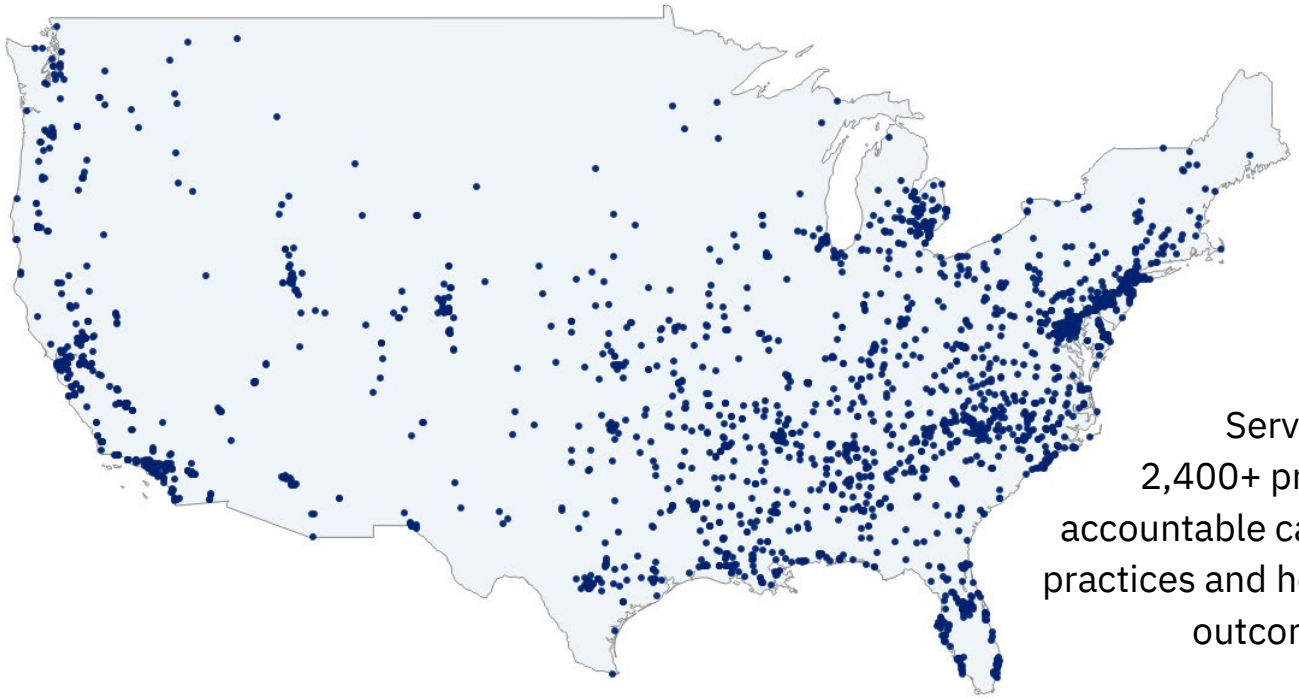
Aligning Incentives:

Designing shared savings and compensation models that work

Paul Trompke
VP, Revenue Management
Aledade, Inc

Aledade

Aledade is the largest independent primary care network in the country, focused exclusively on value-based care.



~3M patients

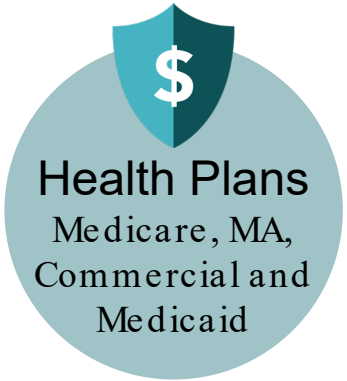
2.4K+ primary care organizations

Serving ~3 million patients across 2,400+ primary care organizations, our accountable care organizations (ACOs) help practices and health centers improve patient outcomes and generate sustainable revenue.

Map shows primary locations for 2025 partner practices

Aligning incentives is core to Aledade's success

Value-based care contracts align parties on providing quality care for patients. Savings generated are shared between Aledade and health plan partners.



Aledade partners with practices in risk-bearing entities, generally ACOs.

Practices continue to have fee-for-service contracts and manage those separately from any interactions with Aledade.

Aledade value-based care arrangements

Practice arrangements

- Shared savings are split 50/50
- Aledade covers 100% downside risk
- ACO operational costs are borne by Aledade and are not deducted from shared savings prior to distribution to practices

Value -based contracts

- Total cost of care arrangements
- Typical revenue types:
  - Shared savings (All ACOs)
  - Quality bonuses (Health plan value-based contracts)
  - Care coordination fees (Health plan value-based contracts)
  - PCP capitation (Health plan value-based contracts)

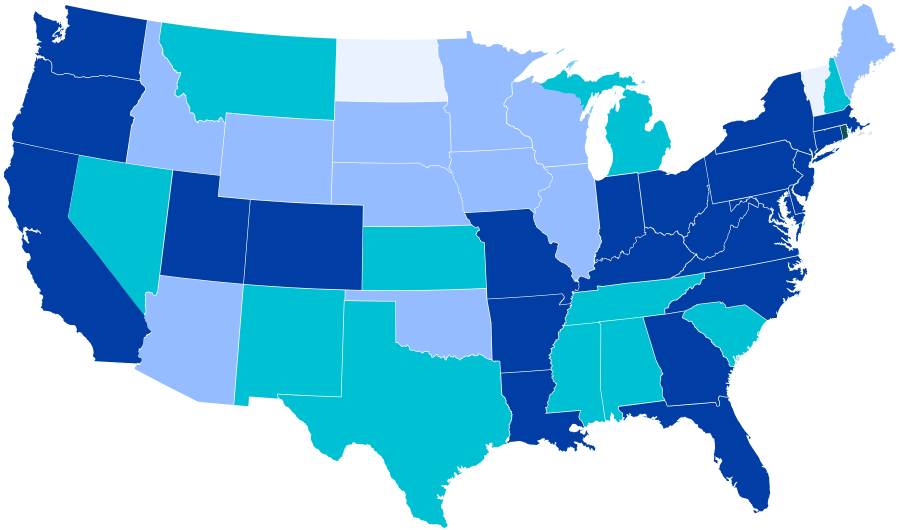
Health Plan Network

FEDERAL GOVERNMENT

MSSP across 46 states

ACO Reach

PC Flex



Contracted Lines of Business[1]

3 2 1

HEALTH PLANS

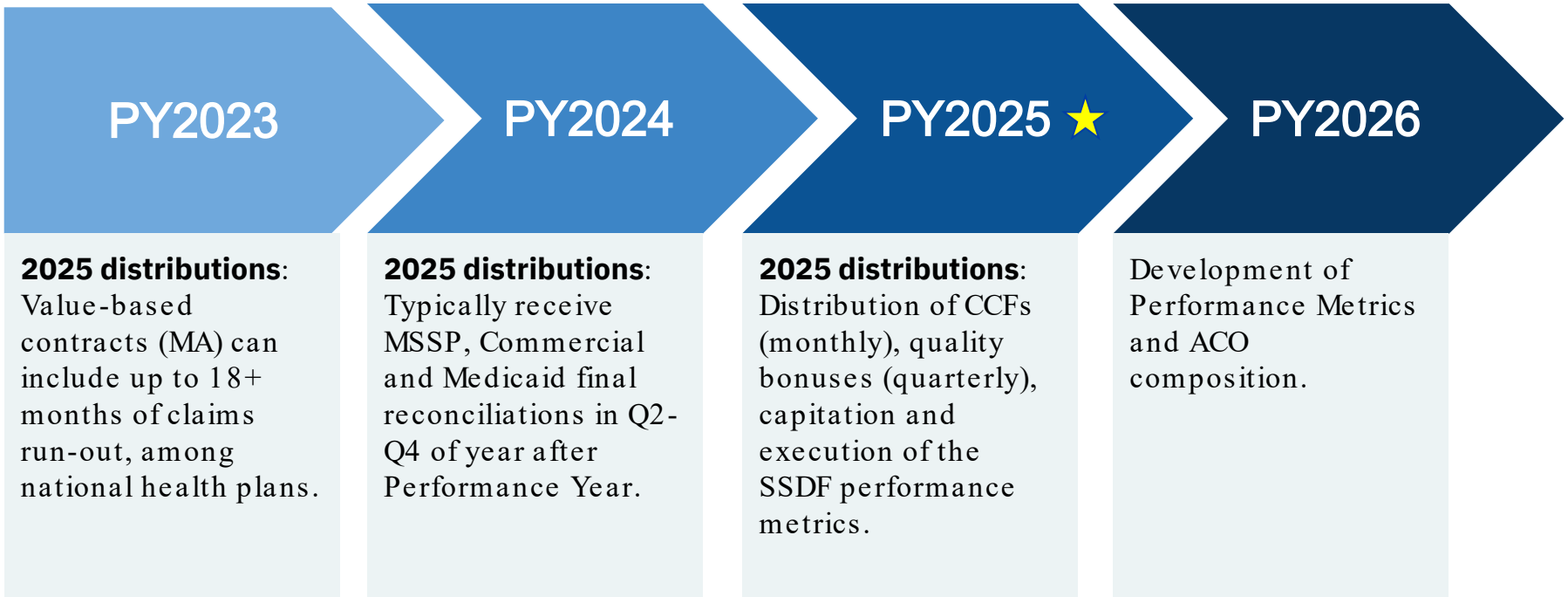
MA contracts with all six national health plans

Commercial contracts with over 15 national and regional health plans

[1] Lines of Business include Medicare Shared Savings Program (MSSP), Medicare Advantage (MA), and Commercial

August 2024. 1055-23

ACO financials span multiple Performance Years



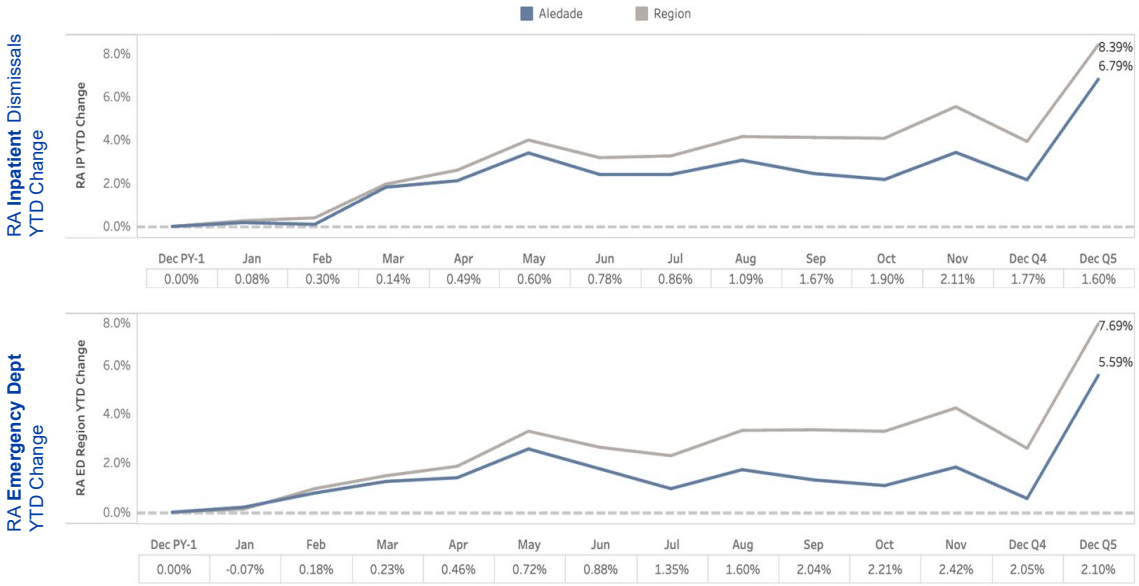
Approach to Performance Metrics for Shared Savings

- **Our public benefit purpose:** To deliver better health, better care and lower costs, creating a health care system that is good for patients, good for practices and good for society.

- **Performance Measures span multiple population health and care transformation activities:**
  - Annual wellness visits (AWVs)
  - Clinical Quality Measurement (eg, Controlled blood pressure, Controlled HbA1c)
  - Post-acute follow-up (eg, Transitions of Care Management visits, ED follow-up calls)
  - Utilization-based metrics (eg, IP/K & ED/K)
  - Patient care programs (eg, Comprehensive Advance Care Planning)
  - Attribution retention
  - Aledade App worklists

Reducing unnecessary hospitalization and ED utilization

Aledade ACOs consistently manage utilization better than regional comparison

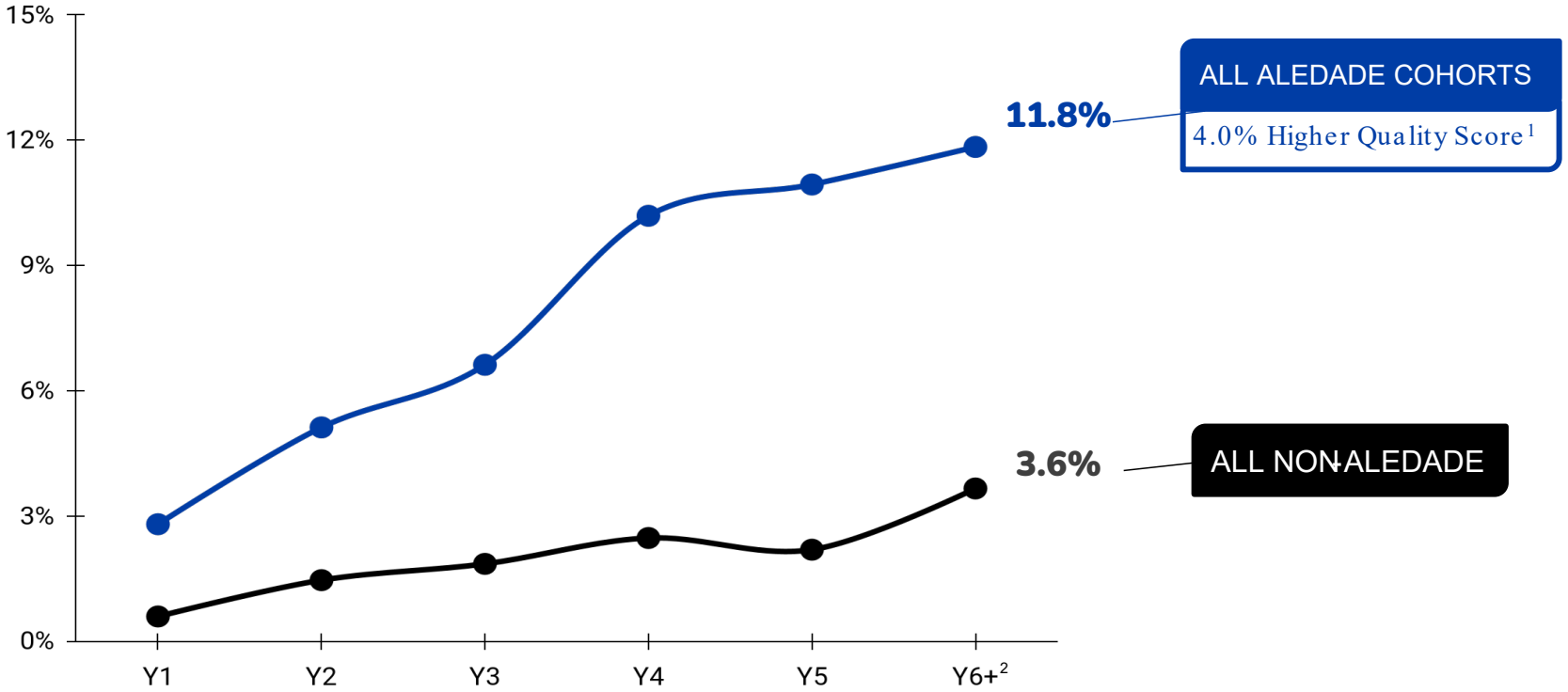


Source: CMS VRDC (MSSP)
Region is weighted average of Aledade practice locations and risk-adjusted for comparability
PY2024

- Aledade outperformed regional peers on key utilization metrics that are included in SSDF:
  - Aledade Inpatient admits **1.6%** lower than the region
  - Aledade Emergency Department (ED) admits **2.1%** lower than the region

- Practices able to earn savings through both <u>improvement</u> or <u>attainment</u> of low risk-adjusted admissions

Aledade ACOs outperform others on cumulative Medicare shared savings.



1. Quality score weighted by LUM and compares Aledade performance to a similar mix of MSSP performance to account for changes in CMS quality methodology in 2022
2. Y6+ is a weighted average by lives of ACO performance for performance year 6 through year 8

Notes: Aledade analysis of CMS Public Use File available at https://data.cms.gov/medicare-shared-savings-program. For Aledade cohorts 2016+, PY2020 adjusted for estimated impact of COVID-19 pandemic for each cohort as a one-year correction. Latest data available through 2023. The individual performance of non-Aledade ACOs may be better or worse than the average

Care Coordination Fees provide a further opportunity for within-year incentive

Monthly PMPMs

Performance Measurement

Participating Practices

Best practices for designing a Shared Savings Distribution Formula

- Standard set of measures
- Flexibility for market & ACO preferences
- Tailor to the Line of Business
- Set measure level thresholds
- Provide visibility with pro forma and scorecard

Aledade

ADVOCATE HEALTH

Aligning Incentives: Designing Shared Savings and Compensation Models That Work

NAACOS Annual Fall Conference

October 2025

ADVOCATEHEALTH

Value Based Services Platform

Managing Health, Quality and Total Cost of 2.4M Lives

18K+
Participating Physicians

13
Networks | ACOs | CINs

2.4M
Managed Lives

2 of 7
CMS ACO REACH Health System Participants in the Nation

117
Value-Based Contracts

$1.9B
Total value created

72
Participating Hospitals

Value-based care success built on capabilities fine-tuned over decades of experience managing shared savings, shared risk, professional and global capitation across CMS, commercial and Medicaid contracts.

- Network Management
- Advanced Analytics
- Value Innovation
- Clinical Programs
- Data Management Infrastructure
- TPA/MSO

Designing Shared Savings Models

Drives Organizational Alignment

Incentive models shape behavior. Well-designed models unite physicians, specialists, and care teams around shared goals (quality, cost, patient experience).

Build Trust and Engagement

Clear and consistent logic for how the model drives financial performance is a must
Involving physicians and administrators in the initial design phases are key
Data feedback and Performance Activation is a must

Common Challenges:

- Attribution methodologies are complex hard to understand
- Lack of Data transparency and administrative burden can limit performance feedback
- Too many quality measures, payer specific segmentation, tedious documentation, and confusing payout formulas impede implementation
- Lack of operational support to deliver performance at a physician level

1. Trends in Engaging Specialists in Value-Based Care | Coker
2. Accountable Care Organization Initiatives to Improve the Cost and Outcomes of Specialty Care | AJMC

ADVOCATE HEALTH

2025 Enterprise MSSP Incentive Project

Objectives
MSSP Surplus Distribution

- Automate
- Standardize eligibility for incentive
- Standardize application of quality measures
- Define distinct state markets
- Calculate state benchmarks
- Fairly apportion Network operating expenses
- Set a policy for shared losses or repayment
- Reconcile incentive splits PCP vs. specialist

Challenges

1. Culture
   - Varying distribution models by state
2. Technology
   - Need for automation
   - Need for quarterly trending at the state level
3. Transparency
   - Operating expenses must be clearly delineated and apportioned
   - Quality threshold will need standard definition and support

Incentive Design Sub-committee → Actuarial Modeling → Board Approval → Transparency

ADVOCATE HEALTH

Current State

	Wake Forest	Illinois	Wisconsin	Charlotte
Infrastructure funding (operating expenses)	Above the line	Above the line	Above the line	Above the line
Risk pool (“rainy day”)	None	None	None	10%
Eligible practices/providers	ACO Participants No Hospital	CIN physicians who saw an MSSP beneficiary	MSSP Participants; Hospital Parent	CIN physicians; Hospital Parent
Basis of distribution	Risk-adjusted attribution	Per measure per patient	Volume of unique patients served	50% equal share 50% volume
Adjustments	Quality, CMD	Quality, CMD, Utilization	None	None
Distribution level	TIN level	TIN level rollup Calculated at NPI	TIN level	TIN level rollup Calculated at NPI

Regional variation in eligibility, adjustments, and division of funds needs to be reconciled

Key Concepts

Benchmarking

Adjustments (Regional, Prior Savings, Risk)

Area specific benchmarks are a composite of the overall ACO adjustments and the local adjustments; Enables each area to reap the benefits of ACO-level adjustments; i.e regional performance, benchmark years, prior savings, and risk score ceiling

Eligibility

Practice/Hospital Relationship

Three different methodologies exist across four states

Hospital Distributions

Handled differently across all four states

Quality Performance

Specific thresholds set by CMS

Primary/Specialty Care Pools

CIN vs Employed specialists share differs by market

Loss-Case Scenarios

ACO Loss with CMS

How much financial risk would practices bear vs. health system

State/Area-Specific losses

Redistribution of Losses to other markets? Lower distribution of positive entities to account for losses?

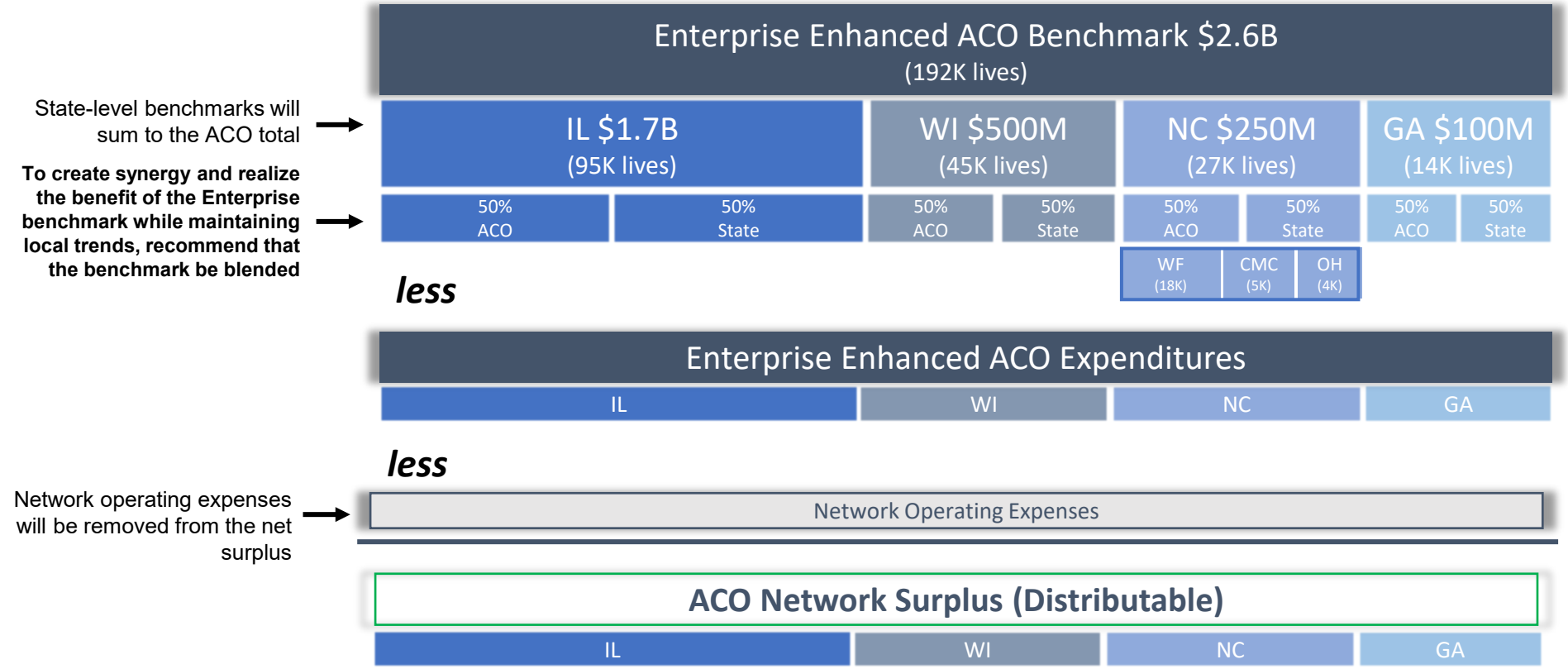
Operating Expenses

State-Level Accountability

How would we account for operating expenses when looking at specific areas?

Data measurement and performance composite score was required by Board driven by financial success metrics

Enterprise Enhanced: State-based Benchmarks



ADVOCATE HEALTH

Finalized Methodology Decisions

Benchmarking

Adjustments (Regional, Prior Savings, Risk)

State benchmarks are a composite of the overall ACO adjustments and the local adjustments; Enables each state to reap the benefits of ACO-level adjustments; i.e regional performance, benchmark years, prior savings, and risk score ceiling

Eligibility

Practice/Hospital Relationship

Only ACO participants can earn a distribution

Hospital Distributions

Distributions will be distributed to the TINS participating

Quality Performance

Specific thresholds set by CMS

Primary/Specialty Care Pools

One incentive pool with attribution defined by TIN-NPI combination

Loss-Case Scenarios

ACO Loss with CMS

Participating TINs to bear financial risk

State-Level losses

Repayment of market specific losses into larger distribution pools

Operating Expenses

State-Level Accountability

Centralized allocation of resources to state. but in event of a loss Advocate Health operating entity will bear that loss in performance year.

State-level benchmarks & balances sum to ACO totals
Quality performance relative to eCQM quality threshold

MSSP Performance Composite

Aligned with Population Health divisional scorecard and drivers of ACO performance. Produced at an organizational, divisional, and Practice Level

Domain	% of Score	Description
Quality	30%	A composite score made up of quality measures. The composite score will be between 0 and 150. Each measure will have a target established and will be individually scored on a scale of 0 to 150 like the overall composite.
CMD	30%	A composite score made up of CMD measures. The composite score will be between 0 and 150. Each measure will have a target established and will be individually scored on a scale of 0 to 150 like the overall composite.
Utilization	40%	A composite score made up of utilization measures. The composite score will be between 0 and 150. Each measure will have a target established and will be individually scored on a scale of 0 to 150 like the overall composite.
Total Score	**100%**	**The weighted score for each of the measures will then be averaged together to produce the overall total composite.**

Illinois: MSSP Line of Business Results

June 2025	TARGET	STRETCH	MSSP
Quality			
Breast Cancer Screening	79.1%	82.9%	82.9%
Cervical Cancer Screening	-	-	-
Colorectal Cancer Screening	78.8%	82.4%	80.5%
Condition Re-Evaluation	57.1%	61.9%	69.8%
Controlling High Blood Pressure	79.6%	85.3%	79.6%
Depression Screening and Follow Up	-	-	-
Diabetes A1c Control < 8%	78.1%	81.1%	77.6%
Diabetes Kidney Health Evaluation	60.3%	69.7%	73.4%
Diabetes Statin Use	81.8%	84.7%	89.0%
Medicare Wellness Visits	77.8%	80.0%	74.0%
Well Child Visits 3-21	-	-	-
Condition Management & Documentation			
Medicare Wellness Visits	77.8%	80.0%	74.0%
Condition Re-evaluation	57.1%	61.9%	69.8%
Utilization Management			
Hospitalizations/1k	216.4	170.4	325.3
Admits/1K	182.1	139.9	272.1
Observations/1k	34.3	30.6	53.3
ED Visits/1k	261.7	240.4	274.9
Readmission Risk-Adjusted Index (O:E)	0.96	0.86	1.11
Post-Discharge Follow-up (7 Day)	50%	55%	54%
SNF Days/1k	850.0	626.0	1110.2

Quality and CMD Notes:

- *Quality targets reflect HEDIS Medicare 75th and 90th percentiles*
- *CMD Targets are set to the Division-level; Condition Re-evaluation measure targets are updated monthly.*
- *Depression Screening and follow-up measure is currently unavailable in the Midwest.*
- *CCS and WCV are n/a for this LOB.*

Utilization Notes:

- *Utilization targets are set using national benchmarks for the line of business; exceptions include Readmission Index (O:E) and Post-Discharge Follow-up which are set to Division-level.*

Peer to Peer comparison drives accountability and problem solving

ADVOCATE HEALTH

Chronic Condition Model: CKD Shared Savings

Unique pilot with WI Nephrology group to address high spend areas with opportunities for increased financial and quality improvement in the MSSP population

Model Construction

Benchmark requires a **2% savings** minimum based on historical total cost

Patients are attributed based on CKD Stage (3-5 using HCCs), MSSP assignment, and service rendered by a group provider in the Performance Year

Shared savings of 75% (group) and 25% (ACO) for any generated savings > 2%. Quality scores (6 measures) will be applied to savings (Year 1 pay for reporting)

Transplant costs are excluded.

Quality Measures

Stage 4	
CKD Education	Percentage of stage 4 patients with CKD education completed
Vein Mapping	Percentage of stage 4 patients with vein mapping completed
Transplant	Percentage of stage 4 patients with transplant episode

Stage 5	
Transplant	Percentage of stage 5 patients with transplant episode
Home Dialysis	Percentage of patients on home dialysis
Readmissions	30-day readmissions rate for Stage 5 patients

Early Results & Learnings

- On track to achieve shared savings in first performance year, performance in ESRD is driving savings (overall 2.7% savings rate)
- Continued technical alignment is needed to ensure coordinated care (standardizing workflows across shared sites)
- Challenges with determining the best quality measures, some CKCC metrics are difficult to leverage ex: Optimal Dialysis start
- Increase in transplant referrals in 2024 (18%)
- Increased operational strategic engagement in 2025 to improve access and operational efficiencies

Final Thoughts

Comprehensive approach to incentive models must evolve to serve the needs of your Organization

Dedicated Governance that evolves incentive strategy as your organization evolves

Non-Financial incentives

Staffing, resources, support tools are often times more powerful than monetary incentives

Care Innovation and Growth

Extraordinary patient experiences focused on empathy and value can drive new business to key physician partners

Team-Based Incentives

Exploring financial incentives to drive behavior with additional Care team members

Built on a Foundation of Trust and Transparency

Appendix

ADVOCATEHEALTH

Physician Scorecard: Example 1

Overall Composite Score*: 100%

Plan: MSSP Enhanced Active Members 10,157
TIN: Unattributed

Measure	Numerator	Denominator	Current Score	Weight	Scaled Score	Weighted Score	Baseline Scaled Score	% Change	2025 Targets 1	2(Threshold)	3(Target)	4	5(Stretch)
Population Health Index						**40**	**38**	**6%**					
Breast Cancer Screening	1,382	2,015	69%	11%	0	0.0	66%	3%	0%	73%	79%	81%	83%
Colorectal Cancer Screening	2,571	4,042	64%	11%	0	0.0	60%	5%	0%	72%	79%	81%	82%
Condition Re-Evaluation	13,614	20,239	67%	11%	118	13.2	60%	13%	0%	60%	65%	68%	71%
Controlling High Blood Pressure	2,203	3,313	66%	11%	0	0.0	66%	0%	0%	76%	80%	82%	85%
Depression Screening	5,468	9,205	59%	11%	69	7.6	63%	-5%	0%	50%	75%	83%	90%
Diabetes - Glycemic Status Assessment (<8%)	629	1,052	60%	11%	0	0.0	57%	5%	0%	74%	78%	80%	81%
Diabetes - Kidney Health Evaluation	884	1,644	54%	11%	63	7.0	55%	-2%	0%	52%	60%	65%	70%
Statin Therapy- Generic Diabetic Group	759	901	84%	11%	142	15.8	84%	0%	0%	79%	82%	83%	85%
Medicare Annual Wellness Visit	4,523	10,118	45%	11%	0	0.0	43%	4%	0%	73%	78%	79%	80%
Ambulatory Quality Composite (AQC) Index						**44**	**45**	**-4%**					
Condition Re-Evaluation	13,614	20,239	67%	50%	118	59.2	60%	13%	0%	60%	65%	68%	71%
Medicare Annual Wellness Visit	4,523	10,118	45%	50%	0	0.0	43%	4%	0%	73%	78%	79%	80%
Condition Management & Documentation (CMD) Index						**59**	**63**	**-6%**					

Measure	Numerator	Denominator	Current Score	Weight	Scaled Score	Weighted Score	Baseline Scaled Score	% Change	Threshold	Target	Stretch
HSP / 1k	2,864	7.53	380.5	35%	0	0.0	415.8	-8%	264.4	216.4	170.4
ADM / 1k	2,510	7.53	333.4	0%	0	0.0	364.3	-8%	224.4	182.1	139.9
OBS / 1k	354	7.53	47.0	0%	0	0.0	51.5	-9%	40.0	34.3	30.6
RAR O:E	138	120	1.15	10%	0	0.0	1.13	2%	1.11	0.96	0.86
ED / 1k	2,029	7.53	269.5	20%	90	17.9	283.9	-5%	299.6	261.7	240.4
FUV Rate	564	1,227	46%	10%	60	6.0	44%	3%	45%	50%	55%
SNF Days / 1k	12,673	7.53	1,683.5	25%	0	0.0	1,602.3	5%	1,120.0	850.0	626.0
Utilization Index						**24**	**14**	**69%**			

Depression Screening contributed 7.6 Points to the overall AQC Index (44) for meeting the Threshold (50%)

AQC: 30%

CMD: 30%

Hospitalizations per 1,000 contributed 0 points because actual performance was worse than the threshold (380.5 vs. 264.4)

Utilization: 40%

Scaled Score: 0	Scaled Score: 50 - 99	Scaled Score: 100 - 149	Scaled Score: 150
Below Threshold	Between Threshold and Target	Between Target and Stretch	Above Stretch

*Overall Composite Score is a weighted average of AQC, CMD, and Utilization measures.

Physician Scorecard: Example 2

Overall Composite Score: 100%

Plan: MSSP Enhanced Active Members 163
TIN: [redacted]

										2025 Targets				
Population Health Index						**109**	**117**	**-7%**						
Measure	Numerator	Denominator	Current Score	Weight	Scaled Score	Weighted Score	Baseline Scaled Score	% Change		1	2(Threshold)	3(Target)	4	5(Stretch)
Breast Cancer Screening	48	56	86%	11%	150	16.7	86%	-1%		0%	73%	79%	81%	83%
Colorectal Cancer Screening	87	102	85%	11%	150	16.7	79%	7%		0%	72%	79%	81%	82%
Condition Re-Evaluation	158	228	69%	11%	137	15.2	60%	16%		0%	60%	65%	68%	71%
Controlling High Blood Pressure	69	92	75%	11%	0	0.0	84%	-10%		0%	76%	80%	82%	85%
Depression Screening	130	159	82%	11%	123	13.6	84%	-3%		0%	50%	75%	83%	90%
Diabetes - Glycemic Status Assessment (<8%)	19	27	70%	11%	0	0.0	68%	4%		0%	74%	78%	80%	81%
Diabetes - Kidney Health Evaluation	31	42	74%	11%	150	16.7	78%	-5%		0%	52%	60%	65%	70%
Statin Therapy- Generic Diabetic Group	16	17	94%	11%	150	16.7	94%	0%		0%	79%	82%	83%	85%
Medicare Annual Wellness Visit	122	163	75%	11%	70	7.8	76%	-1%		0%	73%	78%	79%	80%
Ambulatory Quality Composite (AQC) Index						**103**	**115**	**-10%**						
Condition Re-Evaluation	158	228	69%	50%	137	68.3	60%	16%		0%	60%	65%	68%	71%
Medicare Annual Wellness Visit	122	163	75%	50%	70	35.2	76%	-1%		0%	73%	78%	79%	80%
Condition Management & Documentation (CMD) Index						**104**	**105**	**-1%**						
Measure	Numerator	Denominator	Current Score	Weight	Scaled Score	Weighted Score	Baseline Scaled Score	% Change		Threshold	Target	Stretch		
HSP / 1k	25	0.11	223.2	35%	93	32.5	161.7	38%		264.4	216.4	170.4		
ADM / 1k	18	0.11	160.7	0%	125	0.0	127.0	27%		224.4	182.1	139.9		
OBS / 1k	7	0.11	62.5	0%	0	0.0	34.6	80%		40.0	34.3	30.6		
RAR O:E	0	0	0.00	10%	150	15.0	0.00	N/A		1.11	0.96	0.86		
ED / 1k	30	0.11	267.9	20%	92	18.4	277.2	-3%		299.6	261.7	240.4		
FUV Rate	14	17	82%	10%	150	15.0	90%	-8%		45%	50%	55%		
SNF Days / 1k	17	0.11	151.8	25%	150	37.5	0.0	N/A		1,120.0	850.0	626.0		
Utilization Index						**118**	**128**	**-8%**						

Controlling High Blood Pressure contributed no points to the overall AQC Index (103). This practice was 1% below the Threshold (76%)

AQC: 30%

CMD: 30%

The practice's hospitalization rate met the minimum threshold but **not** the performance target (223.2 vs. 216.4)

Utilization: 40%

Scaled Score: 0	Scaled Score: 50 - 99	Scaled Score: 100 - 149	Scaled Score: 150
Below Threshold	Between Threshold and Target	Between Target and Stretch	Above Stretch

*Overall Composite Score is a weighted average of AQC, CMD, and Utilization measures.

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NAACOS Fall 2025

Natalie McGann, D. O.

Medical Director

Tandigm Value Partners ACO

TriValley Primary Care: Family Physician, Shareholder, and Clinical Co-Chair

Tandigm Value Partners ACO

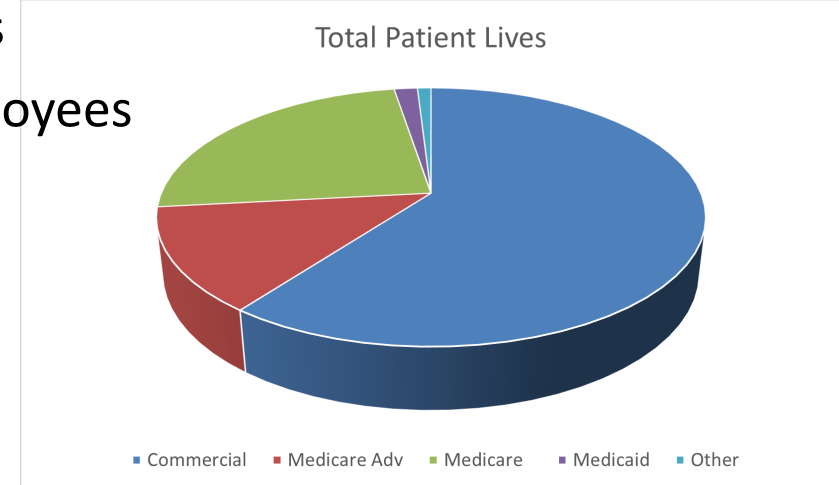
- ACO Greater Philadelphia Area
  - TriValley Primary Care
  - Grand View Health
  - Kuhar Medical Practice
- MSSP Enhanced Track
- Prospective attribution
- Performance by Year:

Performance Year	Attribution	Savings Rate
2022	11,150	6.37%
2023	11,402	8.42%
2024*	11,596	13.37%*

*Pending final adjustment by Medicare

TriValley Primary Care

- Independent Primary Care Practice
- 31 Physician shareholders
- 15 CRNPs
- 200 Employees



- Value Based Contracts
  - Medicare MSSP and Primary Care First
  - Commercial Contracts
    - Aetna
    - Independence Blue Cross
  - Medicare Advantage Contracts
    - Aetna
    - Independence Blue Cross
    - Humana
    - United Healthcare

Approach to Value-Based Care

- All patients, all payors
- Population Health Specialist
- Care Manager
- Clinical Site Lead (Physician)
- Clinical Committee (Physicians)
- Certified coder
- AI Coding software overlay on EMR
- Tech-enabled Care Coordination
- Keep your morale compass pointing true north

BUILDING BRIDGES in VBC

SPECIALIST

- “Call Your Primary”

PCP

- “Call Us First”

A DAY IN THE LIFE . . .

- The average office visit:
  - Screening
    - Falls risk, incontinence, dementia, depression in 15 minutes or less
  - Disease management
    - DM, HTN, Depression
  - Accurate coding
    - Brace yourself . . . I'm about to call you morbidly obese
  - Expectation setting
    - Shouldn't everyone be on a GLP-1 inhibitor?
  - Doorknob extra's
    - Oh by the way chest pain and forms
  - Patient satisfaction
    - If asked, please say you still like me

WHAT DO PCPs WANT?

CONVENORS

- Creative contracts
- Progressive and flexible support
- Data and analytics
- A seat at the table

HEALTHSYSTEMS

- Don’t discount the power of the independents - make room for collaboration
- We don’t have to be diametrically opposed
- Help foster partnership between specialists and pcps
- We can get the right folks across your threshold and keep the right folks out
- A seat at the table

THE INDEPENDENT DIFFERENCE

- AUTONOMY
- PERSONALIZED PATIENT CARE
- OPERATIONAL CONTROL
- FLEXIBILITY

GENERATING SHARED SAVINGS

EARN

- Accurate coding and education
  - Use more than 1 tool
  - AI software
  - Coder support
  - PHYSICIAN leadership
  - Quality STATs
  - Quality Benchmarks

SAVE

- Control utilization
  - Integrated Delivery Network (IDN)
  - Communication
    - ADT feeds, Interfaces, Consults, Provider to provider
  - Reports
  - Relationship building and networking

TriValley's Secret Sauce for MSSP Earnings Distribution

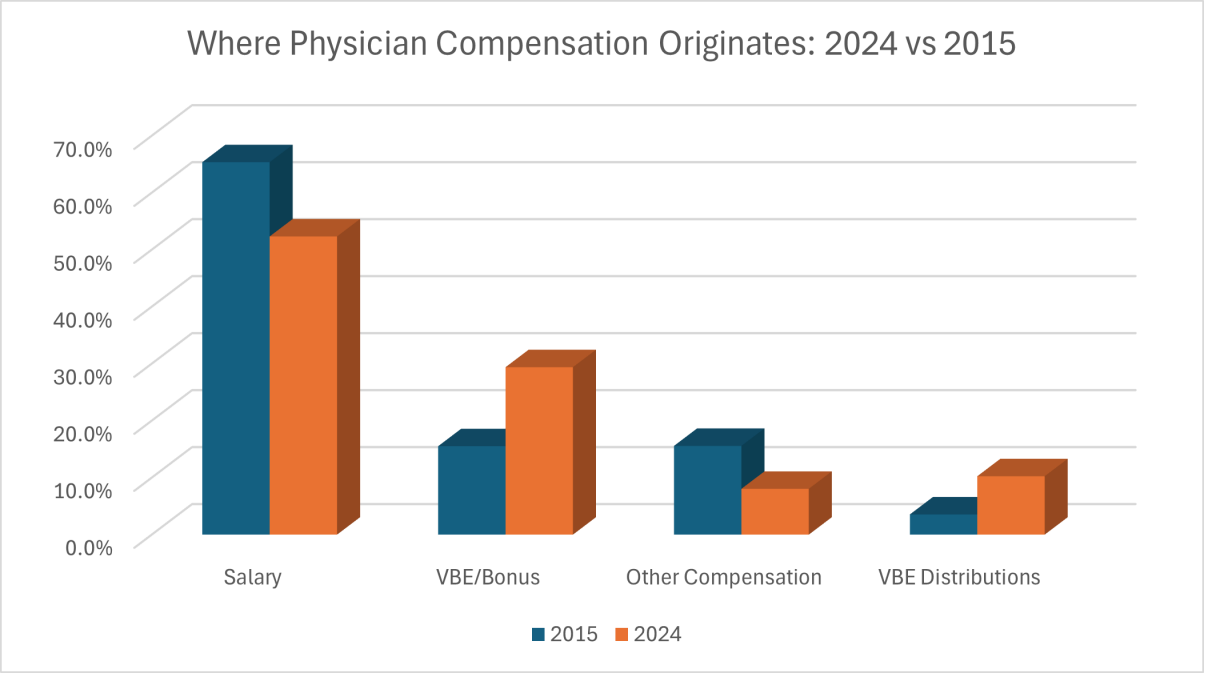
- 10% PMPM advance
- 10% Operational withholding
- 15% Employee bonus/Leadership compensation
- 65% RESERVED FOR PHYSICIAN COMPENSATION
  - 20% Even split per shareholder
  - 80% Allocated to offices based on member lives

TriValley's Employee and Leadership Bonus Breakdown

- Employees:
  - Practice Administrator 1.5% (tin)
  - Office Managers 3% (of all VBE at site level, capped)
  - Population Health Specialists 1% (site)
  - Care Managers 1% (site)
  - Teams divide remaining dollars as determined by office, including CRNPs
- Leadership Roles:
  - Chairperson 1% (tin)
  - IT Lead 1% (tin)
  - Clinical Chair Coding and Compliance 1% (tin)
  - Clinical Chair Strategy and Value-Based Programming 1% (tin)

TriValley Physician Compensation Over Time

- Over the past 10 years, physician compensation has evolved
  - From standard salary + a little in bonus earnings and owner distributions
  - To less originating from standard salary, and much more dependent upon value-based earnings and owner distributions



FOR WHAT IT'S WORTH: LESSONS LEARNED

- It's all about PERSPECTIVE
  - You can't please everyone
- Transparency can be a blessing and a curse
- Leaders are NEEDED to shape the mindset
  - Value-Based Earnings, monies available for distribution
- Be willing to CHANGE
  - Our formula evolves year over year
- You need to invest to earn
  - Figure out what generated your share savings and earmark $ for investment

LOOKING TO THE FUTURE

- SIMPLIFIED ATTRIBUTION
  - AWV
- UNIFIED QUALITY METRICS
  - Single-stream workflows
- BETTER CONTRACT ALIGNMENT
  - CMS, MA and Commercial
- IMPROVED PAYOR CAPITATION RATES
  - Maintain cashflow