Medicare Direct Contracting

What Providers and Payors Need to Succeed

March 2021

Introducing Our Speakers

Allen Miller
Principal &
Chief Executive Officer
COPE Health Solutions

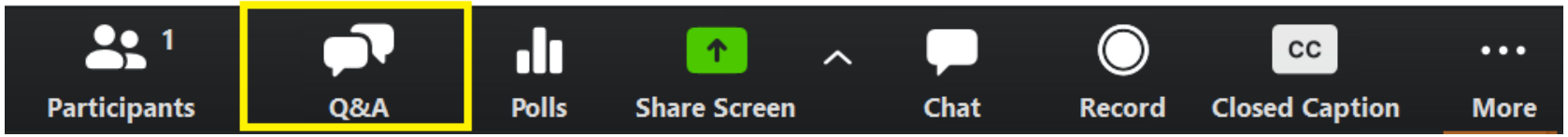
Lesley Reeder, RN
Vice President
COPE Health Solutions

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

David Weathington
Former Senior Vice
President, Health Plan
Operations

Housekeeping

- Please enter questions through the Q&A feature in Zoom (screenshot below), and we will answer questions at the end
  - You may also email questions directly to info@copehealthsolutions.com



- Attendees will receive a PDF copy of the presentation, a link to the recording and a written Q&A

- After the presentation, COPE Health Solutions will send out a brief survey—we'd greatly appreciate you sharing any comments or feedback!

Agenda

1. Defining the Opportunity
2. Provider Perspective
3. Payer Perspective
4. Keys to Success
5. Closing Remarks

Becoming a Direct Contracting Entity

There are three models for becoming a Direct Contracting Entity (DCE):

Standard	High Needs Population	New Entrant
• Have substantial experience serving Medicare FFS beneficiaries • May have participated in section 1115A and/or Shared Savings Program • Minimum 5,000 attributed at beginning of IP or PY1	• Focus on beneficiaries with complex, high needs • Focus on dually eligible individuals • Much lower attribution requirements, from 250 in year one to 1,400 by year five	• Have limited historical experience Medicare ACO programs • Beneficiaries aligned via claims in any baseline year must not exceed 3,000 • Incremental growth to 5,000 attributed over four years

Within each of these models, there are two levels of risk and two types of capitation:

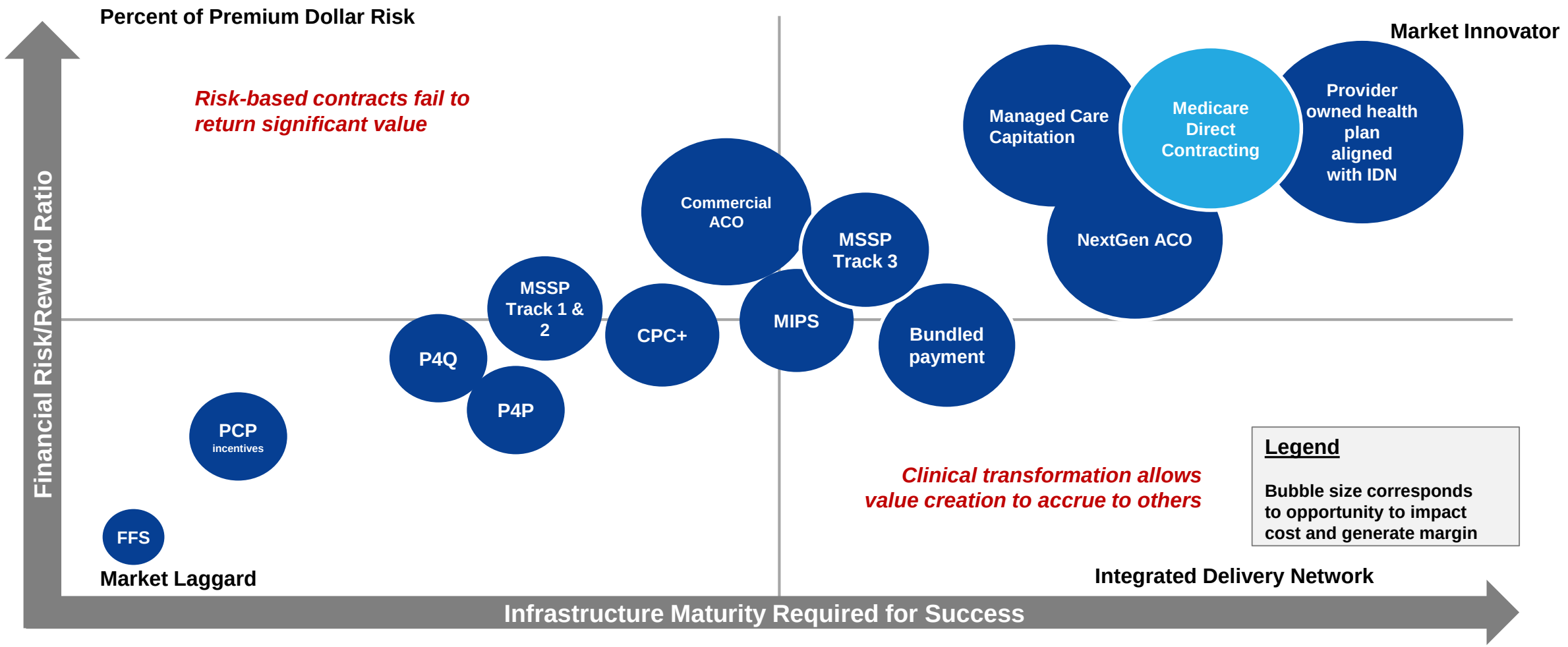
		Primary Care Capitation	Total Care Capitation
Professional	• 50% of savings / losses • Risk corridors with higher cut-offs • Stop-loss for random, high cost expenditures	Only available capitation payment mechanism for Professional	*Not Available*
Global	• 100% of savings / losses • Risk corridors with lower cut-offs • Stop-loss for random, high cost expenditures	Optional – must select one of the two capitation payment mechanisms	Optional – must select one of the two capitation payment mechanisms

Geographic is delayed, may be available for 2023

These represent high-level requirements and are not comprehensive

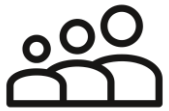
COPE HEALTH SOLUTIONS

Value-Based Reimbursement Continuum

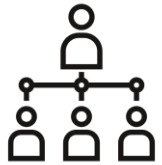


COPE HEALTH SOLUTIONS

Value of MDC to Payers and Providers



Unique ability to **access to premium for Medicare**



Ability to **outreach to beneficiaries and grow attribution**

Consolidated quality metrics aligned with total cost of care reduction goals

Coordinated benefits for dual-eligible members

Enhanced **cash flow** and **first-dollar savings** with no Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR)

Allows for ability to add **supplemental benefits** outside of the medical loss ratio

Ability to have a **contracted network** with **aligned incentives** for Medicare Fee for Service Beneficiaries

Affords additional **economies of scale** to overall VBP strategy

COPE HEALTH SOLUTIONS

Medicare Direct Contracting: Considerations from a Provider

Richard Lipeles, Chief Operating Officer

COPE HEALTH SOLUTIONS

Heritage Provider Network

Quick Facts and Organizational Overview

Total Enrollment	Over 1M*	Facility-Based Physicians	1,000+
Primary Care Physicians	4,000+	RAF Score	Up to 1.6
Specialist Physicians	33,000+	Star Rating	4.5 Average

One of the largest health care delivery systems in the U.S.

- Designed to take full risk with over 40 years of success operating in managed care environments
- Leading market presence in California, New York, and Arizona; growing presence in multiple new markets

Preferred full risk partner for health plans

- Consistently deliver strong results in both new expansion and previously underperforming markets
- Successful track record across all market types is clear competitive differentiator: rural (low revenue), suburban and urban (high revenue) markets
- Success in all product lines (MA, commercial, Medicaid, Duals, Exchange)

Unique delivery model focused on quality outcomes

- Clinics with wrap-around IPA and Stand alone IPAs
- Patient-centric, physician-driven model with Comprehensive care management
- Strong clinical results

*Includes FFS Patients and staff clinics

Heritage Provider Network

Medicare Direct Contracting presented an opportunity to expand risk-based revenue and market share while improving patient outcomes with population health principles

Revenue

- Medicare FFS revenues migrated to a risk model to align with other LOBs
- Ability to distribute more revenue over population health management infrastructure

Growth

- Add attributed lives through expansion of Medicare book of business, with ability to transition some volumes to MA
- Leverage beneficiary engagement tools and voluntary alignment to align lives, and explore effectiveness of these tools to support PCPs in retention and, perhaps, expansion

Network

- Strengthens value proposition to PCPs by offering full portfolio of products
- Aggregate FFS patient volumes utilizing network hospitals under risk model
- Expand share of referral volumes to high quality specialists
- Improve coordination and thus ability to manage total cost of care

COPE HEALTH SOLUTIONS

Heritage Provider Network

HPN enhances Health benefits through exclusive value added services and award winning coordinated care programs which means unparalleled care and value available only to our members

Key Operating Principles

- Healthcare is local and should be delivered locally
- Use technology to scale and expand operations
- Share best practices and benchmark against best performers (which are often other Heritage groups)

Avoid a direct contracting silo: Incorporate MDC into a value driving business model, and leverage for continued enhancement

Heritage Provider Network

Heritage has opted for independent, local DCEs managed by local leadership, with the benefit of leveraging broader HPN technology and best practices

Health care is local	• Local market branding and identities • Local management accountability – separate DCEs established in AZ (New Entrant) and CA (Standard) • Care management programs lead by local medical directors and leadership
Use technology to scale and expand operations	• Centralized technology resources available to all groups, but implemented locally • Leverage home-grown population health management platform designed to manage risk, now available as a separate product through Geniq, an independently operated company
Share best practices and benchmark against best performers	• Continue to measure the 11 core businesses across a variety of attributes and best practices • Goal is not to promote competition among internal groups but rather create forums for sharing of best practice initiatives and operations

Medicare Direct Contracting: Considerations from a Payer

David Weathington, Former Senior Vice President, Health Plan Operations

COPE HEALTH SOLUTIONS

Health Plan Perspective

Medicare Direct Contracting advances the vertical integration of payors and providers, transfer of risk closer to care delivery, and allows for deepened physician and member engagement

Revenue

- Allows health plan entry into Medicare FFS line of business, increasing revenue capture
- Broadens eligible population and allows capture of revenue for existing FFS beneficiaries engaging network practices
- Improved quality performance driven by increased panel share / provider engagement

Growth

- Expand brand recognition among FFS beneficiaries, which is transferrable across Medicare products
- Direct beneficiary engagement can attract volumes and propel growth
- Increased provider engagement through direct contracting will lead to increased provider awareness of other products

Network

- Increase panel share among network providers to better incentivize performance, particularly in markets with low MA penetration
- Ability to improve physician engagement with an aligned incentive model

COPE HEALTH SOLUTIONS

Health Plan Perspective

Operationalizing success requires a coherent approach aligning operations with stakeholder engagement

Optimize Attribution

- Targeted approach to participating provider selection
- Detailed execution plan for voluntary alignment

Engage Provider Community

- Virtual provider onboarding for workflow and technology
- Assignment of customer success managers by practice

Manage Medical Expense

- Preferred provider strategy
- External partnerships for complex care management
- Capitated payment model for participating providers

FFS Beneficiary Awareness

- Medicare approved marketing strategy
- Use of Medicare Waiver benefits
- Provider partnership

COPE HEALTH SOLUTIONS

Keys to Success in Medicare Direct Contracting

Lesley Reeder, Vice President
COPE Health Solutions

Ticket to Play

- A DCE must demonstrate compliance with all applicable **state licensure** requirements regarding risk-bearing entities
- A DCE must be a **legal entity** identified by a federal taxpayer identification number (TIN) that contracts with Direct Contracting (DC) Participant Providers
- Applicants will not be expected to have formed their legal entity or to have verified state licensure until after participant selection but will be required to have satisfied these requirements before executing the **Direct Contracting Model Participation Agreement** with CMS
- A DCE will not be required to be a Medicare-enrolled provider or supplier in order to participate in Direct Contracting, however, all Participant Providers must be a **Medicare-enrolled provider or supplier** prior to the start of the Performance Year
- Additional competencies needed:
  - Adequate operating capital and risk reserves
  - Contracted provider network
  - Capabilities to manage risk (patient engagement, population health analytics, care management, provider relations, capitation management etc.)

Driving Revenue in Medicare Direct Contracting

Like other value based programs, DCEs will need to drive toward quality, control costs, and manage referral patterns to keep care in the community setting

Quality Earn-backs	• 5% Withhold to earn back • Emphasis on CAHPS and avoidable admissions	• Member Satisfaction is best promoted at the site of care, supported by strategically centralized activities • Best practice care management, care planning key driver of outcomes • Leverage Network and Beneficiary Engagement Tools
Performance/ Shared Savings	• 50 – 100% savings/losses • Built in risk corridors and optional stop-loss	• Understand Relationship between your performance and regional benchmark • Plan for true-ups and reconciliations in the budget • Develop a thoughtful and transparent funds flow strategy • Leverage community based strategies in network and care model
Capitated Payments	• Calculated based on PBPM Benchmark and Aligned Beneficiares	• Develop strategies for Voluntary Alignment and Beneficiary Retention • Maximize HCC documentation as soon as possible • Manage referral patterns and promote “stickiness” in participant providers

Population Health Data Analytics

Network Management & Provider Incentives

COPE HEALTH SOLUTIONS

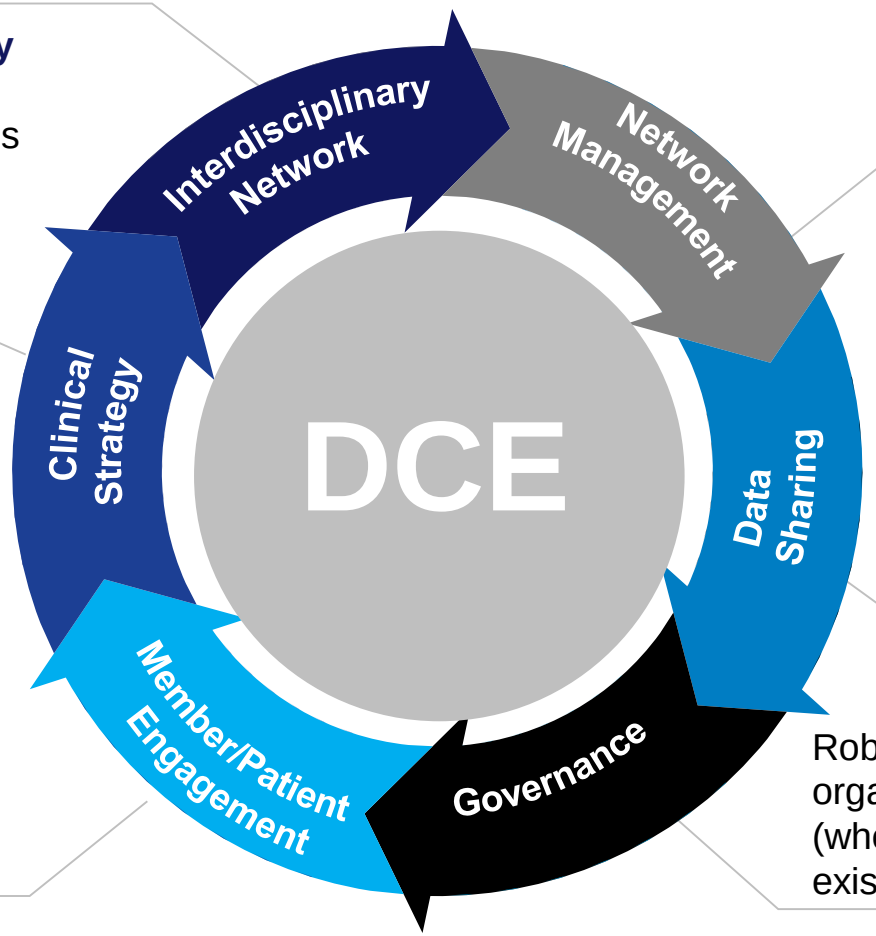
Success as a Direct Contracting Entity

Driving greater value from Medicare FFS Beneficiary premium dollars

Composing an **interdisciplinary network** to drive outcomes and address clinical and social needs

Clinical Strategy that drives quality through focus on value-driving programs

Member/Patient Engagement to drive satisfaction and alignment



Manage the Network through targeted engagement & aligned incentives

Strong **data analytics & sharing** platform

Robust **governance** and organizational structure for DCE (when applicable, aligned with existing ACO, IPA, CIN)

COPE HEALTH SOLUTIONS

Closing Remarks

Allen Miller, Principal & Chief Executive Officer
COPE Health Solutions

Key Takeaways

What should I be doing today if I'm launching or considering MDC?

April 1, 2021 Performance Period Start	January 1, 2022 Performance Year Start
• Understand your current benchmark and establish clear performance targets • Educate providers on ways to promote voluntary alignment • Establish funds flow and contracting strategy that encourages in-network referrals • Deploy targeted care management initiatives to support beneficiaries • Monitor and tightly manage alignment to quickly identify churn or attrition	• If available, analyze existing Shared Savings ACO data for attributed Medicare FFS members • Incorporate lessons learned and best practices from early program results • Use lead time to build/improve core population health infrastructure and consider funds flow and contracting strategy • Identify and engage target providers essential for driving performance and beneficiary alignment • Optimize HCC scores through improved documentation to impact future benchmarking and capitation payments • Prepare risk management strategy and budgeting approach to capitalize on cash flow benefits

Questions & Answers (Q&A)

For more information on how COPE Health Solutions can provide quick, prepared and valuable services during a critical time of need, please contact our team at info@copehealthsolutions.com or 213-259-0245.

www.copehealthsolutions.com