



How Medicare Advantage Experience Drives ACO/Direct Contracting Success

Speakers



Yates Lennon

CHES Health Solutions



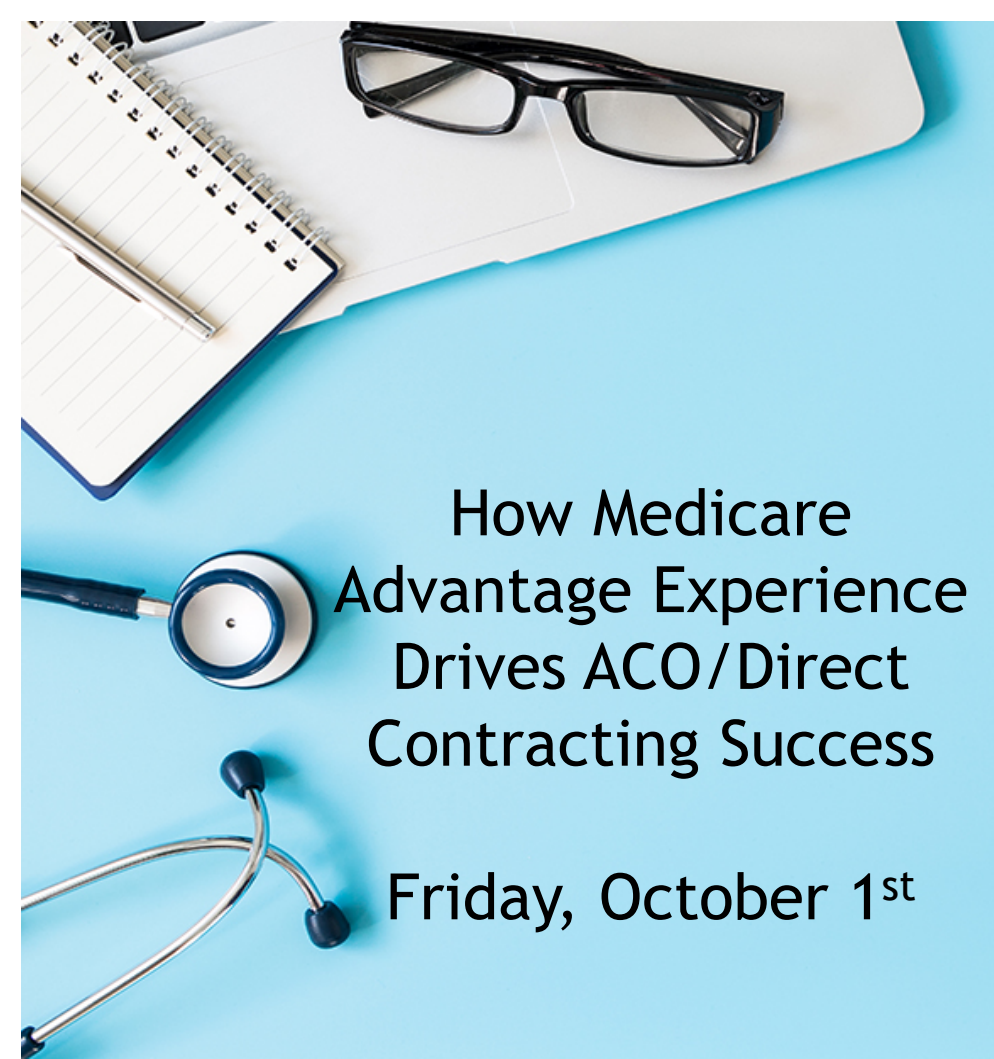
Raj Naik

Best Value Healthcare



Dan Wendorff

Mount Carmel Health Partners

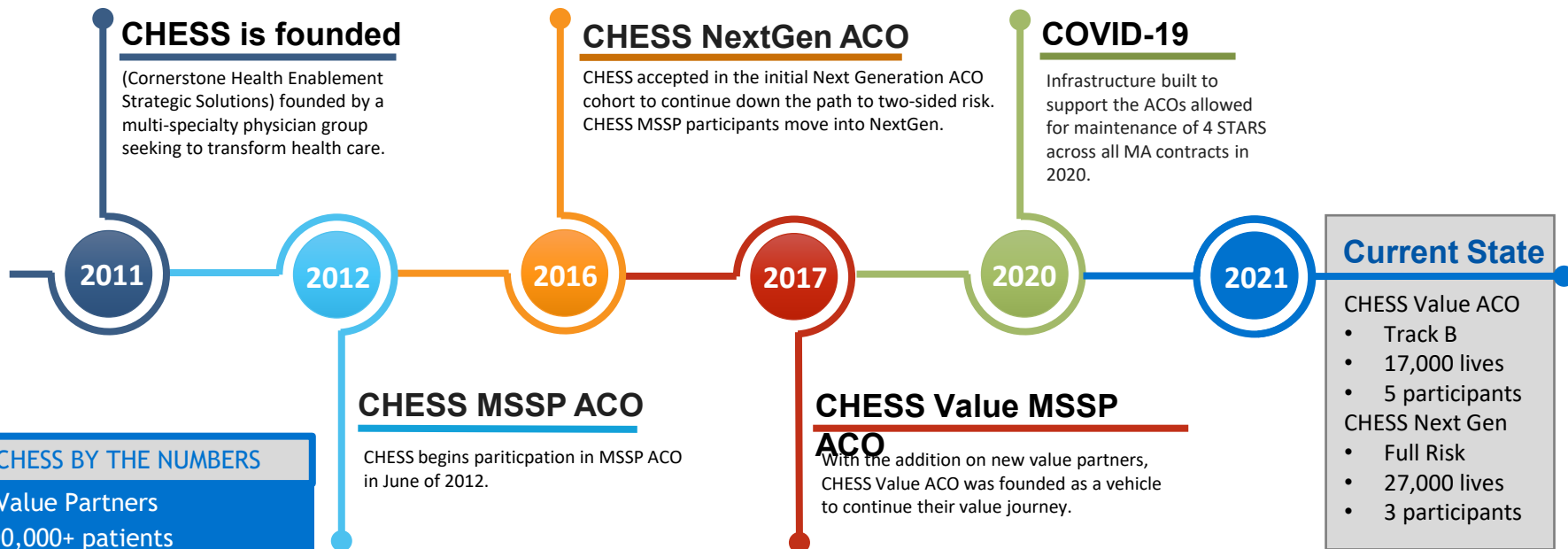


How Medicare
Advantage Experience
Drives ACO/Direct
Contracting Success

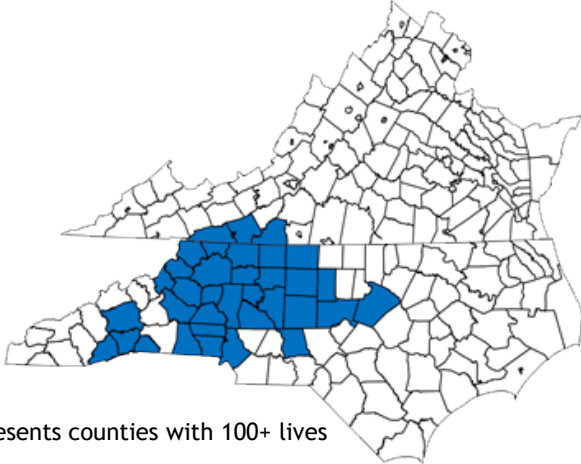
Friday, October 1st



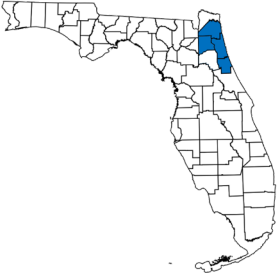
The CHES Value Journey in CMS/CMMI Models



CHES Value Partners

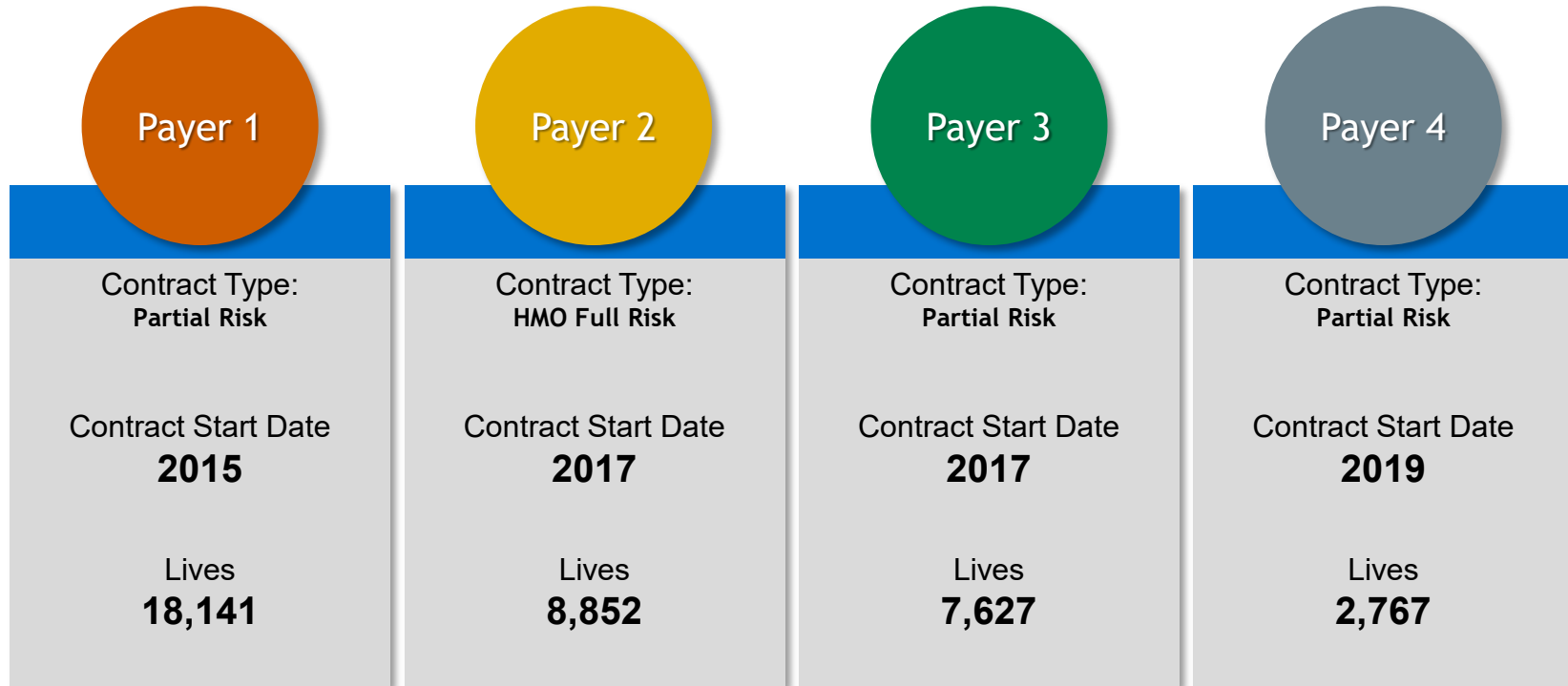


North Carolina Clinically Integrated Network



FCHA Florida Clinically Integrated Network
 83 practices and 170 participating providers
 in eastern Florida

CHES Medicare Advantage Risk Contracts



Pre-COVID ACO Success (key programs, initiatives, success measures)

Intensivist Clinic	Multi-disciplinary high utilizer reviews (Health Navigators, Pharmacists, Social Workers)	Leakage Strategy
<p>Multidisciplinary team seeing value-based patients post hospitalization and partnering with PCPs</p> <p>Annual Impact (~700 patients)</p> <ul style="list-style-type: none">• 4.1% absolute decrease in readmissions• 14.1% decrease in total admissions• \$3.4 million revenue generated and costs avoided - \$700k operating cost = Estimated \$2.7 million net impact	<p>Social Worker has been a great addition</p> <p>Recent CHES analysis found:</p> <ul style="list-style-type: none">• 50% reduction in utilization across the cohort• \$4.4M cost reduction from decrease in utilization• 30% patients had zero utilization post interdisciplinary conference	<p>ADT Feeds (e.g., Bamboo Health (formerly Patient Ping), direct feeds from hospitals) manual facility outreach to maximize awareness of utilization</p>



Incorporating MA Successes into ACO Programs

Ways we have replicated MA operations for our CMS ACO

Supplemental benefits

- 3-day SNF waiver - common offering in MA plans
- CHES NextGen Fund for medication assistance
- Transportation assistance (currently evaluating)

AWV outreach stratification

CHES Outreach Score that incorporates:

- Last AWV, Last PCP visit, Total Quality Gaps, RAF, IP, ED, Total Spend

ACO quality gap lists

- Created from claims and clinical data to mimic payer quality gap lists and summaries

ACO suspect condition list

- Created using claims and clinical data for chronic recapture, BMI, CKD

Transitions notifications

- Applied MA process with ADT data as CMS doesn't provide daily census



Gleanings from the ACOs: Translated to MA

- Preferred Provider Network required for SNF waiver used in discussions with payers
- Helped us understand how to better protect data (CMS sets a high bar)
- Took PIC committee structure and translated to broader network for increased visibility into all contracts (Medicare, MA, Commercial)
- ACO policies helped us structure CHES initiatives for the broader enterprise (CMS requires specific policies)
- Helped us develop minimum necessary reporting requirements from payers



Lessons Learned



Biggest Win

AWV Stratification work

Allowed Care Coordination teams to segment and effectively prioritize patients.

Quality gap lists

Integration of claims and clinical data assisted in accurate outreach.

Biggest Disappointment

Medication Assistance Program within the Next Generation ACO

The program did not yield as much patient usage as initially expected. This was due to several factors including:

- Manufacturers widened their criteria to allow for more patients to use their coupons
- Large administrative burden on Pharmacy team



MAXhealth

ACO/DCE Contracting

How Medicare Advantage Experience Drives ACO/DCE Contracting Success

Raj Naik, M.D.
Executive Vice
President
MAXhealth / BVHC



My Healthcare Journey



- 35+ years experience as a physician in value-based arrangements
- Founded Best Value in 2015 – partnered with Arsenal Capital Partners in 2020
- Previously founded Best Care Family & Geriatric Care (sold to DaVita in 2012)

Best Group IPA eclipses 20,000 full-risk MA Lives and over 10,000 full risk Managed Medicaid lives in FL, GA, KY, TX – Sold to DaVita

Joined Palm Beach ACO

Sold Majority Interest in Best Value to Arsenal Capital Partners

1987	2012	2015	2017	2020 1H	2020 2H	2021
------	------	------	------	---------	---------	------

Earned first Humana Medicare HMO – Full Risk Agreement

Co-Founded Best Value Healthcare in FL

Co-Founded Advanced Doctors ACO

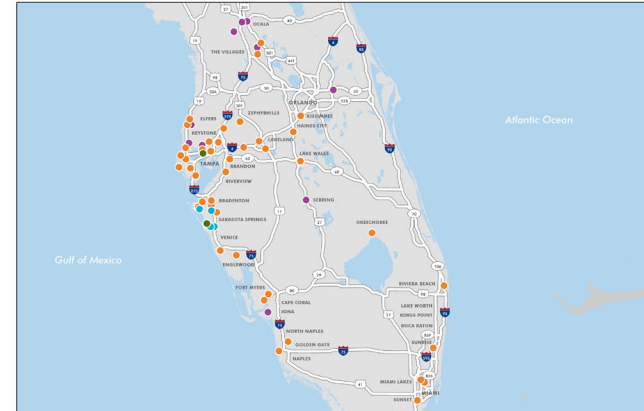
Professional DCE awarded to BVHC – purchased MAXhealth and acquired control of their Global DCE

Business Overview

- Leading value-based primary care platform focused on Medicare, Medicare Advantage and Managed Medicaid patients operating in Central and South FL with ~47,650 VBC members
- ~18,800 MA full-risk lives across 53 owned and 15 affiliate clinics (24 providers)
- ~8,750 attributed Medicare FFS lives in CMMI Direct Contracting Entity models for performance year 2021
- Contractual relationships with 15 health plans in Florida with optionality available to expand in other states
- ~4.5 STARS rating across owned locations ⁽¹⁾
- 92 employed primary care providers and 15 specialists
- ~500 team members with expertise in managing chronic patient populations
- Significant experience providing best-in-class patient experience focused on helping the sick become well by providing a comprehensive care model that assists patients in taking control of their health
- Since partnering with Arsenal in November 2020, the Company has closed six acquisitions, leveraging the group's affiliate network for three of the transactions

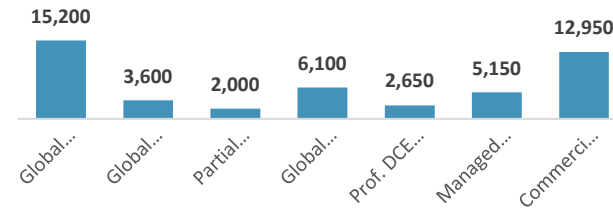
Geographic Presence

53 owned clinics and 15 affiliate clinics



● Corporate ● Primary Care ● Specialists ● Affiliates

Value-Based Care Membership Overview ⁽²⁾



Risk Stratification Report (“RSR”) Enables a Consolidated View of High-Risk Patients to Eliminate Potential Care Gaps

The Risk Stratification Report (“RSR”) is a weekly report that takes EMR and payor data and displays it in a comprehensive view, identifying key outputs

The RSR Identifies...

High Risk / High Utilizing Patients

Costly Patients
(High Paid Medical Expenses)

Patient Billing & Insurance Accuracy

In-Office Appointment Cadence

Patients Not Seen

Internal Provider / Extender Utilization
Appropriateness

Mismatch between Risk Membership Payor Roster
and EMR Patient Record

Emergency Room Frequent Flyers

Weekly RSR is Used to...

Facilitate clinic level outcomes discussions between Health Coach / Center Manager, Medical Director and Chief Operating Officer

Provide discussion points for weekly meetings between Medical Directors and individual PCPs

Assist Health Coaches in appropriately targeting outreach, which includes checking-in and proactively scheduling appointments for patients identified as ER frequent flyers

**Pre-COVID
MA / ACO
Success**



Access to Care – EMR data to give visit priority to patients not seen in the last six (6) months



Health Coach Program – Organized effort to call high-risk patients weekly – address social determinants of health – break down barriers to care (i.e. transportation Uber / Lyft)



Risk Stratification (RSR) – Weekly report outlining the highest-risk members used to address any and all outstanding needs or requirements



Census Report / Meeting – Weekly review with all clinical / care management resources to review and identify all patients currently at hospitals, their needs, and address next steps



Year End Assessment (YEA) – Twice yearly forms leveraging our proprietary algorithm using EMR / payer data to close care gaps

New in ACO



No Part D risk



No referrals, but gatekeeper model still works – PCP selects and manages preferred specialists



Appropriate monitoring of HHC use



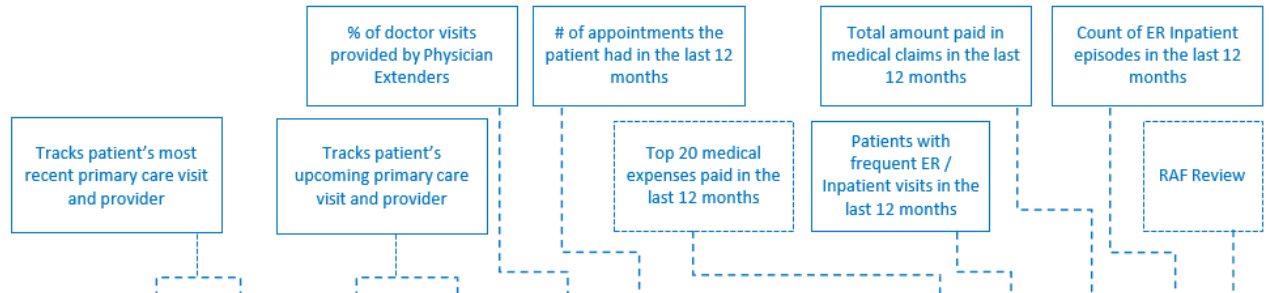
Appropriate utilization of SNF, LTAC, IRF



Big Win: Treating Medicare FFS members like MA Full Risk Members

Big Bomb: Claims delay and Voluntary Alignment

Care Team Able to Quickly Analyze Highest Risk Patients through RSR and Determine Near-Term Action Plan



Center	Patient	DOB	Last Scheduled Appt	Last Scheduled Provider	Next Scheduled Appt	Next Scheduled Provider	Percent Extdr Visits	Last 12mo Appt Count	LOB	Payor	Top 20 Flag T12	Freq Util Flag T12	Paid Med Clms T12	ER INPT Episodes T12	RAF Score
Cypress Medical Center	Patient 1	01/01/1900	2020-06-10	Provider 1	2020-06-17	Provider 1	0.00%	20	MAHMO	Payor 1	Y	Y	111,554	12	4.14
	Patient 2	01/01/1900	2020-06-11	Provider 2	2020-07-01	Provider 2	0.00%	11	MAHMO	Payor 1	Y	Y	46,516	11	2.69
	Patient 3	01/01/1900	2020-04-07	Provider 2	2020-06-17	Provider 2	0.00%	3	MAHMO	Payor 1	Y	Y	28,441	10	0.77
	Patient 4	01/01/1900	2020-05-28	Provider 2	2020-06-18	Provider 2	0.00%	7	MAHMO	Payor 1	Y	Y	59,409	7	4.37
	Patient 5	01/01/1900	2020-06-10	Provider 1	2020-06-18	Provider 1	8.00%	9	MAHMO	Payor 2	Y	Y	28,453	5	4.33
	Patient 6	01/01/1900	2020-05-27	Provider 1	2020-07-01	Provider 1	4.00%	17	MAHMO	Payor 1	Y	Y	26,634	5	2.92
	Patient 7	01/01/1900	2020-05-13	Provider 2	2020-07-15	Provider 2	0.00%	16	MAHMO	Payor 1	Y	Y	98,074	3	1.02
	Patient 8	01/01/1900	2020-06-11	Provider 2	2020-07-09	Provider 2	0.00%	11	MAHMO	Payor 1	Y	Y	76,496	3	1.11
	Patient 9	01/01/1900	2020-05-21	Provider 2	2020-06-24	Provider 2	0.00%	27	MAHMO	Payor 1	Y	Y	70,392	2	4.36
	Patient 10	01/01/1900	2020-06-11	Provider 2	2020-07-09	Provider 2	0.00%	12	MAHMO	Payor 3	Y	Y	24,225	2	2.72
	Patient 11	01/01/1900	2019-03-08	Provider 2	None Found	Provider 2	0.00%	0	MAHMO	Payor 4	Y	Y	22,191	2	2.95
	Patient 12	01/01/1900	2020-06-12	Provider 1	2020-07-10	Provider 1	0.00%	4	MAHMO	Payor 3	Y	Y	19,644	2	0.79
	Patient 13	01/01/1900	2020-06-12	Provider 2	2020-06-26	Provider 2	0.00%	23	MAHMO	Payor 1	Y		39,138	1	2.56
	Patient 14	01/01/1900	2020-04-15	Provider 2	None Found	Provider 2	0.00%	9	MAHMO	Payor 1	Y		26,022	1	2.3
	Patient 15	01/01/1900	2020-05-29	Provider 1	2020-07-08	Provider 1	0.00%	9	MAHMO	Payor 3	Y		24,199	1	3.69

Health Coaching Program

Health Coach Program is Focused on Managing High Risk Patients

- Launched in early 2020, target patients are identified through RSR, primary care provider or case manager referrals, or based on discharge data
- Target patients are likely to be high cost or high utilization and require very proactive outreach
- Each Health Coach is responsible for 40 – 60 calls per day and patients are assigned based on clinic locations and geography
- Health Coach calls patients weekly, tracks progress and shares interventions and outcomes with clinical team
- Initial outreach breaks communication barrier with patient and establishes Health Coach as a friend, easing path to future touchpoints
- With increased compliance and monitoring, touchpoint frequency and length can be adjusted

Patient Engagement Protocol

Call Scripts & Protocols

Verify Insurance in RSR

Weekly Outreach to High Risk Patients

Referral & Discharge List Assigned by Case Manager

Schedule Appt.

Verify Provider

~15% of patients requiring appointments scheduled them through the call center

Data on ~90% of patients

~3,000 calls per month

Non-reachable: 3 call attempts, then two-way text via **TextMagic**

Note: (1) National Committee for Quality Assurance 2017 Emergency Department Utilization Rate.

Multitude of Factors Addressed Through Weekly Calls



- Barriers to Care (psychosocial, behavioral, physical and cognitive)
 - Encourage seeking behavioral health management
 - Coordinate with family member to remove physical barrier
- Social Determinants of Health (housing, food, transportation, loneliness, finances)
- Verify all patients have appointments scheduled every 2 – 3 months
- Same day appointment for primary care consultation
- Speedy referral process and medication refills

Early Success in Improving Care and Managing Utilization

Significant decline in hospital visits due to increased outreach efforts in 2020

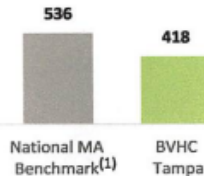
Patient 1 ER Visits



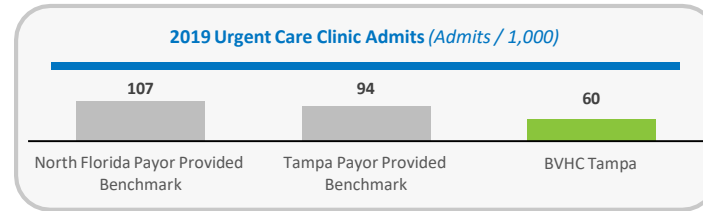
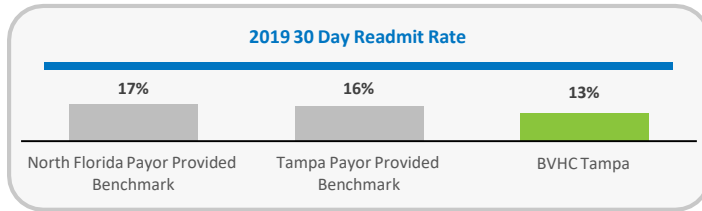
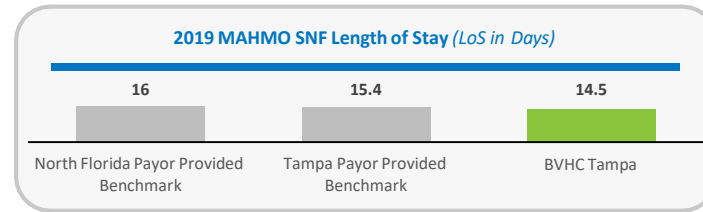
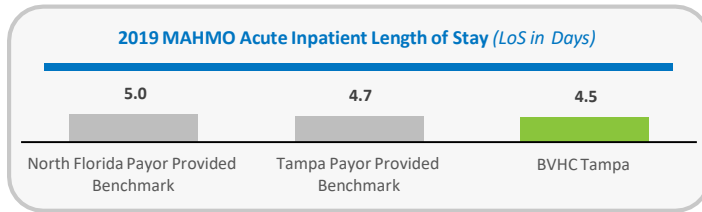
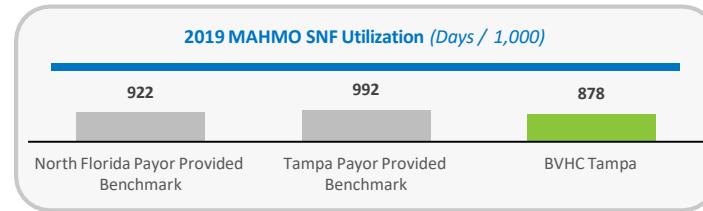
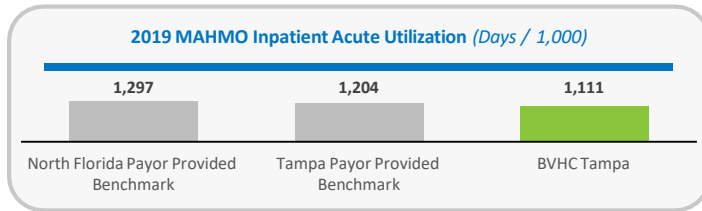
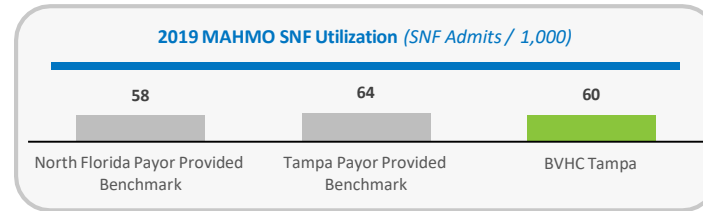
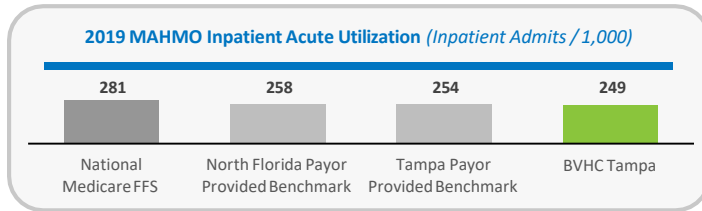
Patient 2 ER Visits



Highly Successful in Reducing ER Admissions (ER Admits / 1,000)



Active Case Management – Performance



Note: Figures represent owned locations.
Source: Based on market benchmarks provided by Humana; Centers for Medicare & Medicaid Services

How Medicare Advantage experience drives ACO/Direct Contracting Success

Dr. Daniel Wendorff
President Mount Carmel
Health Partners



Medicare ACO

Next Generation ACO – Trinity Health ACO

- Lives pooled nationally with 2 other CINs (Loyola & West MI) and large multi-specialty medical group in NJ (Summit)
- 69,763 total lives nationally
- 11,039 in Columbus at Mount Carmel Health Partners
- Moved from local MSSP Track 1 to Next Generation ACO in 2016



Medicare Advantage VBAs

Medicare Advantage VBA	Date of Contract	Level of Risk	Attributed Lives
Aetna	2015 2020	Upside-only Enhanced Upside-only as unable to reach agreement on Full Risk	5,910
Anthem	2015 2020	Upside-only Full Upside/Downside	6,501
Humana	2014 2019 2020	Performance Incentive Upside-Only Full Upside/Downside	5,324
MediGold	2009 2017 2019	Performance Incentive Upside-only Full Upside/Downside	13,721
Medical Mutual of Ohio	2019	Upside-only Re-evaluate Payor Readiness for Full Risk for 1.1.23	1,564
UnitedHealthcare	2020	Performance Incentive	5,205

Pre-COVID Success



Population health TCM and longitudinal CM

- Better care navigation for patients and collaboration with providers



Data and analytics support

- Leverage multiple datasets to target highest-needs patients



Pre-visit planning certified risk coders

- Coding and documenting full burden of illness



Quality specialists with integrated gap in care database

- Reduce reliance on claims for gaps – more accurate, actionable scheduling



Performance-based incentive program

- Improved buy-in and understanding of levers for success



MA Experience Transferred to ACO

Annual scheduling lists with patient info

- Provides easy access to panel contact information for scheduling

Emphasize importance of annual wellness visits

- Reinforces primary care relationship and preventative health for challenging population (patient engagement)

Quarterly provider engagement meetings

- Regular meeting cadence increases provider engagement, highlights areas needing focus

Support closing quality gaps in care

- Dedicated resources to support scheduling visits for patients with gaps in care



ACO Experience Transferred to MA

System office support from Trinity Health

- MECA claims database and system office data analytics

SNF collaboration

- Open communication between SNF staff, SNF physicians, and navigators



Lessons Learned, Wins, and Misses

Lessons Learned

- Providers want to treat all patients the same, regardless of payor
- Move to common quality metrics and workflows = better engagement from providers
- Involvement in several MA VBAs allows scaled programs, same goals

Biggest Win

- Evolution of performance-based incentive program has spurred engagement

Biggest Miss

- Overly conservative provider selection for NGACO