMS/HRSA/Medicaid/Medicare violations before they happen, shifting compliance from after-the-fact auditing to built-in protection.

3

24/7 Virtual Healthcare Worker for rural clinics:

A always-on digital team member that routes patients to the right local provider at the right time, effectively extending thin rural staffing.

4

Revenue protection at the front end:

Billing intelligence is embedded into daily workflows to prevent errors before claims go out, strengthening the financial survival of rural clinics.

5

Designed with Virginia's rural clinics, not for them:

Years of listening and customer discovery in Virginia make 3C a "Virginia rural operating system" ready to pilot in five clinics and then scale statewide and beyond.

US MARKET

Clinic Types 1. Independent 2. FQHC 3. Tribal	Clinics	$35k/clinic
TAM	All independent RHCs + all rural FQHC parents + all Indian/Alaska Native/Native Hawaiian primary-care orgs	2,300	**$80.5M/year**
SAM	50% of CONUS TAM (realistic adopters over 3–5 years)	1,150	**$40.25M/year**
SOM	Target share in 5 years (≈8% of SAM ≈ 95 orgs)	95	**$3.3M/year**

US PLUS GLOBAL MARKET

TAM	U.S. TAM + non-US rural primary-care orgs that could eventually adopt 3C.	22,300	**$780.5M/year**
SAM	50% of global TAM as realistic adopters over time	11,150	**$390.25M/year**
SOM	5-year target footprint (115 orgs total ≈ 95 CONUS + 20 global)	115	**$4.0M/year**

MARKET

Market Barriers and Alignment with Virginia State Priorities

1

Financial & resource

Specific Barrier: High upfront costs for resource-constrained RHCs

How ACT + 3C Aligns: ACT will work with VVP/VIPC to accelerate deployment across Virginia's 87 RHCs, delivering measurable ROI through reduced compliance costs and protected reimbursements—aligning with DMAS and SORH sustainability goals.

Supports Gov. Spanberger's Policies: EO 12 (2025): Rural Economic Development—lowers capital barriers for rural tech adoption, enabling small RHCs to participate in state transformation grants and workforce retention incentives.

2

Technical & integration

Specific Barrier: Interoperability concerns

How ACT + 3C Aligns: 3C adheres to HL7/FHIR and CMS standards, with ACT maintaining a roadmap tied to Virginia's rural health transformation priorities for seamless data sharing and statewide analytics.

Supports Gov. Spanberger's Policies: Health Data Modernization Task Force: Enables the statewide rural health dashboard Spanberger mandated, feeding real-time RHC compliance and outcomes data to state leadership.

3

Adoption, workflow & trust

Specific Barrier: Clinician time constraints and tool complexity

How ACT + 3C Aligns: ACT co-designs 3C workflows with state pilot clinics, delivering role-specific, "minutes per week" interfaces that reduce administrative burden and support SORH's focus on clinician retention and burnout prevention.

Supports Gov. Spanberger's Policies: Clinician Retention Act (2025): Directly reduces burnout (Spanberger's top rural health priority), qualifying 3C users for her $5K/clinician retention bonuses.

4

Market & competitive

Specific Barrier: Incumbent vendor preference

How ACT + 3C Aligns: ACT seeks SORH/DMAS channel partnerships and co-branded pilots to position 3C as the state-preferred solution, leveraging early reference sites for statewide adoption.

Supports Gov. Spanberger's Policies: Rural Health Partnership Executive Order: Formalizes ACT-state consortia model Spanberger champions for scaling rural solutions statewide.

5

Policy & timing

Specific Barrier: Evolving CMS/HIPAA/state rules

How ACT + 3C Aligns: ACT maintains a dedicated policy team to push Virginia-specific regulatory updates into 3C, keeping RHCs survey-ready and aligned with the Virginia Rural Health Plan 2022–2026.

Supports Gov. Spanberger's Policies: Regulatory Relief for Rural Providers: Keeps RHCs audit-ready amid CMS changes, supporting Spanberger's waiver expansion for rural compliance flexibility.

6

Ecosystem & relationships

Specific Barrier: Alignment with state rural priorities

How ACT + 3C Aligns: 3C maps directly to Virginia Rural Health Plan goals (access, quality, sustainability); ACT co-sponsors pilots with SORH and rural vitality programs to embed 3C as a state transformation asset.

Supports Gov. Spanberger's Policies: Governor's Rural Health Cabinet: Positions ACT as the operational arm for Spanberger's 10-year rural health plan, with 3C metrics feeding her statewide dashboard.

TEAM

James Pfautz

CEO

Authentic Consortium

Alexandria Based

20 years experience Business scaling quant/qual metrics, team leadership, healthcare RHC support, GMU Entrepreneur, VIPC/VVP.

Mandy Peckham

CEO

BSR Consulting

Alexandria Based

Member of Abigail Spanberger Campaign , Small Business Team. 15 years experience in bringing healthcare products to market.

Will Nelson

CEO

All Terrain IT

Arlington Based

30 Yr +IT, Artificial, HIPAA/HRSA/CMS Intelligence, Database, Cybersecurity Marketing, product, Call Center,

Cari Ann Bulzone

CRO

Compliance Operations

Connecticut Based

20+ years Healthcare operations & compliance executive aligning regulatory strategy, revenue integrity, and clinical workflows to protect reimbursement sustain RHCs

Jessica Dove

CRHCO

VA RHC NP

Staunton Based

Virginia RHC Nurse Practitioner, Local Medical Examiner, innovator, for Preventive Wearable BioMetrics , Cardiac monitoring

Antonio Moscatelli

CSO

Authentic Consortium

Fairfax Based

Healthcare strategist and medical logistics expert, combined with outstanding leadership and motivational skill.

PRODUCT

C1 – Compliance Engine (Phase 1 Scope)

C1 encodes high-impact CMS, Medicare, Medicaid, and RHC billing and documentation requirements into structured, updateable rule tables within Salesforce.

Core Mechanics

- Regulatory requirements are translated into configurable validation logic.
- Rules are applied at key workflow points (scheduling, documentation, coding, claim preparation).
- Validation occurs during daily work, not after submission.

Hard Stops and Alerts

- Hard stops prevent submission when required documentation or billing elements are missing.
- Soft alerts flag potentially risky combinations for staff review.

Rule Maintenance

- Regulatory updates are incorporated through a defined governance process.
- Rule tables are updated centrally within the Salesforce configuration layer.
- No automated federal feed ingestion is implemented in Phase 1.

Impact for Rural Clinics

Structured validation reduces preventable denials, documentation gaps, and compliance risk while lowering administrative burden on small teams.

C2 – CARE: Structured Intake & Routing

The CARE component provides structured digital intake and routing workflows that standardize how rural patients are guided and documented.

Core Function

- Patients engage through defined digital channels (text, phone routing, portal).
- Structured intake questions capture essential clinical and access information.
- Routing logic directs cases to appropriate care pathways or escalates to staff.

Human-in-the-Loop

- The system supports staff decision-making.
- It escalates to human personnel when clinical risk or ambiguity is detected.
- It does not replace clinicians or provide autonomous medical decision-making.

Operational Benefit

Standardized intake and routing reduce variability, support telehealth integration, and improve follow-up consistency in thinly staffed rural settings.

C3: COLLECT CASH

C3 – Revenue Integrity & Front-End Validation

C3 applies payer-specific validation logic before claims are created or submitted.

Pre-Submission Checks

- Verifies required documentation elements.
- Checks codes, modifiers, visit type, and RHC billing structure.
- Flags incompatible combinations before submission.

Guided Correction

- Provides clear prompts to correct common billing errors.
- Reduces dependency on individual billing expertise.
- Standardizes billing workflow practices.

Denial Pattern Review

- Tracks common denial categories for operational review.
- Supports workflow refinement over time.
- Does not include autonomous denial-learning models in Phase 1.

Financial Impact

Improves revenue integrity by reducing preventable errors and protecting rightful reimbursement.

PRODUCT

Integrated 3C Architecture & Institutional IP

Intellectual property emerges from integration, not from isolated features.

Shared Workflow Foundation

- Compliance validation, intake routing, and billing checks operate within a unified Salesforce data model.
- Structured data capture supports consistency across all three pillars.

Configuration Templates

- Pilot deployment generates reusable rule libraries, workflow patterns, and onboarding templates.
- These structured assets form a repeatable rural implementation framework.

Operational Playbook

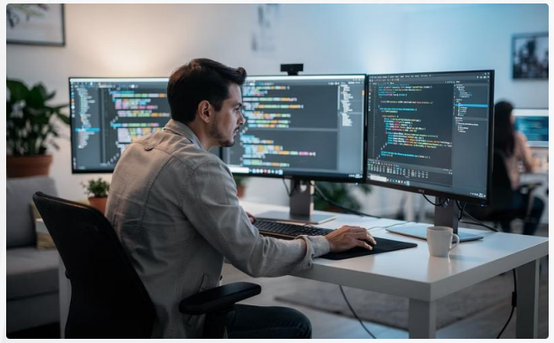
- The 3C implementation model becomes a codified methodology under The Authentic Consortium brand.
- Future advanced analytics layers may be added as the system matures.

Bottom Line

3C’s defensibility comes from coordinated workflow design and implementation methodology—not from AI claims or automated regulatory ingestion.

VIPC $50K Launch Grant — Putting Every Dollar to Work

A focused 12-month pilot designed to make select Virginia RHCs the nationwide "Gold Medal" standard for billing, compliance, and productivity.



Product & Technical Build

≈$25–30K

Harden MVP for Virginia RHCs — billing accuracy, compliance alerts, productivity KPIs. Implement critical integrations (EHR export/import, claims/clearinghouse feeds) and cover core engineering, testing, security, and logging.

Virginia RHC Pilot Deployment

≈$15–20K

Onboard 3–5 representative Virginia RHCs as pilot "gold medal" sites. Fund workflow mapping, configuration, go-live support, and staff training — collecting before/after data on billing, denials, and staff time.

Commercialization & Validation

≈$5–7.5K

Structured interviews with VA RHCs, FQHCs, and tribal clinics to refine pricing and roadmap. Produce the Virginia RHC Pilot Outcomes Report and **Virginia Gold Medal RHC Playbook** for VIPC, VDH, DMAS, and investors.

Required Match

Outside $50K (noted to VIPC)

Founder/engineering time beyond grant scope, discounted/free pilot licenses as in-kind match, and contributed clinical/advisory time from Virginia partners.

Total grant deployment: $50K — structured to produce measurable proof points that unlock the next stage of funding and statewide expansion.

SALES

Roadmap To Success
Prove It in Virginia.
Then Sell the Model to the Nation.

Year	Market	Total clinics (end of year)	ARR at year-end ($35k/org)
1	VIRGINIA only	5	$175k
2	CONUS only	20	$700k
3	CONUS only	45	$1,575k
4	CONUS only	70	$2,450k
5	CONUS + Global (start global)	115 total (e.g., 95 CONUS + 20 global)	$4,025k

THE AUTHENTIC CONSORTIUM

Rural Healthcare Technology

Why This Matters for Virginia & Beyond

> "Executes Governor Spanberger's mandate: affordable care close to home via rural innovation."

This initiative advances Virginia's Rural Healthcare Transformation and Medicaid modernization agenda while demonstrating responsible, measurable use of public funds. Success here creates a template that can be replicated across the nation, establishing Virginia as the innovation leader in rural health technology.

Gold Medal Standard

Positions Virginia as the national leader for Rural Healthcare Transformation, demonstrating innovative public-private partnership.

STEM Job Creation

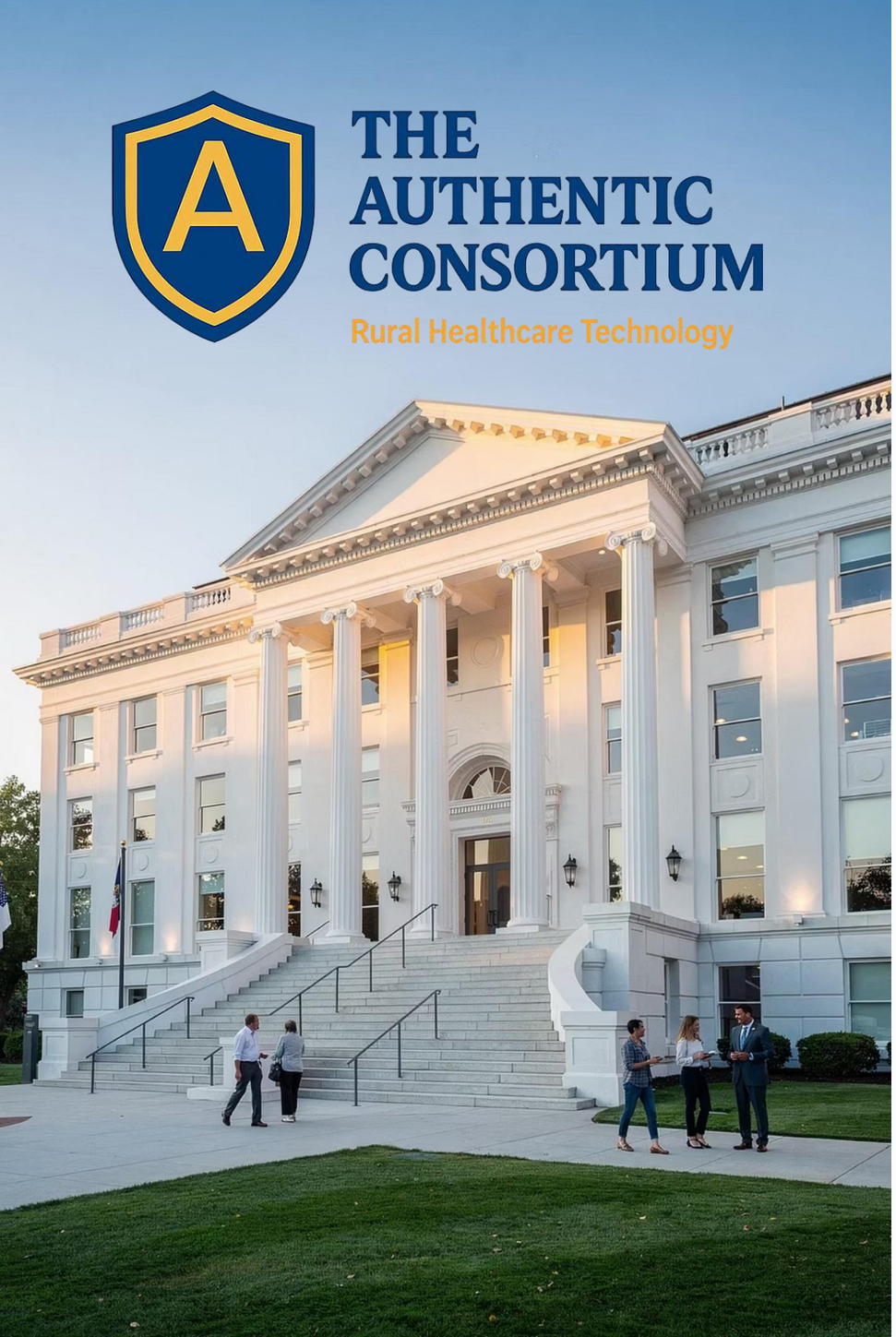
Creates and retains STEM and tech-enabled healthcare jobs in Virginia, building long-term economic capacity in the Commonwealth.

Scalable Model

Produces a proven model that can scale nationwide and across the Commonwealth, creating exportable IP and thought leadership.

Priority Alignment

Aligns with state and federal priorities for access, equity, and sustainability in rural healthcare delivery systems.



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James Pfautz

CEO – Founder

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