



# Collaborative Health Systems

a Universal American company

## CHS and ACO Overview

May 2016



**COLLABORATIVE  
HEALTH SYSTEMS**



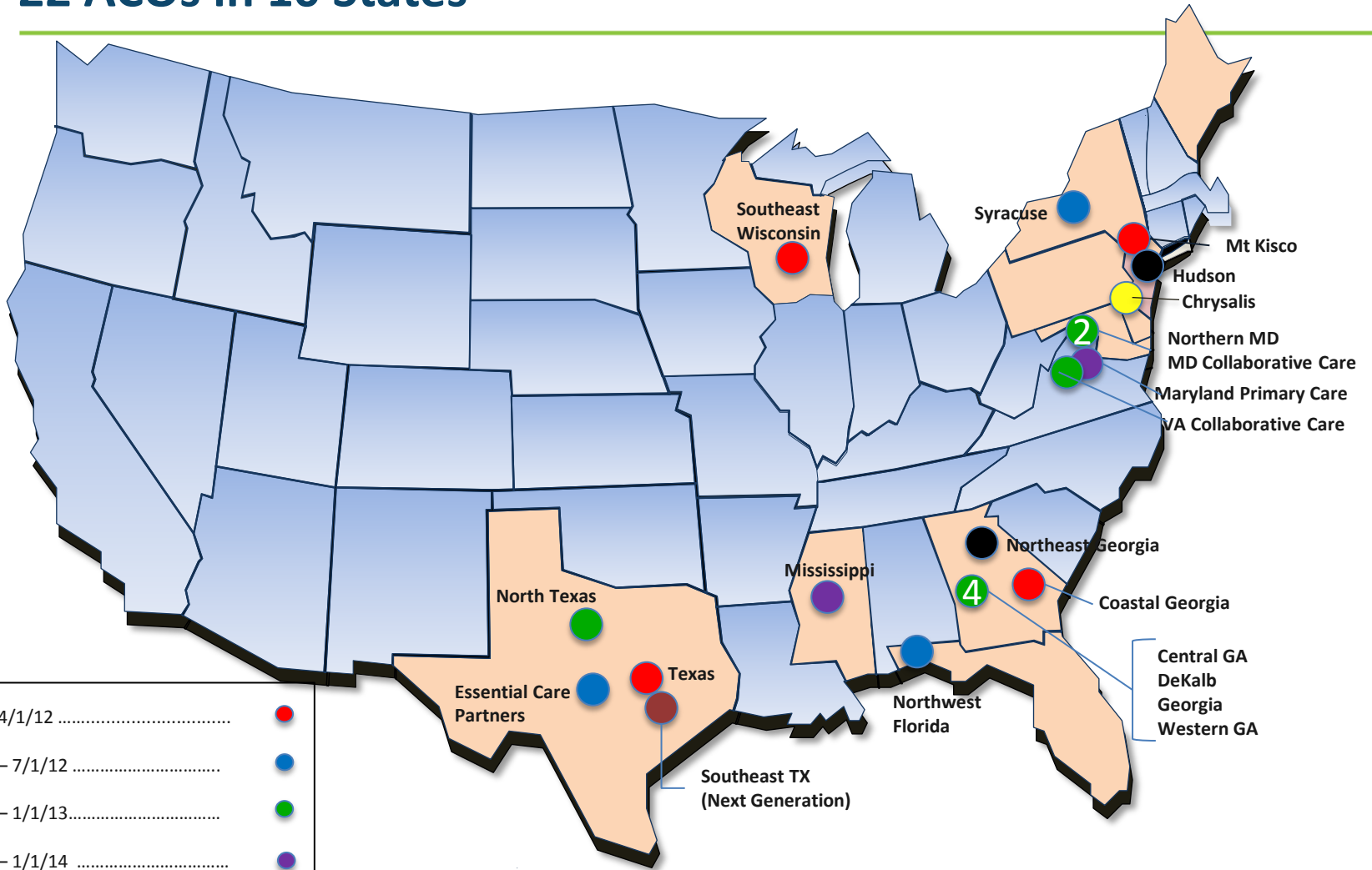
## CHS Is the Largest Sponsor of MSSP ACOs

---

- Collaborative Health Systems (CHS) is a wholly-owned subsidiary of Universal American Corp. (NYSE: UAM), which, through its health maintenance organizations and health insurance companies, offers and administers MA plans in Texas, New York, and Maine.
- CHS currently manages 22 MSSP ACOs, with more than 4,000 ACO providers, covering approximately 337,000 assignable Medicare beneficiaries in 13 states.
- We are champions of the independent, primary care physician (PCP)
- Universal American is the largest sponsor of MSSP ACOs in the country and has invested over \$100 million in MSSP ACOs since the program's inception in April 2012. Investments include:
  - Innovative population health information technology tools and analytics
  - Clinical care coordination and care management programs to help community-based physicians deliver high-value care.
- Our ACOs have generated savings to CMS of over \$137 million for PY2012, PY2013, and PY2014 combined.



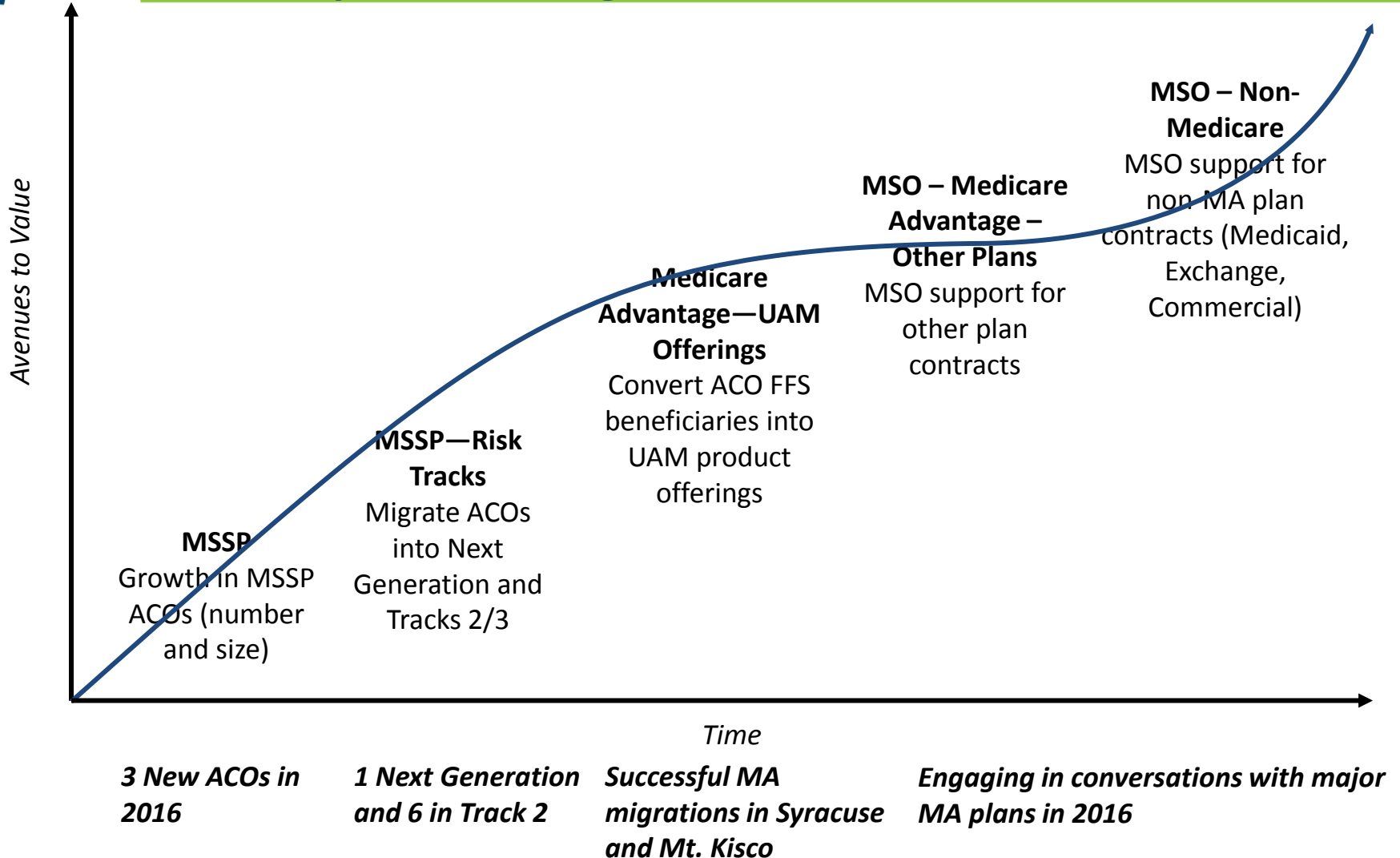
# 22 ACOs in 10 States



4 Approved ACOs 4/1/12 .....	●
4 Approved ACOs – 7/1/12 .....	●
8 Approved ACOs – 1/1/13.....	●
2 Approved ACOs – 1/1/14 .....	●
1 Approved ACO – 1/1/15 .....	●
2 Approved ACOs – 1/1/16 .....	●
1 Approved Next Generation ACO – 1/1/16 ..	●



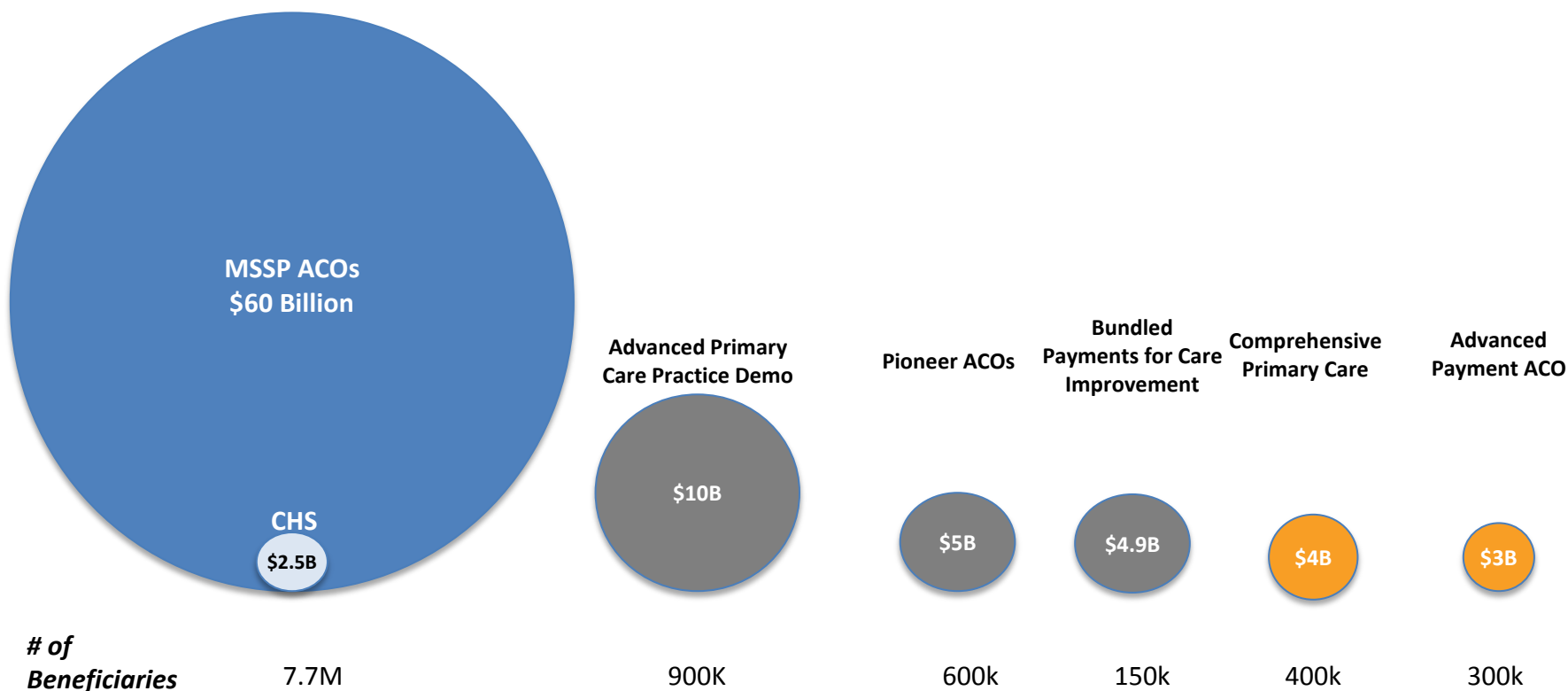
# Our ACOs Are Transitioning Up the Curve to Greater Risk-Based Payment Arrangements





# While CMS is Testing Many Models, MSSP is, by far, the Largest Initiative to Reduce the Rising Cost of Health Care

Estimated Total Medicare FFS Spend Managed\*, 2016



# of Beneficiaries

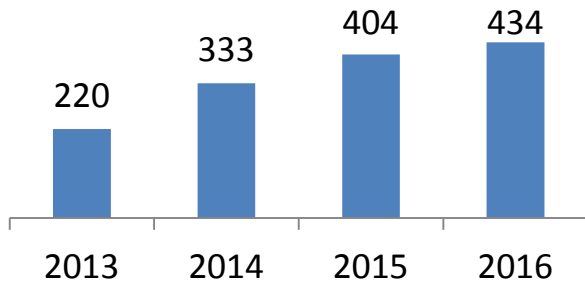
\*Estimates based on total Medicare FFS expenditures of \$445 Billion and number of Medicare beneficiaries enrolled in each model. Source: CMS, Lewin Group BPCI Analysis, CMMI, "Two Year Cost and Quality in the Comprehensive Primary Care Initiative," NEJM.



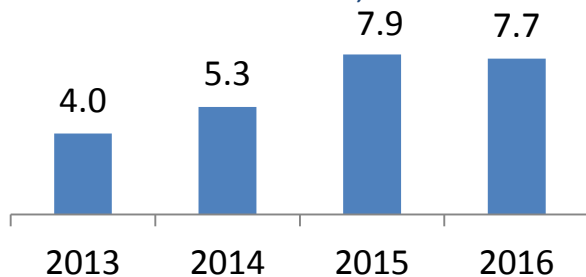
# To Date, the MSSP Has Had Mixed Success

## Significant Growth in ACOs and Attributed Lives

### Medicare ACOs



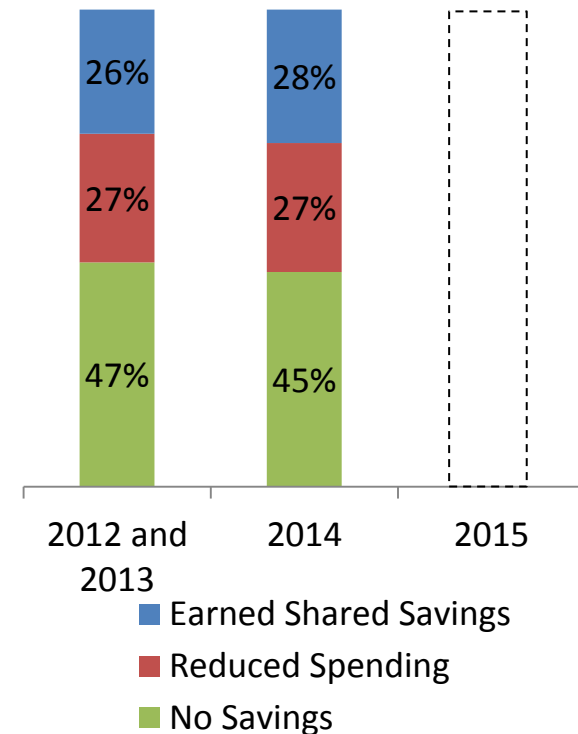
### Medicare Beneficiaries Receiving Care from ACOs, Millions



## Positive Quality Results and CMS Realized Savings

- The first three years of the program can best be described as a valuable learning experience for all participants
- In PY 2013, MSSP ACOs improved on 30 of 33 quality measures
- ACOs that reported in both performance year two and three showed improvement in 27 out of the 33 quality measures
- \$315 million in shared savings earned by 2012/13 MSSP ACOs and \$341 million earned in 2014

## ...However, Less Than 1/3 of Participants Earn Shared Savings\* Financial Results by MSSP ACO Cohorts



Source: CMS.gov; <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>

\*Results based on 220 MSSP ACOs in 2012/2013 and 333 in 2014.



# CMS Proposed Several Changes to Improve MSSP in 2017

In January, CMS released a proposed benchmarking rule for MSSP that would improve the benchmarking methodology by incorporating regional spending. We anticipate the rule will be released in June 2016.

Proposed Change	Detailed Description
<b>Incorporate regional FFS expenditures into the benchmarking methodology</b> <i>*Note: Only applies to second or subsequent agreement period beginning on or after 1/1/17</i>	<ul style="list-style-type: none"><li>• <b>Replace the national trend factor with a regional trend factor</b> to rebase and update the benchmark annually.</li><li>• <b>Gradually incorporate regional spending</b> into the ACO's benchmark.</li><li>• <b>Remove the shared savings adjustment</b> when rebasing the benchmark.</li><li>• <b>Define region according to counties</b>, weighted by the proportion of the ACO's beneficiaries in the county for all but ESRD beneficiaries.</li><li>• <b>Use all beneficiaries eligible for ACO assignment</b> (as opposed to all FFS) when determining regional expenditures</li><li>• <b>Account for regional differences in risk-adjustment</b> when adjusting the rebased benchmark.</li></ul>
<b>Facilitate transition to risk</b>	<ul style="list-style-type: none"><li>• <b>Add an option</b> for Track One ACOs <b>to extend for one year and defer moving</b> to Track Two or Three</li></ul>
<b>Streamline the methodology for adjusting an ACO's benchmark when its composition changes</b>	<ul style="list-style-type: none"><li>• <b>Adjust an ACO's historical benchmark for changes in participant composition using an expenditure ratio calculated for a single year</b> (as opposed to the current methodology that recalculates based on three years)</li></ul>
<b>Refine criteria for reopening financial reconciliation decisions</b>	<ul style="list-style-type: none"><li>• <b>Set a four-year limit</b> on reopening shared savings or losses determinations (contingent on good cause, such as new material evidence).</li></ul>
<b>Provide enhanced access to ACO data</b>	<ul style="list-style-type: none"><li>• <b>Publish new data files</b>, including per capita county-level FFS spending an risk scores for 3 historical years .</li></ul>

Source: Proposed Changes to the Medicare Shared Savings Program Regulations.



# In Addition, Next Generation ACO Model Offers Stronger Financial Incentives and Tools to Create Systems of Care

## Higher Levels of Risk and Reward



- Option of choosing between two risk arrangements—shared risk or full risk
- Shared risk option:
  - First three years, ACOs savings/losses will be 80%
  - During PYs 4 and 5, increases to 85%
- Full risk option:
  - ACO's share of savings/losses will be 100%
- ACO's share of savings and losses under both options is capped at 15% of benchmark

## Broader Range of Payment Options



- *Normal Fee-For-Service*
- *Fee-For-Service With ACO Support Payment:* FFS rates plus an additional PBPM payment of up to \$6 PBPM which is repaid at the end of the PY
- *Population Based Payments:* CMS will reimburse all claims submitted by ACO contracted providers/suppliers at a discounted rate
- *Capitation:* PBPM capitation payment

## Improved Benchmarking Methodology



- Prospectively set benchmark and beneficiary attribution
- Annual benchmark risk adjustments (+/- 3% corridor) using all components of CMS's HCC risk scores to adjust the benchmark
- An additional "discount" adjustment to the benchmark to reflect the ACO's quality and efficiency

## Tools to Create Informal Systems of Care



- Ability for ACOs to select preferred providers who may offer benefit enhancements to attributed beneficiaries
- Enhanced access to home visits, telehealth, and SNFs
- Reward payment to beneficiaries for receiving care from the ACO
- Process that gives beneficiaries a decision in their alignment with ACOs





## Factors Determining the Future of ACOs and Alternative Payment Models (APMs)

- **2015 MSSP ACO results** will provide more data on the success of ACOs in terms of cost and quality. CMS is anticipated to release final 2015 reconciliation reports in July/August 2016.
- **MSSP final benchmarking rule** will determine how many ACOs have a viable path to success under the structure of the program. As proposed, we are concerned that the rule puts ACOs that are higher cost relative to their region at a perhaps insurmountable disadvantage.
- **MACRA implementation** will incent more physicians to move to two-sided risk models; ACOs represent the most widespread vehicle to accomplish this.
- **CMMI alignment of value-based models:** New APMs spun out of CMMI (e.g. Comprehensive Primary Care Plus) need be structured such that they ensure fair participation, rather than establishing competing models of care.
- **New administration in the White House:** Pending the results of the Presidential election, CMMI funding could be in jeopardy, undermining the Next Generation ACO model and other APMs.