Aligning Your Business Model with CMS's 203 Vision for Value-Based Care

Contracting and performance in Medicare Advantage

September 20, 2023

Aledade

Agenda

Panelist and organization introductions: 1:00 - 1:45pm

Overview of Medicare Advantage: 1:45 - 1:55pm

MA contracting: 1:55 - 2:50pm

Break: 2:50 - 3:05pm

MA performance: 3:05 - 4:00pm

Breakout sessions: 4:00 - 4:30pm

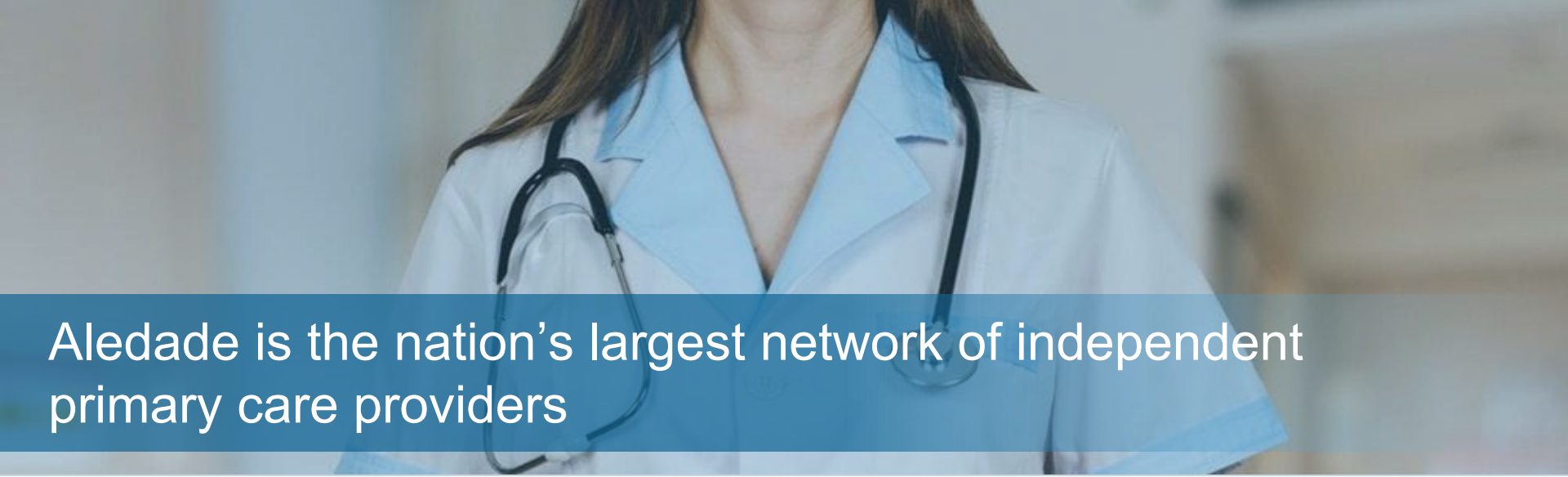
Breakout summary and final comments: 4:30 - 5:00pm

Participant introductions (45 minutes)

Jarvis Leigh, National VP for Strategic Payer Partnerships, Aledade

Jarvis joined Aledade the summer of 2020, and brought with him decades of experience in network development, strategic relationship management and value-based contracting in support of Aledade's national network of independent primary care providers.

Prior to Aledade, Jarvis spent years at UnitedHealth Group where he developed and managed relationships with UHN's largest and most influential strategic provider and hospital relationships. Jarvis also spent over a decade on the Contracting and Network Management team at Aetna.



Aledade is the nation's largest network of independent primary care providers

Our mission is to build a better healthcare system for patients, practices and so
That means meeting every patient where they are, with the coverage they have

We partner with small and midsize practices, enabling their success and ability to remain independent.

The shift to value-based care supports practice viability, improves patient outcomes, and reduces cost of care.

Why We're Different

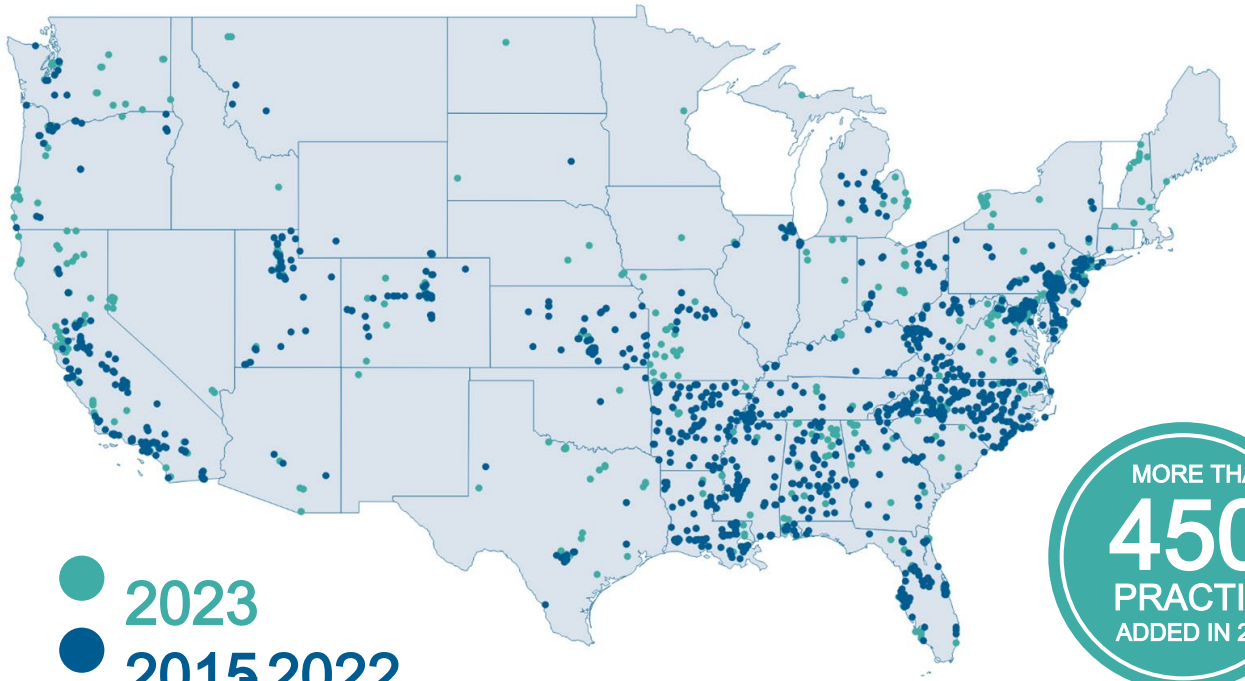
WHAT WE DO

Aledade partners with all types of primary care practices, across diverse payer contracts, with a singular focus on taking risk.

WE DON'T

Buy or build practices, rely on health systems, focus only on Medicare Advantage, or rely on fee-for-service billing.

Unlike Competitors, Our Footprint Encompas
Rural & Urban Areas



MORE THAN
450
PRACTICES
ADDED IN 2023

NETWORK

16,300+ CLINICIANS*
1,500+ PRACTICES

SCALE

2M+ LIVES
145+ VALUE-BASED CONTRACT
$20B+ MEDICAL SPEND

RESULTS

$450M+ '22 REVENUE
$135M+ '22 PLATFORM

CONTRIBUTION
EBITDA POSITIVE SINCE 2020

Aledade analysis of internal data; MSSP-only practice & ACO data available at https://data.cms.gov/medicare-shared-savings-program. 2022 results are unaudited.
* Clinicians includes physicians and physician extenders, such as nurse practitioners.

Michael Stanzione, Director of Medicare Advantage Network Performance, Ale

Michael Stanzione currently serves as the Director of Medicare Advantage Network Performance at Aledade, where he partners with internal and external stakeholders to drive performance in Medicare Advantage Value-Based Contracts across the US and supports independent primary care practices and physicians in maintaining their independence and making the transition to value-based models of care.

Prior to his current role Michael has held numerous positions throughout the healthcare community including health plan strategy and management, healthcare consulting, physician group management, and Health IT. Michael holds an MBA from Rutgers University and a BS in Public Health/ Health Policy and Administration from The Richard Stockton College of NJ.

Ben Quirk, Founder and CEO, Healthly

Chief Executive Officer
Healthy Medical Centers & Network

- **Founder and CEO**, **Healthy** Medical Centers & Network
- **Chief Strategy Officer** for **CareMax** (NASDAQ: CMAX) 2015 – 2022, leading organic and inorganic growth from **1000 to 250,000 Medicare beneficiaries**
- Led CareMax's public listing and national expansion strategic
- Orchestrated merger of **CareMax (primarily Medicare Advantage) with Steward Healthcare Network (second largest ACO in the country)**
- **Modern Healthcare Top 25 Innovator 2022**

healthly Caremax Hill Physicians

healthly

Live your best life.

Senior-focused integrated full risk delivery system comprised **of 4 dedicated medical centers** and **700** like minded **primary care physicians and specialists.**

Clinical model is based on the principles of the **American College of Lifestyle Medicine**, focusing on **disease prevention and reversal** rather than just treatment.

Supported by a **proprietary rising risk Connection System technology platform** which helps ensure patients receive proactive treatment between visits.

Economic model is via incentives and risk sharing through 20 Medicare Advantage, Commercial and Medicaid contracts. **Healthly is the delegated payer of record**, allowing for reinvestment into different aligned lifestyle professionals to support patients on their health journeys.

Wilson Gabbard, VP of Quality and Condition Management, Advocate Aurora H

Wilson joined Advocate in 2020 where he is responsible for CIN and medical group quality across over 1.3M value based members and risk adjustment strategy for over $3 billion in system risk -based revenue. This includes responsibility for operationalizing programs for a portfolio of joint -ventures, fully delegated capitation, upside/downside risk, shared savings and pay for performance contracts.

Previously, he spent seven years leading population health operations for UNC Health Care where he was responsible for strategy and operations during its transition from fee -for-service to value-based reimbursement. The UNC population health services team grew from two to over 200 team members during his seven-year tenure. Prior to joining UNC, he led regional operations for primary and specialty care practices and regional emergency and hospitalist service lines for Vidant Medical Group. Mr. Gabbard received his Bachelor and Master of Business Administration degrees from Morehead State University and is a Fellow of the American College of Healthcare Executives (FACHE).

ADVOCATE HEALTH

NEARLY 6M UNIQUE PATIENTS	NEARLY 150K TEAMMATES	MORE THAN 21K PHYSICIANS	NEARLY 42K NURSES	NEARLY $5B COMMUNITY BENEFIT	MORE THAN 1K SITES OF CARE	67 HOSPITALS	$27B+ REVENUE

AdvocateAuroraHealth

- **2.9M** unique patients
- **77K** teammates
- **10K** physicians
- **22K** nurses
- **$2.4B** in community benefit
- **500+** sites of care
- **27** hospitals
- **$14B+** in annual revenue

Atrium Health

- **2.9M** unique patients
- **73K** teammates
- **11K** physicians
- **20K** nurses
- **$2.46B** in community benefi
- **500+** sites of care
- **40** hospitals
- **$13B+** in annual revenue

MAGNET RECOGNIZED · 2019-20 TOP HOSPITAL FOR DIVERSITY · LGBTQ+ HEALTHCARE EQUALITY LEADER · Modern Healthcare Best Places to Work 2021 · 2022 Practice Greenhealth SYSTEM FOR CHANGE AWARD · American Hospital Association Quest for Quality Prize · Forbes 2022 AMERICA'S BEST-IN-STATE EMPLOYERS · 100 Top Hospitals · AMERICA'S MOST LOVED WORKPLACES · Equity of Care AWARD

Advocate Health has a long history with value-based care, and partners with 13,000+ physicians in 13 ACOs/CINs

13,000+
Participating Physicians in our CINs

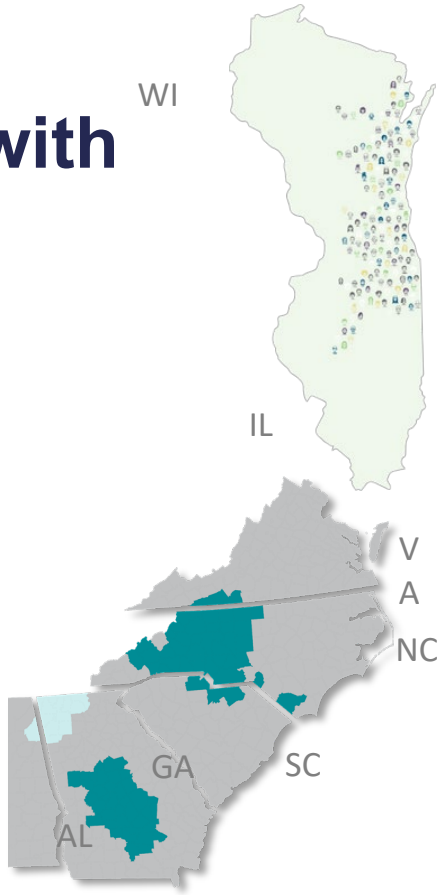
2.3 M
Total Managed Lives

~50
Hospital Organizations Part of our CINs

108
Unique Value Contracts Across All ACOs/CINs

$1.2 B
Annual managed Capitation revenue

$1.25 B
Paid Out in Value payments



BlueCross BlueShield of South Carolina

Jason Sloan
Vice President, Medicare Advantage Stars and Risk Programs

At BlueCross BlueShield of South Carolina Jason leads the strategic vision and implementation for Medicare Advantage quality improvement activities, risk adjustment programs and value-based provider partnerships. Under Jason's leadership the MA program has markedly increased quality outcomes by helping beneficiaries navigate the healthcare system and by establishing strong partnerships with local healthcare providers.

Jason has spent his career managing local and national Medicare Advantage quality programs along with experience in medical research and physical therapy health programs. He earned an MBA from the University of Notre Dame and a Masters in Biomedical Science from Midwestern University in Chicago. To stay well rounded Jason enjoys fishing with his kids and playing golf as often as possible.

THE POWER OF BLUE

Exceptional Choice, Service and Experience to Medicare Members

Local

Only Medicare Carrier based in South Carolina

Strength

Largest Health Insurer in South Carolina

Innovation

Providing solutions and creative product designs

Support

Local Representatives across the state

Stability

Serving South Carolinians

Security

Rating by AM Best 22 Consecutive Years

Service

Award-winning Local Customer Service

Lifetime

Products for every stage of a member's life

South Carolina

Simon Moody, Principal and Consulting Actuary, Milliman

Simon has more than 25 years of experience working with health provider organizations, insurers, and a variety of other healthcare organizations. His main areas of expertise include working with providers and payers in the design, evaluation, audit, and performance monitoring of various population -based reimbursement agreements. Simon also has extensive Medicare Advantage expertise from preparing and certifying Medicare Advantage bids for several health plans and developing Medicare Advantage feasibility analyses for new startups.

Milliman Healthcare Consulting

Consultants to the top payers, hospitals, life science companies, and more

Milliman leverages expertise gained from consulting to stakeholders across the healthcare industry.

We serve the **full spectrum** of healthcare clients (payers, providers, PBMs, pharma, government, reinsurers)

Consult to the **25 largest** health **payers** in the U.S.

Consult to the **50 largest** health **providers** in the U.S.

Certify nearly 50% of **Medicare Part C/D bids** nationally

Support 19 out of the **top 20** pharmaceutical **manufacturers**

Provide actuarial support for **30+ state Medicaid/Exchange programs**

Provide **predictive analytics** for hundreds of clients

Manage **proprietary database** of claim data for over **80 million lives**, spanning across the commercial, Medicaid, and Medicare markets

Overview of Medicare Advantage (10 minutes)

MSSP vs. Medicare Advantage

Beat the field **vs.** **Beat the contract**

If done right, a win -win for payers and providers

What is Medicare Advantage

Medicare Advantage (Part C) Plans bundle Traditional Medicare benefits but are offered by Private Insurance Companies

- Cover all the services Traditional Medicare covers (with limited exceptions)
- Most Medicare Advantage plans also include pharmacy (Part D) benefits

Typically Include Supplemental Benefits

- Vision, Hearing, and Dental Benefits
- Clinical Programs/ Services such as Chronic Disease Management Programs
- Non-Clinical Programs like transportation assistance and gym memberships

MA Plan Revenue and Patient Costs

- MA Plans receive Per-Member-Per-Month payments from CMS for each enrollee
- MA Patients still pay their Part B Premium + a plan premium (many are $0)
- Deductibles, Co-Pays, and Co-Insurance can apply and will vary by plan

MA Plans have Provider Networks

- Out-of-Network coverage varies by plan, but like Commercial plans, many MA payers offer PPO and HMO plan options

MA Plans MUST have MLRs > 85% (80% in some cases) or face penalties from CMS

In MA VBC contracts, payers expect more from their contracted providers than expects in MSSP

Plans share premium dollars with providers in exchange for:

Baseline expectations

Medical cost management (MLR)

Accurate risk coding (RAF)

Clinical quality management (Stars)

New member growth

*Collaboration between providers and payers is key to success across all metrics

MA Contracting (55 minutes)

Contract economics: negotiating MLR deal terms

- **MLR Target**: No less than ~84% (scale orgs) or 80% (subscale orgs)
  - Fixed target for 3-5 year term
  - Part D excluded or Part D included, but not at risk (limits exposure to factors beyond the ACO's control: charges / utilization trends, benefit design changes, formulary changes)
- **Quality Bonus**: Positive MLR adjustment for 4.0+ Stars performance
- **Group Retirees**: If included, retirees are a separate cohort with financial target set at historical performance
  - Upside only for the first 2 performance periods

Contract economics: glide path to risk

- **Performance Years 1 -2: Upside only**
  - Shared savings target: 40-50%
- **Performance Years 3 -4: Asymmetrical upside / downside**
  - Higher upside / lower downside
    - e.g. PY3: 60% upside / 30% downside; PY4: 75% upside/ 50% downside
- **Performance Years 5+: Full risk**
  - Based on strong historical performance: 100% upside / 100% downside

Contract economics: care management fees and other front-end incentives

There will be differences in fees and incentives available for partial and full risk contracts, but the payments may include:

- **Care management fees** : Up to $10 PMPM
- **Primary care cap:** $75 - $125 (based on market and scope of services)
- **Quality-based incentives:**
  - AWV bonuses
  - Stars-based PMPY bonuses
  - Stars-based MLR adjustment examples
    - 4.50 - 4.74 Stars: +1% added to MLR target
    - 4.75 - 5.00 Stars: +1.5% added to MLR target
- **Advance (quarterly) shared savings payments**
- **Full cap PMPM (with DoFR)**

Contract economics: quality measures

Provider quality measure wish list. Focus on limiting included quality measures to those that:

1. PCPs can directly impact
2. Can be accurately measured (often not the case when it comes to Patient Experience)
3. Have sufficient lives under management (LUM) in denominators to hedge against volatility
4. Are focused on increasing quality and limit administrative (check the box) burden
5. Align with overall plan performance needs

Contract economics: key contractual language terms

- **Division of Financial Responsibility (DoFR)**
  - List of administrative responsibilities between the MCO and the ACO
  - Increasing responsibility to the ACO should be paired with an increase in MLR/PMPM
- **Contract Termination:** Should hold Payer accountable for payments for any truncated term, i.e. if terminated midterm by either party
- **Attribution** : Contract should clearly state which members are included in the cost of care and quality measurements; including product types (HMO, PPO), DSNP and H-contract names
- **Data/Reporting:**
  - Detailed listing of all data/reports and the timing for distribution of each
  - Service Level Agreement language to ensure reports/data is sent within reasonable timelines, and outlining the quality and/or financial remedies if not met

Break (15 minutes)

MA Performance (55 minutes)

Providers have a few levers to improve their financial position in $ and % terms

1. Improve the accuracy and comprehensiveness of documentation and coding to ensure accurate Risk Adjustment, which drives accurate premium (% premium value increases as premium dollars increase)
2. Increase quality (Stars) performance, which can unlock more favorable risk sharing terms and quality bonus payments for MA Plans
3. Effectively manage medical costs and utilization
4. Take responsibility for delegated services (UM, claims processing, etc.) and increase the % of premium allocated to the provider
5. Improve attribution (patient selection) to ensure every patient they are actually treating is accurately attributed to them

Medical Loss Ratio (MLR) and Risk Adjustment

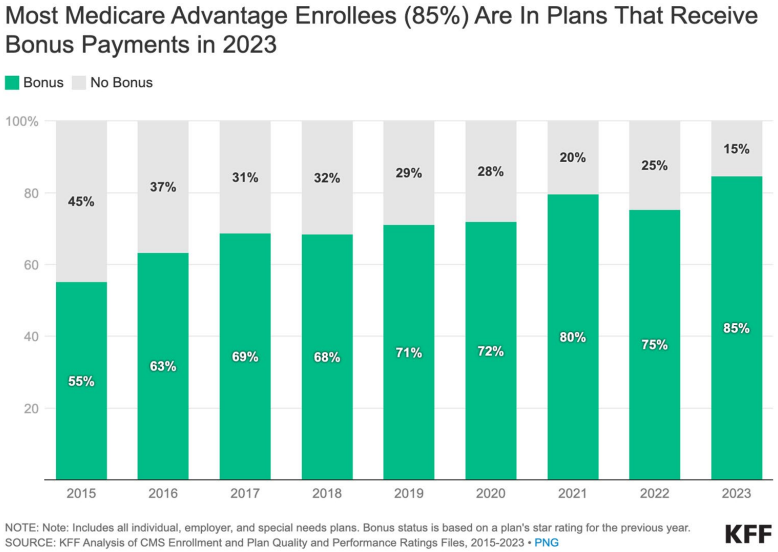
MA risk contracts usually have MLR (% of Premium spent on medical costs) targets

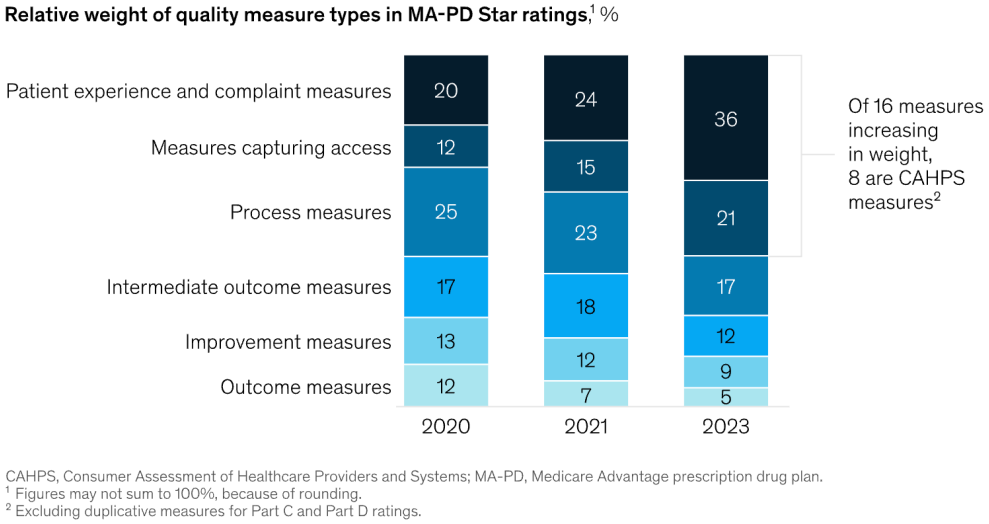
- Plans receive capitated Per Member Per Month payments from CMS for all enrollees
- PMPM payments are influenced by three factors
  - CMS County Benchmark Rate + the Plan "Bid Rate" (inclusive of quality bonus payments)
  - Patient Premiums (if applicable, many plans are $0 premium)
  - Risk Adjustment Factor (RAF score)
- Each enrollees RAF score is a combination of their demographic status (age, sex, Dual eligibility), their special status (aged vs disabled) and their disease burden
- Disease burden is based on diagnoses captured in the previous calendar year
- MLR = Total Medical Costs as a % of Premium
- Plans MUST have MLRs ≥ 85% (80% in some cases) or face penalties from CMS, so where they can, they push risk downstream to providers interacting directly with the patients to align incentives and de-risk

Why does risk adjustment matter for VBC Participants

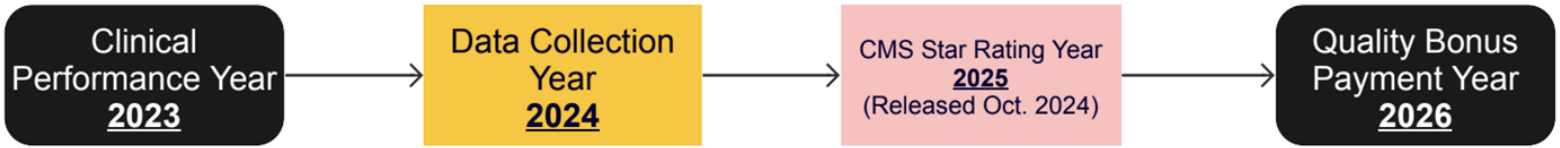
- Complete and accurate risk adjustment and effectively managing medical costs is imperative to success in MA
- Risk adjustment also promotes coordination of care across providers caring for the patient and incentivizes providers to spend the time necessary to investigate, monitor and manage patient chronic conditions
- Ensures PCPs are aware of - and are managing - all chronic conditions
- Dx capture is the ONLY lever providers have to influence revenue in **most** MA contracts

Stars performance is a crucial competency for MA Plans and providers





CAHPS, Consumer Assessment of Healthcare Providers and Systems; MA-PD, Medicare Advantage prescription drug plan.
[1] Figures may not sum to 100%, because of rounding.
[2] Excluding duplicative measures for Part C and Part D ratings.



Sources: KFF, McKinsey

Stars- maximizing performance with targeted interventions

- Quarterly focus on specific and actionable quality goals
  - Example:
    - 1Q: Annual Wellness Visits for new and high-risk patients, preventive screenings, prior year medication adherence fails and 90-day Rx conversions
    - 2Q: Addressing gaps in care for chronic conditions, order follow up, missed refill due dates for medication adherence
    - 3Q: Order follow up, missed refill due dates for medication adherence
    - 4Q: Remaining annual visits, uncontrolled chronic disease members check-in, missed refill due dates for medication adherence
- Aligned incentives tied to clinical outcomes
- Regular cadence of actionable feedback based on performance

Stars- prioritizing measures

Triple Weighted Stars measures - especially Medication Adherence which represents 30-40% of aggregated Star ratings - are critical to success in MA

Measure	Weight	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Controlling Blood Pressure	3	5	4	4	4	4
Diabetes Care - Blood Sugar Controlled	3	5	4	4	4	4
Medication Adherence - Cholesterol	3	5	4	4	3	3
Medication Adherence - Diabetes	3	5	4	4	3	2
Medication Adherence - Hypertension	3	5	4	4	3	2
Breast Cancer Screening	1	4	5	4	5	5
COA: Medication Review	1	4	5	4	5	5
COA: Pain Assessment	1	4	5	4	5	5
Colorectal Cancer Screening	1	4	5	4	5	5
Diabetes Care - Eye Exam	1	4	5	4	5	5
Statin Use in Persons with Diabetes	1	4	5	5	5	5
Follow-up after Emergency Room Visit	1	4	5	5	5	5
MTM Program Completion Rate for CMR	1	4	5	5	5	5
Osteoporosis Management in Women Who Had a Fracture	1	4	5	5	5	5
Statin Therapy for Patients with Cardiovascular Disease	1	4	5	5	5	5
TRC - Medication Reconciliation Post Discharge	0.5	4	5	5	5	5
TRC - Patient Engagement after Inpatient Discharge	0.5	4	5	5	5	5
Plan All-Cause Readmissions (needs at least 150 in denominator to count)	3	4	5	5	5	5
Aggregate Star Rating		4.52	4.48	4.31	4.17	3.97

Stars- prioritizing contracts

- Your organization may have one, a few, or dozens of MA contracts across health plans
- While all contracts are important, you will likely have to make tradeoffs across contracts to hit specific targets. Some of the things you may need to consider are:
    - Level of downside risk
    - Contractual implications of current performance/status
    - Relationship with plan (strategic, anchor, investor, etc.)
    - Revenue opportunity
    - # of patients in the contract
    - Historical performance

Delegated services and additional med exp. mgmt levers

Some value based contracts may include delegation of services ordinarily performed by the health plan

Delegation usually requires significant scale, but can be done with smaller patient populations

Examples can include:

- Delegated networking, contracting and credentialing
- Delegated Utilization Management
- Delegated Care Management Services
- Claims Delegation

Operational mechanics

TIN & NPI rosters, network participation, panel status, and assignment & attribution

Managing the right population is paramount to being successful in any value based care arrangement

- Rosters serve as the basis for attribution and maintaining up to date and accurate practice and provider rosters is key to ensuring you are managing the right population of patients
- Providers will likely need to be "participating providers" in the health plans' network to gain attribution and participate in the value based contract (VBC)
- Participating providers can receive newly attributed patients so long as they have an "open panel" with the health plan (are accepting new patients)
- Your VBC may require all or some of your providers to have an open panel as a requirement of the VBC
- Patient assignment and attribution methodologies can vary across different health plans but generally fall into a few buckets
    - PCP Selection: when a patient self selects their PCP
    - Claims-based attribution: patient attribution based on historical claims utilization (either by preponderance of claims or preponderance of spend) and are assigned to the PCP they see most often
    - Auto-assignment: patient assignment can be based on other factors like where the patient lives and the PCP's geographical service area in absence of the patient identifying their PCP and sufficient claims history for claims-based attribution (more common with patients newly enrolled with the health plan)

Breakout Sessions (30 minutes)

Breakout #1: Contracting

You represent a provider organization with these characteristics:

Org data	2021	2022	2023 (exp.)
Star rating	2.7	3.1	3.4
MER	84%	84.5%	85%
Patient count	20,000	25,000	30,000
Payer X patients	200	225	5,000
RAF	1.03	0.98	0.92

What are the top 5 terms that you'd negotiate into an MA contract with Payer X given those data? How might you try to generate optimal terms assuming that Payer X does not have access to your performance data?

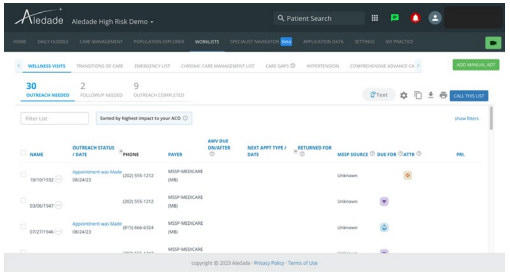
Breakout #2: Performance

You've done MSSP, you're signing your first MA deal, what are the 5 things you need to start doing (beyond what you're doing in MSSP) to be successful in your first MA contract?

Breakout Summary & Final Thoughts (30 minutes)

Final thoughts: how do you perform well in MA?

By engaging your patients in care, and addressing their needs!



- Use data and analytics tools to identify patients who need to be engaged
- Key areas from our experience where you can drive both MLR and Stars performance
  - **Early MA AWVs** = better quality ratings, improved accuracy in documentation/ diagnosis coding, and cost savings
  - **Care Gaps** = improved patient care and better quality ratings
  - **Accurate Documentation/ Diagnosis** = better care and accurate revenue
  - **Transitional Care Management** = reduced readmissions, cost savings, and better quality ratings
  - **ED Follow Up** = reduced ER (and IP!) utilization, cost savings and better quality ratings
  - **Identify, address and manage** high needs populations