



How Medicare ACO Experience Informs Medicare Advantage Strategy



Agenda

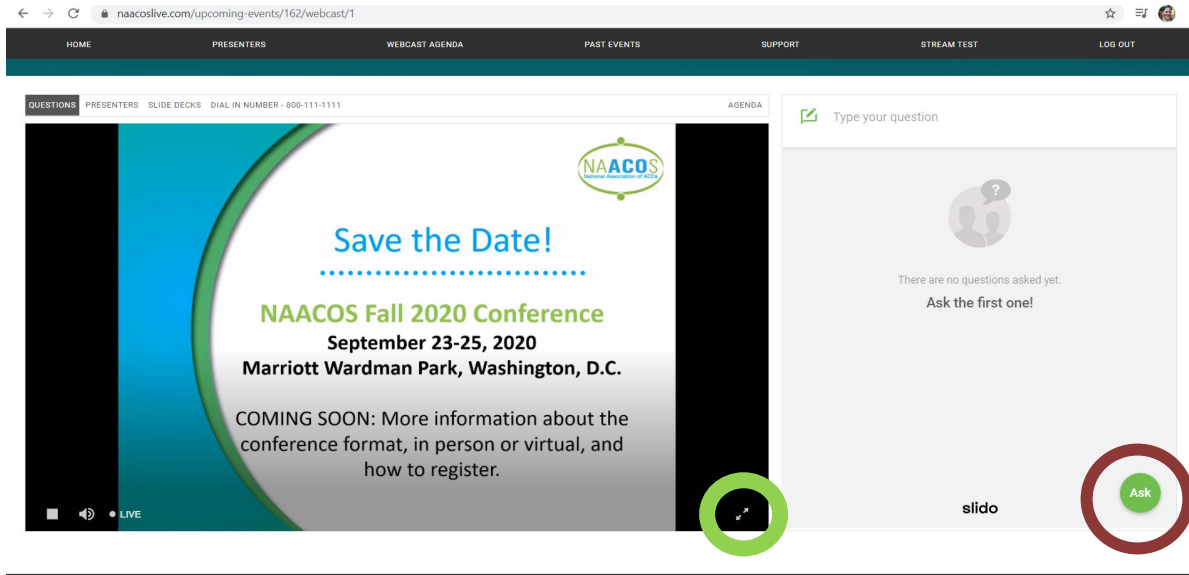


- Housekeeping
- Each of our Panelists will speak to:
 - ACO Composition & Keys to Success
 - Medicare Advantage Experience
 - What Translates? What new Capabilities were needed?
 - Lessons Learned for both MA and ACO continued success
- Followed by Audience Q&A

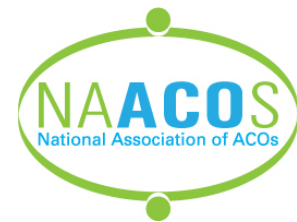
Housekeeping



1. If you would like to make the presentation full screen on your device, hover over the presentation and hit the double arrow button circled in the screen shot below in green.
2. To ask a question, click on the green “ask” button in the bottom right of the questions box. Please see the red circle in the screen shot below.
 - You can type in a question at any time during the presentation.



Speakers



Emily Brower

Senior Vice President of Clinical Integration and Physician Services
Trinity Health



Daniel L. Bair

Executive Director
Trinity-Health Mid-Atlantic



Mike Barrett

Vice President, Business Development
Collaborative Health Systems



Tom Kloos

Executive Director
Atlantic Health MSO



Trinity Health
Mid-Atlantic

Learnings from the Medicare Shared Savings Program

Can they translate to success in full-risk Medicare Advantage?

Dan Bair
Regional Executive Director
Trinity Health Mid-Atlantic Clinically Integrated Network

Trinity Health Mid-Atlantic Regional Clinically Integrated Network (CIN) Overview

Trinity Health's 22-State Diversified System

\$18.3B

In Revenue

1.5M

Attributed
Lives

\$1.1B

Community
Benefit Ministry

133K

Colleagues

7.8K

Employed Physicians
& Clinicians

28K

Affiliated
Physicians

94

Hospitals
in 22 states

18

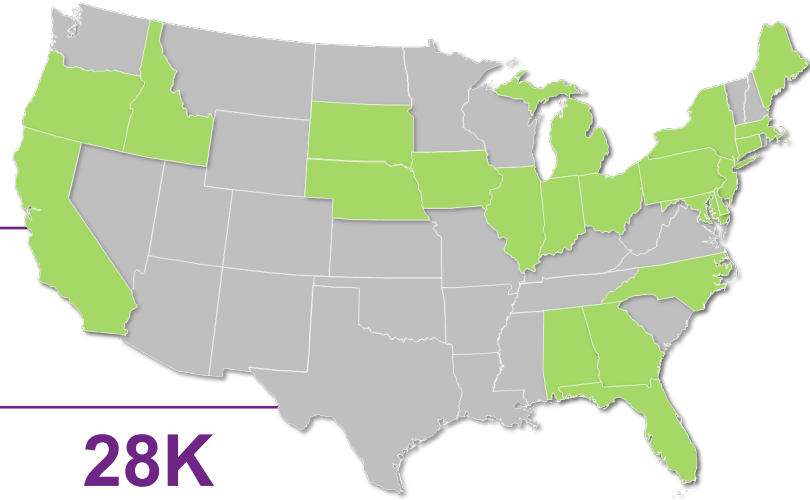
Clinically Integrated
Networks

17

PACE
Programs

109

Continuing
Care Locations

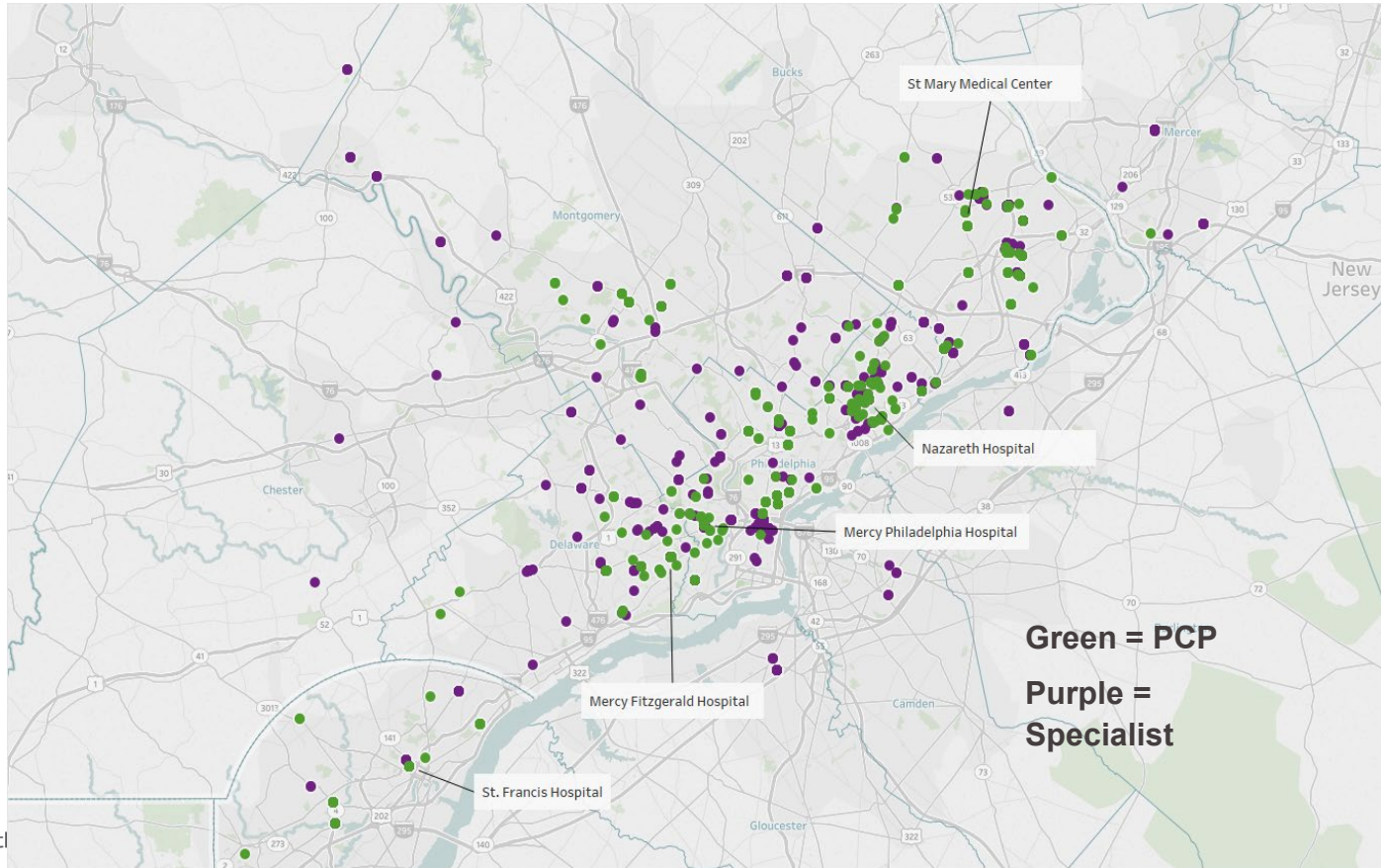


Expanding **ACO** programs are the primary driver of **alternative payment model** growth

- **~15K** physicians participating in our **18** Clinically Integrated Networks accountable for **1.5M** lives



Trinity Health Mid-Atlantic (THMA) Clinically Integrated Networks of Primary Care Physicians, Specialty Physicians, and Acute Care Hospitals



Trinity Health Mid-Atlantic CIN Snapshot

Mercy Accountable Care



961
participating physicians
(197 PCPs & 764 specialists)



38,541
attributed lives

Quality Health Alliance



549
participating physicians
(134 PCPs & 415 specialists)



43,384
attributed lives

Delaware Care Collaboration



58
participating physicians



8,000 – 9,000
attributed lives

Trinity Health Mid-Atlantic Medicare Advantage Risk Profile

Trinity Health Mid-Atlantic Medicare Advantage APMs



- **Cigna Medicare:**
 - Effective 1/1/2019;
 - Full Risk (effective 1/1/2020);
 - 1,237 Attributed Beneficiaries;



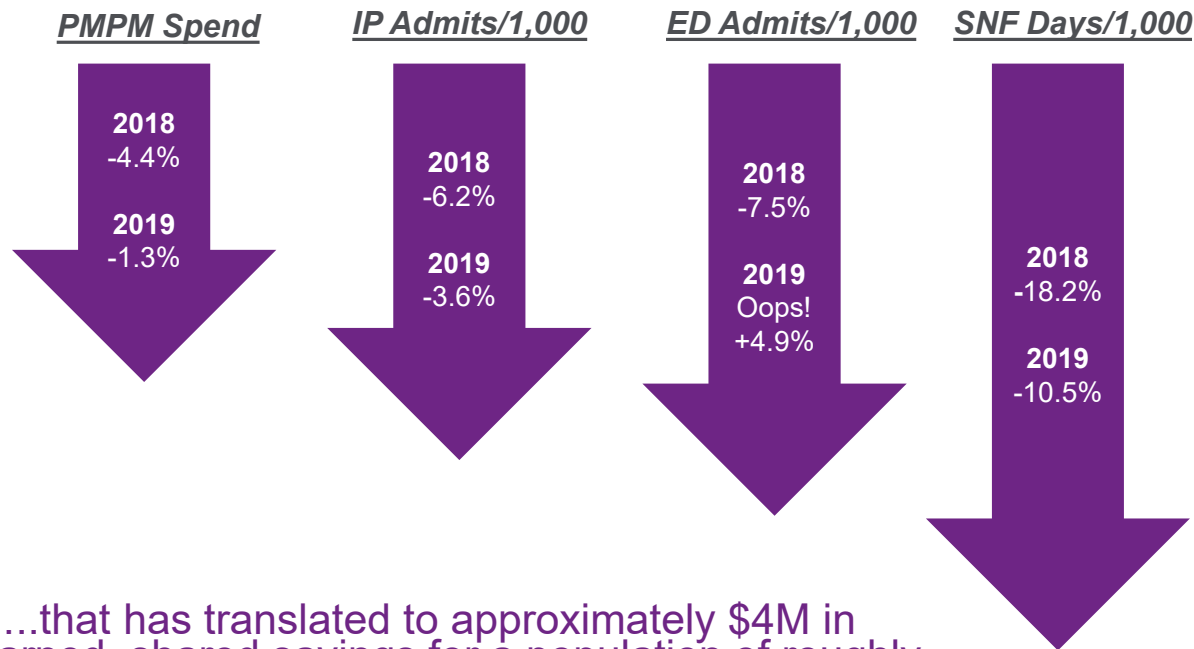
- **Independence Blue Cross:**
 - Effective 9/30/2013;
 - Partial Risk (effective 1/1/2020);
 - 2,016 Attributed Beneficiaries;



- **Aetna Medicare:**
 - Effective 1/1/2017;
 - Upside Only;
 - 3,775 Attributed Beneficiaries;

Demonstrated Success in MSSP

Mercy Accountable Care has been successful in MSSP...



.....that has translated to approximately \$4M in earned shared savings for a population of roughly 6,000 attributed beneficiaries over 3 years.

Key Resources for Success in MSSP*



- ✓ Complex Care Managers
- ✓ Population Health Nurses
- ✓ Behavioral Health Specialists
- ✓ Social Workers
- ✓ Medical Directorship
- ✓ Data/Analytics
- ✓ Post-acute Network Liaisons
- ✓ Pharmacists
- ✓ Community Health Workers
- ✓ Quality Specialists
- ✓ Provider Network Liaisons
- ✓ Marketing/Communications

*Specific levels of CM staffing determined based on numbers and types of attributed lives according to industry standard ratios

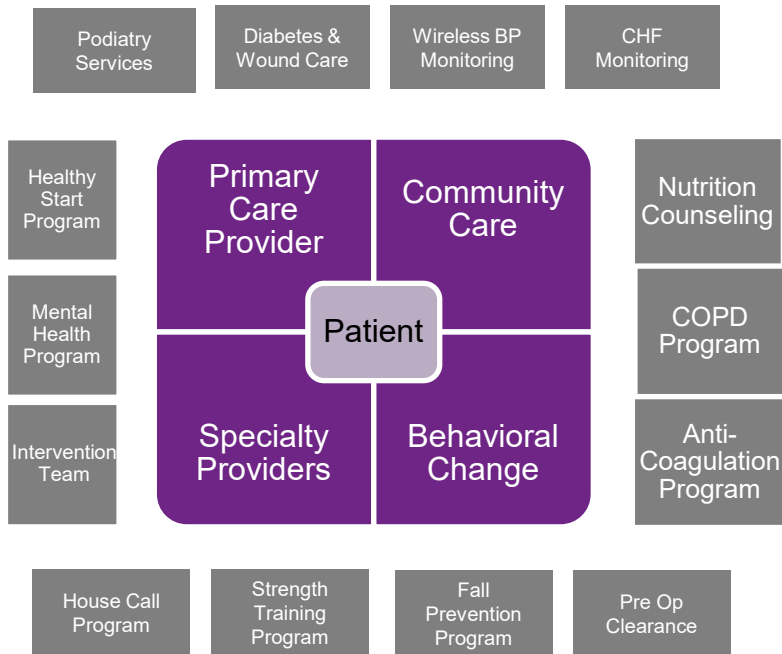
Key Strategies for Success in MSSP



- Identify high cost, high risk cohort for longitudinal care management;
- Hard wire care gap closure at the physician practice level;
- Promote performance ownership through transparency of data to participating physicians;
- Do NOT take your eye off the ball!

Parlayed Success for Medicare Advantage

Mercy Senior Health Medicare Advantage Clinic amplifies our already successful ACO model in one location.....



Primary Care Hub Contains:

- ✓ *Physicians*
- ✓ *Advanced Practice Providers*
- ✓ *Office Nurses*
- ✓ *Transitional Care / Case Mgmt Nurses*
- ✓ *Social Workers*
- ✓ *Medical Assistants*
- ✓ *Community Wellness Partners*
- ✓ *Behavioral Health Specialists*
- ✓ *Pharmacists*
- ✓ *Coding Specialists*
- ✓ *Referral Coordinators*
- ✓ *Patient Concierge*
- ✓ *Community Space and Amenities*

Patient enrollment was a totally new skill set brought in for Medicare Advantage Program growth.....



...so we hired a patient enrollment specialist from the PACE (LIFE) sector!

Lessons Learned

Biggest Win




The secret sauce of focus on the high cost, high risk patients and associated key performance drivers works as well in MA as MSSP.

Biggest Bomb!



We took this for granted, but it's really difficult to convince patients to switch their PCP!

Thank you!

A dark blue oval with a starry background, containing yellow text. The oval is set against a white background with faint, curved lines. The text inside the oval reads: "May the Stars Align with your HCC Scores and Medical Cost Ratios".

May the Stars Align
with your HCC Scores
and Medical Cost
Ratios

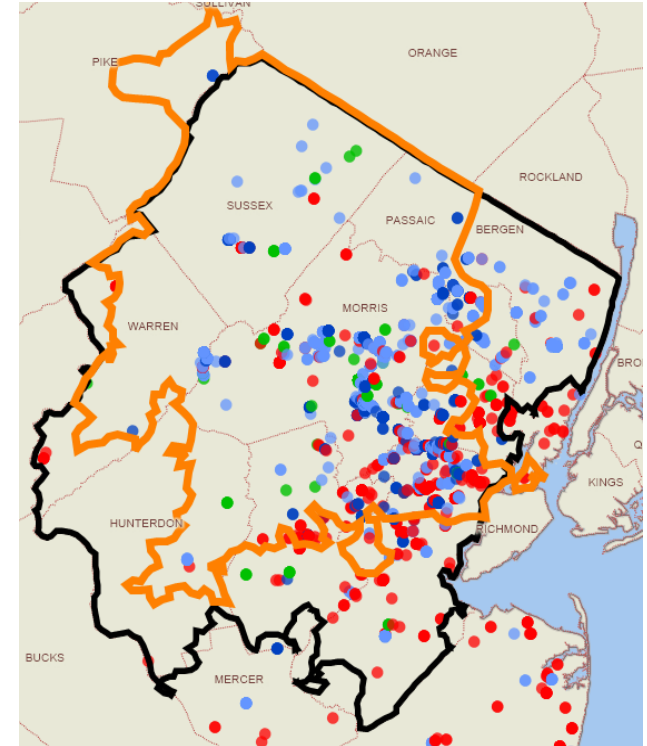
NAACOS
Medicare
Advantage
Presentation



Providers	Primary Care	Specialists	Grand Total
Atlantic ACO MSSP Track 1	506	1,538	2,044
Optimus ACO MSSP Track 1	222	337	559
Healthcare Quality Partners ACO MSSP Track 1+	56	16	72
Total Providers	784	1,891	2,675

Goal: Quadruple AIM

Quality – Experience – Affordability – Joy of Practice




AtlanticALLIANCE ACO's in 2020

Programs	Commercial Attribution	MSSP Attribution
Atlantic ACO <ul style="list-style-type: none"> MSSP BASIC E Downside Risk Commercial Contracts 	202,533	37,634
Optimus ACO <ul style="list-style-type: none"> Basic B. Upside Only Commercial Contracts 	157,643	14,712
Healthcare Quality Partners ACO <ul style="list-style-type: none"> MSSP Track 1+ 		9,779
Care Better ACO <ul style="list-style-type: none"> MSSP Basic B Upside Only 		13,061
Total Attribution	360,176	75,186

Proven Success in MSSP Programs

2013-2019 Total savings to Medicare	\$129,053,928
2013-2019 Net Savings to Medicare	\$ 82,608,668
2013-2019 Total Shared Savings Payments	\$ 52,573,191



CMS Quality consistently averages over 90%

Atlantic ACO's Medicare Advantage Contracts



- **United Medicare Advantage:**

- Effective 1/1/2019;
- Upside (effective 1/1/2019);
- 5000 Attributed Beneficiaries;



- **NJ Horizon Medicare Advantage:**

- Effective 9/30/2013;
- Upside (effective 1/1/2018);
- 1200 Attributed Beneficiaries;



- **Aetna Medicare Advantage:**

- Effective 1/1/2018;
- Upside Only on 21,000 members
- Downside risk on 2000 members
Narrow Network Product

What 4 levers are most important to produce shared savings in a MA contract



How Quality Scores Can Effect Value Based Reimbursement:

Example: Medicare Advantage Contract in one ACO

- Attribution 10,530 lives
- Currently we are at 2.19 Stars score and we receive \$5 PMPM for that quality score or \$ 631,800
- Improving quality to 4 stars which is attainable would increase the PMPM to \$8 or total of \$1,010,880.
- And 4.5 stars brings us \$1,389,960



After review of the most recent financial statements as of June 2020 reporting it is projected that these MA attributed lives will end up in a significant surplus for this ACO

Applying today's surplus to a full year's experience, leaves this ACO with a shared savings opportunity of ~\$3.8M. All Unlocked if we achieve 4 stars



RISK SCORING: Accurate coding of all diagnosis yearly on each of your patients

- Represents the level of clinical illness burden of the population you care for.
- Sicker more complex patients take more of your time and services
- **YOU should be paid for this extra level of clinical team effort.**
- Especially important in Medicare Advantage programs
 - Higher risk score (HCC) of a patient means Medicare pays the plan (Aetna, United, Horizon etc) more for that patient monthly
 - That means a higher BENCHMARK target, which is easier to come in under
 - Risk scoring is for every provider: PCP and specialists
 - Every contract sets the benchmark targets based on the risk score of our population

A **Hierarchical Condition Category (HCC)** is defined as a risk adjustment model that is used to calculate risk scores to predict future healthcare costs. The Centers for Medicare and Medicaid Services' (CMS) CMS-HCC model is used to predict healthcare spending for Medicare Advantage Plan enrollees.

ed yearly.



MA Advanced Risk Adjustment Program Impact

.01 Increase RAF Score



1% Increase in PMPM

An increase in AHS's RAF score can be driven by improvements in its risk adjustment analytics, programs and processes

Due to accurate and comprehensive diagnosis capture, AHS's RAF score directionally impacts revenue

Sample Revenue Enhancement from RAF Investment

	Current RAF	Improved RAF
Risk Score*	0.91	0.92
Base Enrollment	20,000	20,000
Base Rate	\$1000	\$1000
% Increase	N/A	1.0%
Adjusted Rate	\$1000	\$1011
Revenue	\$240M	\$242.6M
Revenue Increase	-	\$2.6M

*2019 Risk Score in Aetna Prime

ATTRIBUTION



Screenshot of Attribution Retention Reports



Atlantic Health System: Department of Clinical and Business Intelligence

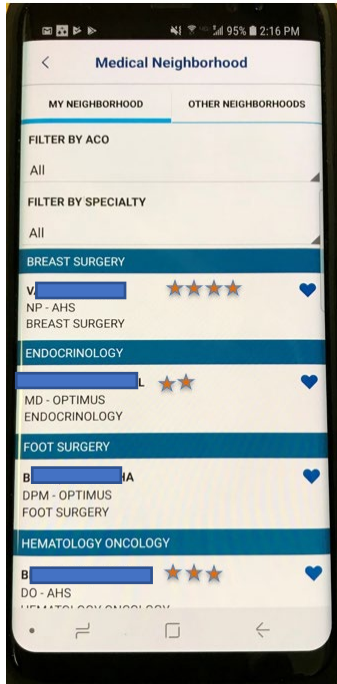
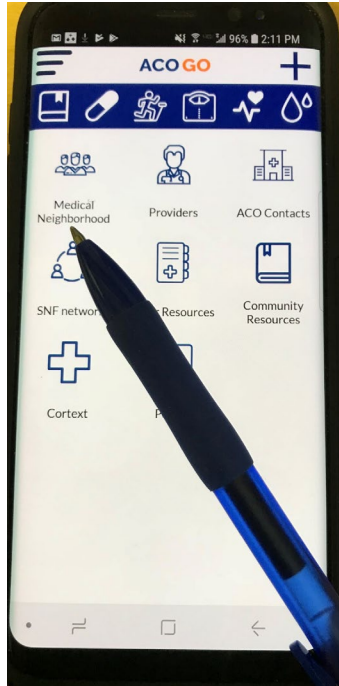
MSSP Population: Patients Retention

PCP PLEASANT RUN FAMILY PHYSICIANS

Time Period: 2019-01-01 - 2019-06-30

Patient Information				Actions Needed			Recent Wellness	Wellness Exam In-	Last
Attributed Provider Name	Patient Name	Birth Year	Probability To Leave	Action	Office Visits Deficit	Date	Net YN		
RIGA		1933	62.30%	Schedule AWV After 2019-11-28	1 Office Visit(s)	2018-11-28	Y		
DELL		1949	50.61%	Schedule AWV After 2019-11-05	1 Office Visit(s)	2018-11-5	Y		
RIGA		1949	93.09%	Schedule AWV After 2019-11-23	1 Office Visit(s)	2018-11-23	Y		
RIGA		1949	68.66%	Schedule AWV Immediately	1 Office Visit(s)				
DELL		1939	55.94%	Schedule AWV After 2019-12-06	1 Office Visit(s)	2018-12-6	Y		
RIGA		1953	53.70%	Schedule AWV After 2019-11-01	1 Office Visit(s)	2018-11-1	Y		
RIGA		1946	52.34%	Schedule AWV After 2019-07-31	1 Office Visit(s)	2018-7-31	Y		
RIGA		1947	86.25%	Schedule AWV After 2019-09-17	1 Office Visit(s)	2018-9-17	Y		
RIGA		1940	76.92%	Schedule AWV Immediately	1 Office Visit(s)				
RIGA		1953	74.37%	Schedule AWV After 2019-11-26	1 Office Visit(s)	2018-11-26	Y		
RIGA		1948	53.60%	Schedule AWV Immediately	1 Office Visit(s)				
RIGA		1951	56.65%	Schedule AWV After 2019-08-17	1 Office Visit(s)	2018-8-17	Y		
RIGA		1943	73.50%	Schedule AWV After 2019-12-11	1 Office Visit(s)	2018-12-11	Y		
DELL		1948	53.61%	Schedule AWV After 2019-11-01	1 Office Visit(s)	2018-11-1	Y		

Network Integrity



Department of Clinical and Business Intelligence: Atlantic Health System

Full List of Relationships With Cardiology Specialists

Southern Region, [REDACTED]

Only Outpatient and Elective Inpatient Claims, No Transplant Procedures
 Medicare Population; Time Period: 2019-04-01 - 2020-03-31

Your Full Profile for Cardiology (% Utilization):

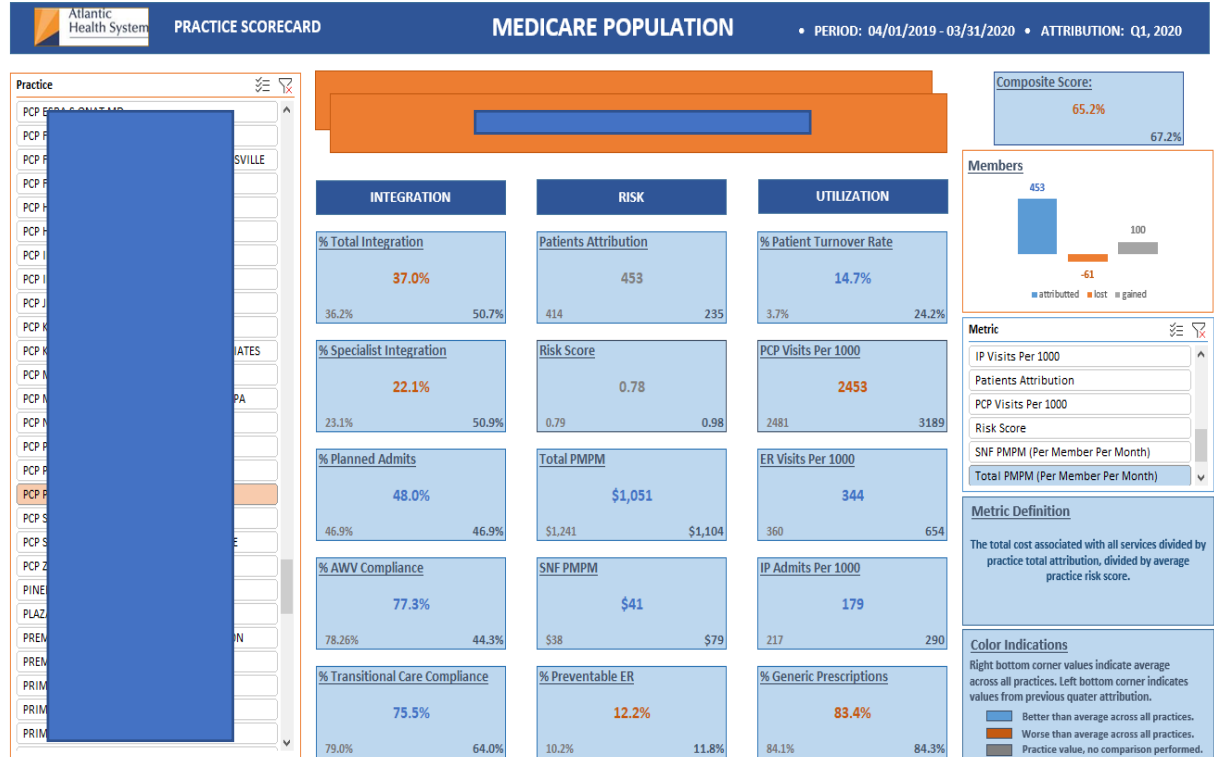
ESP	[REDACTED]	26.2%	LEEDS	[REDACTED]	2.2%	KW	[REDACTED]	1.1%
BER	[REDACTED]	8.6%	TAYLO	[REDACTED]	2.1%	SK	[REDACTED]	1.1%
HOF	[REDACTED]	6.8%	KRELL	[REDACTED]	1.4%	RIC	[REDACTED]	1.1%
BAR	[REDACTED]	5.7%	OVAK	[REDACTED]	1.4%	CO	[REDACTED]	1.1%
RUD	[REDACTED]	5.3%	FUNG	[REDACTED]	1.4%	DO	[REDACTED]	1.1%
SIM	[REDACTED]	3.8%	PARIK	[REDACTED]	1.3%	SID	[REDACTED]	1.1%
TOM	[REDACTED]	3.4%	ROSEN	[REDACTED]	1.3%	MA	[REDACTED]	1.0%
CAT	[REDACTED]	3.4%	PATEL	[REDACTED]	1.3%	SH	[REDACTED]	1.0%
GEO	[REDACTED]	3.3%	RAND	[REDACTED]	1.2%	MA	[REDACTED]	1.0%
SCH	[REDACTED]	3.3%	HALL,	[REDACTED]	1.2%	LEE	[REDACTED]	1.0%
IVA	[REDACTED]	2.4%	DILOR	[REDACTED]	1.2%	AH	[REDACTED]	1.0%

Available Specialists within 15 miles by Clinical Network Usage (% CIN Facility):

BREM	[REDACTED]	NTHA	100.0%	PASS	[REDACTED]	0.0%
LEV, J	[REDACTED]	[REDACTED]	100.0%	HUA	[REDACTED]	0.0%
RAMJ	[REDACTED]	IE	100.0%	GLIC	[REDACTED]	0.0%
HORN	[REDACTED]	[REDACTED]	100.0%	PATE	[REDACTED]	0.0%
SHERI	[REDACTED]	[REDACTED]	100.0%	YOU	[REDACTED]	0.0%
BARO	[REDACTED]	[REDACTED]	99.9%	MAH	[REDACTED]	0.0%
LEEDS	[REDACTED]	[REDACTED]	98.0%	WEI	[REDACTED]	0.0%
CHEN	[REDACTED]	G	97.9%	YOU	[REDACTED]	0.0%
HALL	[REDACTED]	[REDACTED]	95.4%	MON	[REDACTED]	0.0%
FRIED	[REDACTED]	[REDACTED]	95.3%	MCC	[REDACTED]	0.0%
KULK	[REDACTED]	A	90.3%	MER	[REDACTED]	0.0%
AHN,	[REDACTED]	[REDACTED]	88.1%	SHAF	[REDACTED]	0.0%
GEOR	[REDACTED]	[REDACTED]	83.7%	ZAKI	[REDACTED]	0.0%
OVAK	[REDACTED]	[REDACTED]	76.1%	GOV	[REDACTED]	0.0%
RACH	[REDACTED]	D	74.5%	HOR	[REDACTED]	0.0%
SCHA	[REDACTED]	M	59.2%	SHAF	[REDACTED]	0.0%

Pre Covid ACO success

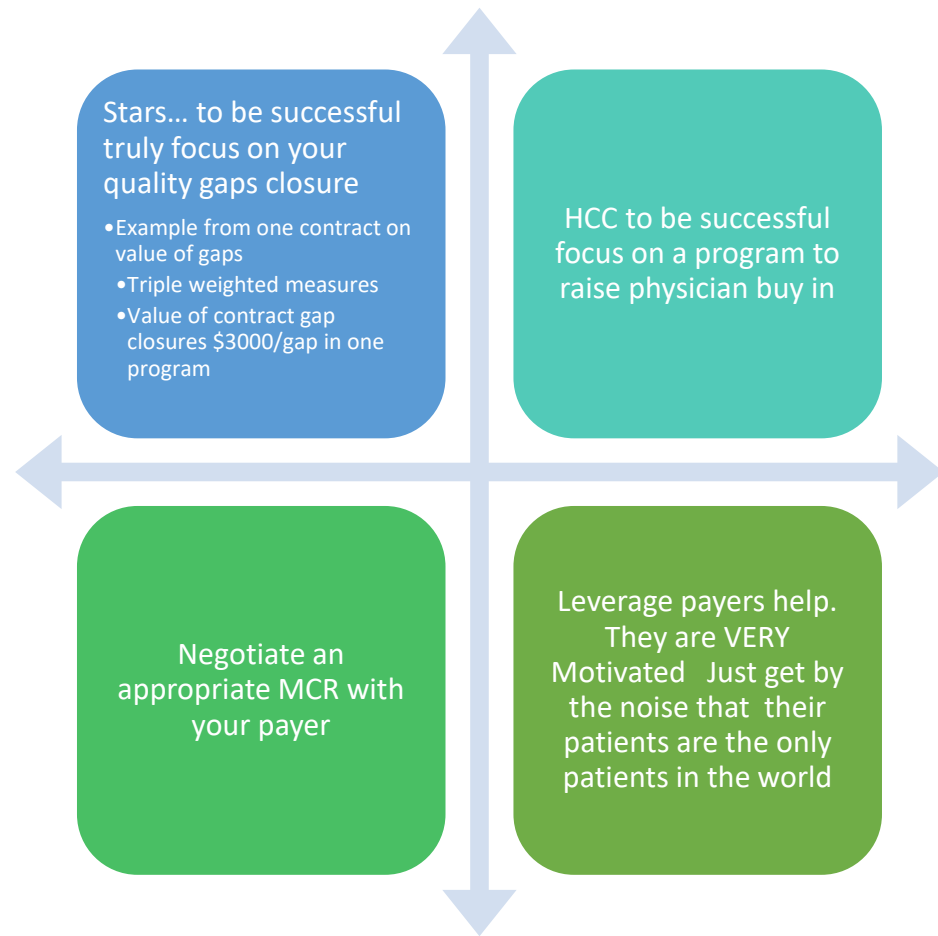
- Physician engagement
- Weekly webinars
- Practice scorecards
- AWV compliance



Post COVID activities to benefit MA

- Telemedicine
- Focus on retaining attribution to support practice finances
- Focus on AWP as perfect bridge between FFS and Value based Care

Lessons Learned May the Stars Align with HCC and MCR



Thank you!

MA & DCE vs. MSSP: Similarities and Differences

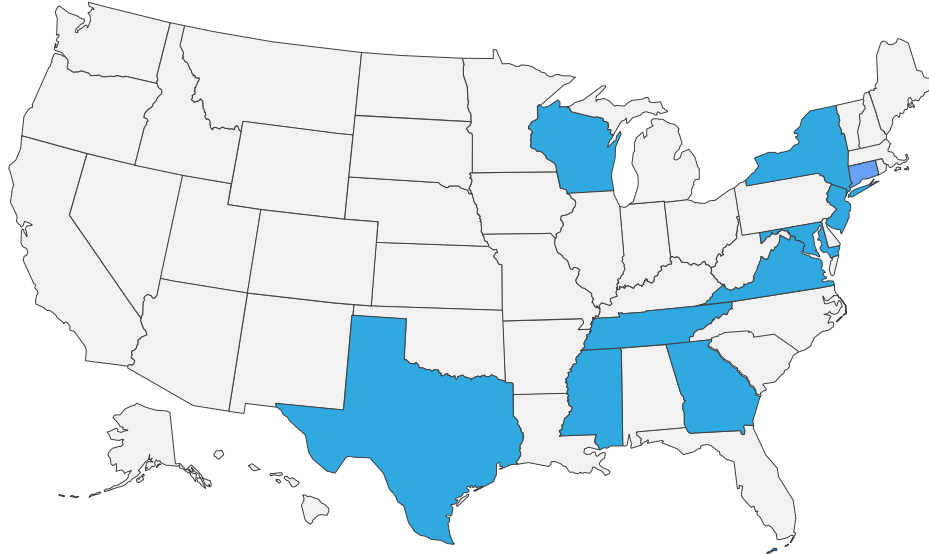
NAACOs Fall 2020 Conference

To paraphrase... It's about Risk and the Tipping Point



CHS manages:

- Nine Medicare Shared Savings Program (MSSP) ACOs
- Two Next Generation Model ACOs
- One Maryland Collaborative Care Transformation Org.
- Three IPAs with multi-product contracts



- Partners with over 2,200 primary care physicians as they move to **value-based payment systems**
- Subsidiary organization of Centene Corporation
- Demonstrated success in Medicare ACO programs:
 - \$57.4 Million bonus payments to doctors (shared savings) for ACOs.
 - 90%+ overall quality score in 2018.

Centene is committed to transforming the health of the community, one person at a time.

#51

FORTUNE® 500
(2019)

#7

FORTUNE® Change the
World (2019)

69,000+

diverse and
dedicated employees

Serving
1 in 15
Individuals

24+ million managed care members

Leading government-sponsored
healthcare across the United States

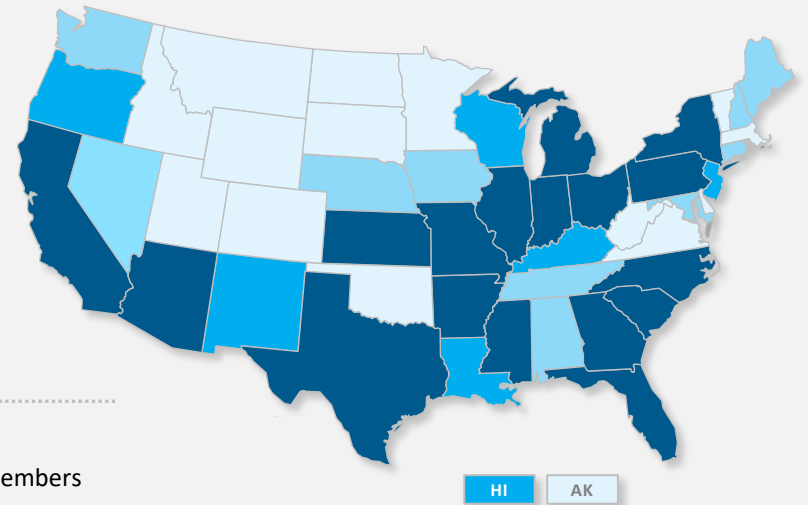
- Health plan operations
- Medicaid or Medicare
- Medicaid or Medicare
- Medicaid, Medicare, and Marketplace

11.8M
Medicaid members
across 30 STATES

1.0M
Medicare members
across 28 STATES

2.2M
Marketplace members
across 21 STATES

4.5M
Prescription Drug Plan members
across 50 STATES



Centene operates internationally through subsidiaries and investments in the UK, Spain, and Slovakia.

**Medicare
ACOs**

- 1 Top Line
- 2 Network
- 3 Risk & Margin Management
- 4 Data, Data, Data
- 5 Delegation & Parallel
- 6 Provider Sponsored HP

**Medicare
Advantage**

- **Not Subtle Difference Between Benchmark and Premium**
 - MSSP/DCE improvement is an absolute requirement
 - For MA those with low cost performance have less pressure to change
 - Competitive bidding vs. national FFS trend
 - Low cost vs. High opportunity
- **Revenue Management is Substantially Different**
 - STAR/RAF Bonus vs. Quality Penalty and a bit of RAF
 - Economic feedback loop
 - What does it take to earn a 5% revenue event everything else being equal?
- **MA – Health Plan Monthly Cash Flow vs. MSSP vs. DCE**
 - Contract terms? WellCare “FRM” has 4,500 lines of puts and takes from % of premium from “Standard T&C”
 - Market relevance will drive T&C in MA

- **Get really good at Excel, model, model, model.**
 - How does your gain, and more importantly, your downside change from program to program and MA contract
 - Who pays for what activity changes depending on which side of -0- you are on.
- **MA and MSSP are, and DCE will be, transparent – understanding the transparent regulations is secret sauce. MA regulations are significantly larger, longer, and subtle.**
- **MA.... If you have seen one deal....**
- **Part A & B vs. Part A,B & D**
 - Influence vs. Control
 - Part D performance vs. risk corridors
- **MA Health Plan? Plan for R.B.C.**
 - Most states have adopted NAIC model
 - Some have enhanced it
 - It includes start up losses

- **MA drives to providers who will result in lowest total cost of care.**
 - Stable low cost = profits
 - STAR measures performance is effectively mandatory, incremental STAR performance can outstrip incremental RAF scores in many circumstances
- **MSSP introduces benchmark optimization, as well as, improvement from historical costs.**
 - Stable costs, low or high = no savings, no profits
 - Regional benchmark caps result in focus on cost reduction vs. stable low costs.
 - Max adjustment is $\sim \$600 \times .15$ or \$90 PM PY or .6% of benchmark.
 - Once favorable cap is exceeded, adding high cost providers increase total savings payment

- Reinsure Your Strategy 1st , the Organization 2nd.
 - Assuring pandemics and other meteors don't derail the strategy
- Size matters, but doesn't overtake execution – which line are you managing?
- MSSP largely managed by engagement level of providers
- DCE has more tools, some limits, but effectively unlimited risk
- MA... if you have seen one deal....
- MA has “Physician Incentive Regulations” which must be checked
- RBC 200%+

- **It's About the Rebates – or is it?**
 - The real issue is incremental revenue, but rebates is the form
 - Drug rebates, which Azar in January termed “a shadowy system of kickbacks,”
- **Rx is still the “Wild West” of Managed Care**
- **MFN Executive Order, intention is clear, operation of it is not**
- **MA, Understand the Targets, Risk Corridors and Your Performance**
- **MSSP/DCE are not currently at Risk for Part D, but Part B Rx Inflating at Unsustainable Rates**
 - Brown bag “D” to administer in Physician Office... a “B”?

- Use technology (data) on purpose
- Panacea “Perfect”: real time at point of care with complete clinical, SDOH, EMR integration.....
- Better: POC alerts, Precertification alert, claim submission and adjudication
- Standard: CCLF claims dump 30,60,90 days late... too late.
- Integration of Rx data – DUR is clearly too weak (how does a bene get to 6+ Rx w/ redundancies)
- Acquiring “real” time claims/precert feed is important

- **MA**
 - Fully delegated models create nearly a “wholesale HMO” environment.
 - Claims, UM/CM, Appeals & Grievances, Network, Credentialing, Contracting
 - Paid by payer within premiums
- **MSSP & DCE**
 - Delegation is more akin to some form of outsourcing analytics.
 - Some delegation can be done through waivers with providers whose “in kind services” can take on some care coordination and similar functions
 - CCM, CCCM, PCF, AWV, and other programs that are transactional funded
 - ACOs will double check administrative and clinical services outsourcing
- **Solutions for entire population needs & wants**

Administrative vs. Health Services Cost Illustrative Calculation

Integrated System	MSSP/DCE	Health Plan	Growth/Change
Direct Care = 50%			
Indirect Care = 20%			
Administration = 25%	Administration = 2%	Administration 10%	$10/25 = 40\%$ or $25/2 = 1200\%$?
Profit/Surplus = 5%	Profit/Surplus = 3%	Profit/Surplus = 5%	100%, 200%?

Substantively expansion of SG&A in a health plan for MSSP/DCE or from even an integrated system.

- **Perspective Matters**
 - What is it worth to move from 85% of the premium for the added complexity/effort?
 - Is it starting a business that has nearly no risk (?) and a 20-36% operating margin business? (Humana, WellCare, Anthem operation margins on 85% PoP equivalence)
 - Is there an increase in consistency over PoP?
- **Benefits – SDOH increasingly important to the member**
- **Patient vs. Member**
 - Market share of members or transactions, not the same.
 - Low/non using members, low patient value, high member value
 - Leakage
- **State(s) regulations**
- **COVID and diversified revenue models?**
 - Revenue disconnected from transaction count
 - Transaction counts disconnected from revenue
 - Risk of single MSA exposures

