Trinity Health – Population Health Journey: Advanced Alternative Payment Models

March 23, 2017
Trinity Health Overview
Agenda

• Trinity Health Overview
• Clinically Integrated Network Strategy
• Value Based Payment
• Incorporating MACRA
• Questions
Our Mission drives our Vision and strategy
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values

• Reverence
• Commitment to Those Who are Poor
• Justice
• Stewardship
• Integrity
Our People-Centered 2020 Strategic Plan includes five focus areas to achieve our Vision

- People-Centered Care
- Engaged Colleagues
- Operational Excellence
- Leadership Nationally
- Effective Stewardship

Our 22-State Diversified Network

92 Hospitals* in 20 Regional Health Ministries**
47 Home Care & Hospice Locations Serving 116 Counties
59 Continuing Care Facilities
14 PACE Center Locations
23.9K Affiliated Physicians
5.3K Employed Physicians

*Owned, managed or in JOAs or JVs.
**Operations are organized into Regional Health Ministries ("RHMs"), each an operating division which maintains a governing body with managerial oversight subject to authorities.
Building a “People-Centered Health System” together

People-Centered Health System

Episodic Health Care Management for Individuals
Efficient & effective episode delivery initiatives

Population Health Management
Efficient & effective care management initiatives

Community Health & Well-being
Serving those who are poor, other populations, and impacting the social determinants of health

Better Health • Better Care • Lower Costs
Transforming care requires a transformed business model

Strategic Aim: 75% of all care will be reimbursed via Alternative Payment Models (APM)

Fee For Service (FFS) Population

Episodic Care Population

Attributed Population

78%

3% → 22%

19%
Our people-centered system in 2020 will provide care under a different mix of payment models.

<table>
<thead>
<tr>
<th>FFS Population</th>
<th>Episodic Care Population</th>
<th>Attributed Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>FFS Payment/service DRGs, Per Diem, Other</td>
<td>90 Days all-in Bundle Payment</td>
<td>Shared Savings/Risk/Capitation</td>
</tr>
</tbody>
</table>

75% APM Goal
Expanding ACO programs are the primary driver of APM growth

- 14 Medicare Shared Savings Program ACOs
- 5 markets partnering as a Next Generation ACO
- Participating in 98 non-CMS APM contracts
- 13.8K physicians participating in our Clinically Integrated Networks accountable for 1.2 million lives
We operate one of the largest clinical episode payment programs in the nation

• **43** Model 2 Bundled Payment for Care Improvement (BPCI) hospitals
• **13** Model 3 Skilled Nursing Facilities (SNF)
• **2** Comprehensive Joint Replacement (CJR) sites
• **22,400** total annual episodes for all three programs
We are working to improve care across clinical conditions with 43 of 48 possible bundles

(in millions)
Total Program Size: $550m
## Alternative Payment Model Summary

<table>
<thead>
<tr>
<th>Program parameters</th>
<th>Risk Share Arrangement</th>
<th>Estimated Lives</th>
<th>Estimated annual spend (i.e. Total Cost of Care)</th>
<th>TCOC - Upside Risk only</th>
<th>TCOC - Upside/Downside Risk</th>
<th>Risk Sharing Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ in 000s</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>ACO/CIN:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trinity Health ACO (THACO) - NextGen</td>
<td>Upside/Downside risk</td>
<td>80% Trinity/ 20% CMS; 6.5% cap</td>
<td>85,316</td>
<td>$930,329</td>
<td>$</td>
<td>Not available yet; 2016 is first performance year</td>
</tr>
<tr>
<td>Trinity Health Integrated Care (THIC) - MSSP-3</td>
<td>Upside/Downside risk</td>
<td>2% savings threshold; up to 75% of gain in PY 1; at least 40% of loss up to 75% based on quality score; savings cap- 20%; loss cap - 15%</td>
<td>52,799</td>
<td>656,000</td>
<td>656,000</td>
<td>Not available yet; 2017 is first performance year</td>
</tr>
<tr>
<td>Medicare Shared Savings Plan - 1 (MSSP-1)</td>
<td>Upside Only</td>
<td>2%-4% threshold for shared savings depending on assigned beneficiaries; 50% share with CMS</td>
<td>122,277</td>
<td>1,342,618</td>
<td>$1,342,618</td>
<td>Received $6 M for performance year 2015 in FY 17</td>
</tr>
<tr>
<td>Commercial &amp; all other (1)</td>
<td>Upside Only</td>
<td>Varies</td>
<td>877,722</td>
<td>4,297,321</td>
<td>4,297,321</td>
<td>Not available</td>
</tr>
<tr>
<td>Commercial &amp; all other (1)</td>
<td>Upside/Downside risk</td>
<td>Varies - generally 50% split with payors</td>
<td>68,837</td>
<td>314,618</td>
<td>314,618</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>BPCI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$3.3 M loss w/CMS for April-June 2015 qtr to an estimated $1.5 M gain w/CMS for July-Sept 2016</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,207,951</td>
<td>$7,988,996</td>
<td>$5,639,939</td>
<td>$2,349,057</td>
</tr>
</tbody>
</table>

ACO/CIN: Accountable Care Organization/Clinically Integrated Network  
BPCI: Bundled Payment for Care Improvement  
(1) Includes Medicaid, colleague, Medicare Advantage, etc.
Clinically Integrated Network Strategy
We have developed a schema to consistently describe our journey.

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Full-risk / Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Model</td>
<td>Future State</td>
</tr>
<tr>
<td><strong>Highly Integrated Care</strong></td>
<td><strong>Loosely Integrated Care</strong></td>
</tr>
</tbody>
</table>
We have a compelling rationale for pursuing this strategy.

Why pursue this strategy?

- The strategy aligns with our mission – it’s the right thing to do and it’s better care for our patients
- We will be strategically advantaged as leaders in value based care

There are better ways to practice that:

- Makes the right thing to do the easiest thing to do
- Removes cross motivations and limitations of the FFS world
- Focus on the needs of the patient and away from the visit
The journey to value based payment requires deep focus and vigilance.

- With each initiative, ensure that the interventions and initiatives are aligned
- Success is defined clinically and financially
- Models are created that allow flexibility yet remain consistent as possible for patients and providers
- Diverting from the center path results in financially unsustainable models, putting our mission at risk
Success in programs throughout are critical.

- We need to develop our skill set with target populations to ensure we can successfully travel the “center” route and avoid the danger zones.
- With a smaller initial populations, we can prove our reliability to payers and employers, allowing these programs to progress.
- Each of the population health programs allow our community of providers and associates to gain experience and excellence in population health.
- The transition will require multiple programs executing simultaneously.
Clinically Integrated Networks are important components of our integrated delivery systems.
We are working to develop a clear vision for our Clinically Integrated Networks and how they help us achieve our strategic goals.

Trinity Health Clinically Integrated Networks will mobilize a people-centered, evidence-based approach to managing health, consistently producing excellent triple aim outcomes.
Clinically Integrated Networks are developing defined, focused business and operation objectives and outcomes that will help us achieve the triple aim.

- Trinity Health CINs collaboratively design and successfully deploy population specific management programs
- Drives growth in new payment models in a financially sustainable way
- Achieve and exceed customer, payer, colleague and provider expectations
- Utilize a consistent approach which respects local imperatives while applying system focused best practices
The CIN business model includes core components to assure competencies that are necessary to deliver.

1. Comprehensive Networks Across the Continuum
2. Advanced Care Model
3. Closely Aligned Providers
4. Innovative Payer/Provider Relationships
5. Analytics & IT Capabilities
6. Clinical Leadership & Governance
## CI Scorecard (Govt & MA Programs)

<table>
<thead>
<tr>
<th>Value</th>
<th>Defined Population</th>
<th>Target</th>
<th>Benchmark Reference</th>
<th>Process / Outcome</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of PCPs$^1$</td>
<td>4,143</td>
<td>Total CIN-participating PCPs</td>
<td>TBD</td>
<td>N/A</td>
<td>Process</td>
</tr>
<tr>
<td>Number of Attributed Lives$^2$</td>
<td>149,345</td>
<td>MSSP, MA (BCN My Choice, BCN-MA, MediGold, Columbus Aetna MA)</td>
<td>TBD</td>
<td>N/A</td>
<td>Process</td>
</tr>
<tr>
<td>Network Integrity$^2$ (% Inpatient Discharges from Trinity Health Ministries)</td>
<td>40%</td>
<td>MSSP (Loyola, Lourdes and Columbus ACOs)</td>
<td>TBD</td>
<td>N/A</td>
<td>Outcome</td>
</tr>
<tr>
<td><strong>Better Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Poor HbA1c Control$^3$</td>
<td>TBD</td>
<td>MSSP (Loyola, Lourdes and Columbus ACOs)</td>
<td>TBD</td>
<td>N/A</td>
<td>Outcome</td>
</tr>
<tr>
<td>Hypertension Control$^3$</td>
<td>37.1%</td>
<td>TBD</td>
<td>TBD</td>
<td>70%</td>
<td>Outcome</td>
</tr>
<tr>
<td>Depression Screening$^3$</td>
<td>14.1%</td>
<td>TBD</td>
<td>TBD</td>
<td>70%</td>
<td>Outcome</td>
</tr>
<tr>
<td>Gaps in Care/1,000$^3$</td>
<td>5,135</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>Outcome</td>
</tr>
<tr>
<td>Patient Experience, Overall Rating of Provider</td>
<td>TBD</td>
<td>MSSP / NGACO / MA</td>
<td>TBD</td>
<td>75th %ile</td>
<td>Outcome</td>
</tr>
<tr>
<td><strong>Lower Cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Discharges/1,000</td>
<td>297</td>
<td>MSSP, MA (BCN My Choice, BCN-MA, MediGold, Columbus Aetna MA)</td>
<td>3.5% Decrease</td>
<td>191.7</td>
<td>Outcome</td>
</tr>
<tr>
<td>SNF Days/1,000</td>
<td>1,911</td>
<td></td>
<td>10% Decrease</td>
<td>998.3</td>
<td>Outcome</td>
</tr>
<tr>
<td>Dollars Realized / Opportunity in Risk Contracts</td>
<td>TBD</td>
<td>Total across all Risk-based Contracts</td>
<td>TBD</td>
<td>N/A</td>
<td>Outcome</td>
</tr>
<tr>
<td>Medical Cost of Care PMPM$^3$</td>
<td>$839</td>
<td>MSSP / NGACO</td>
<td>2% Decrease</td>
<td>$600.91</td>
<td>Outcome</td>
</tr>
</tbody>
</table>

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*Note: Benchmarks and targets are subject to change. Frequency may also vary depending on specific requirements.*
Trinity Health ACO, A Next Generation ACO
Why we chose to participate

- Replaces the Medicare Shared Savings Program with an enhanced model which is very similar to a Medicare Advantage (MA) program
- Enhancements to the model facilitate executing on our patient promise with improved financial opportunity - albeit with upside and downside risk
- As a national ACO, there is a larger cohort of attributed beneficiaries that helps with risk mitigation
- Prospective vs. retrospective assignment model - stable population without the turnover seen in MSSP
- No hurdle rate for shared savings while continuing to be paid fee-for-service
- National and regional trend applied in the baseline; only national in MSSP
- Innovation in the post-acute market
- Modest Coordinated Care award to beneficiary
- Benefit waivers enable new care pathways

It’s a compelling story in our quest to be a People Centered Health system....
The Trinity Health ACO is Uniquely Structured

- Separate legal entity: Trinity Health ACO (a.k.a. THACO)
- Participants are known as Chapters:
  - Affinia Health Network – Muskegon and Grand Rapids, MI
  - Lourdes Health Network – Lourdes Health System, Camden, NJ and St. Francis Medical Center, Trenton, NJ
  - Health Collaborative of Central Ohio – Mount Carmel Health System – Columbus, OH
  - Loyola Physician Partners, ACO LLC – Loyola University Health System – Chicago, IL
  - Summit Medical Group – Berkeley, NJ - private, non-Trinity Health medical group.
- 3-year program with CMMI/CMS
- Performance year began January 1, 2016
THACO providers are responsible for all categories of Medicare beneficiaries

<table>
<thead>
<tr>
<th>Trinity Health ACO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligned Beneficiaries</td>
<td>64,088</td>
</tr>
<tr>
<td>Participating Providers</td>
<td>2,638</td>
</tr>
<tr>
<td>% Employed Providers</td>
<td>53%</td>
</tr>
<tr>
<td>% Primary Care Providers</td>
<td>22%</td>
</tr>
<tr>
<td>Beneficiaries per provider</td>
<td>79</td>
</tr>
<tr>
<td>Aged, Non-Dual Beneficiaries</td>
<td>49,391</td>
</tr>
<tr>
<td>Dual Beneficiaries</td>
<td>7,786</td>
</tr>
<tr>
<td>ESRD Beneficiaries</td>
<td>553</td>
</tr>
<tr>
<td>Disabled</td>
<td>8,579</td>
</tr>
</tbody>
</table>
Our success depends on multiple elements

- Understand who the aligned beneficiaries are and their clinical conditions
- Proactively manage the total cost of care and utilization for the beneficiaries aligned to TH ACO
- Care management resources
- Data and Analytics to understand and measure performance
- Chronic Care Documentation
- Beneficiary and Provider Engagement
- 5 Chapters working together
Several key financial drivers for THACO that impact shared savings or loss

• **Benchmark (target):**
  - Baseline: calendar year 2014
  - Baseline cost trended forward using national and regional Medicare FFS trend
  - CMS discount: the Medicare savings requirement ranges between 0.5% to 4.5%; based on regional efficiency, national efficiency and quality scoring
  - Benchmark is then risk adjusted to account for differences in severity of patients, creating a +/- 3% opportunity or risk.

• **Risk share %:** Trinity’s portion of the surplus or deficit is 80%; CMS retains 20%

• **Medical cost trend** is largely impacted by our operational initiatives in managing the total cost of care
THACO is projected to break even over the first three years

<table>
<thead>
<tr>
<th></th>
<th>CY 2016</th>
<th>CY 2017</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Membership</td>
<td>53,000</td>
<td>73,504</td>
<td>73,504</td>
</tr>
<tr>
<td>NGACO Benchmark</td>
<td>$869.75</td>
<td>$886.45</td>
<td>$903.47</td>
</tr>
<tr>
<td>+ Risk score impact</td>
<td>$12.00</td>
<td>$12.00</td>
<td>n/a</td>
</tr>
<tr>
<td>Projected Medical Cost Improvement</td>
<td>-2.18%</td>
<td>-3.70%</td>
<td>-2.00%</td>
</tr>
<tr>
<td>- Projected Medical Cost</td>
<td>$871.33</td>
<td>$855.20</td>
<td>$854.19</td>
</tr>
<tr>
<td>Trinity 80% Surplus/(deficit) before expenses</td>
<td>($1.26)</td>
<td>$34.60</td>
<td>$49.03</td>
</tr>
<tr>
<td>Clinical expenses</td>
<td>($13.34)</td>
<td>($16.91)</td>
<td>($17.42)</td>
</tr>
<tr>
<td>Risk score expenses</td>
<td>($6.00)</td>
<td>($6.00)</td>
<td>($6.00)</td>
</tr>
<tr>
<td>Physician gain share</td>
<td>$0.00</td>
<td>($7.02)</td>
<td>($15.37)</td>
</tr>
<tr>
<td>Net NGACO gain / (loss)</td>
<td>($20.60)</td>
<td>$4.68</td>
<td>$10.24</td>
</tr>
</tbody>
</table>

3 Year Total $59,261
## Next Generation ACO (NGACO) Scorecard - YTD

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Affinia - West MI</th>
<th>Columbus</th>
<th>Loyola</th>
<th>Lourdes</th>
<th>Summit</th>
<th>Target</th>
<th>Benchmark Reference</th>
<th>Process / Outcome</th>
<th>Frequency</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better Health</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Number of Providers with Attributed Lives(^1)</td>
<td>773</td>
<td>237</td>
<td>197</td>
<td>44</td>
<td>97</td>
<td>198</td>
<td>TBD</td>
<td>N/A</td>
<td>Process</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>Number of Attributed Lives(^2)</td>
<td>53,081</td>
<td>11,185</td>
<td>12,614</td>
<td>5,473</td>
<td>11,482</td>
<td>12,327</td>
<td>TBD</td>
<td>N/A</td>
<td>Process</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>Person Years</td>
<td>572,385</td>
<td>10,913</td>
<td>12,369</td>
<td>5,380</td>
<td>11,277</td>
<td>12,096</td>
<td>TBD</td>
<td>N/A</td>
<td>Process</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>Network Integrity(^2) (% of Acute Inpatient Admits to Trinity Health Ministries)</td>
<td>44%</td>
<td>61%</td>
<td>56%</td>
<td>62%</td>
<td>29%</td>
<td>N/A</td>
<td>TBD</td>
<td>N/A</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td><strong>Lower Cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Admits/1,000(^2)</td>
<td>294</td>
<td>296</td>
<td>293</td>
<td>349</td>
<td>317</td>
<td>246</td>
<td>192(^3)</td>
<td>10% Decrease</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>SNF Days/1,000(^2)</td>
<td>1,889</td>
<td>1,548</td>
<td>1,856</td>
<td>2,544</td>
<td>2,046</td>
<td>1,795</td>
<td>998(^3)</td>
<td>10% Decrease</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>SNF ALOS (in Days)(^2)</td>
<td>24.1</td>
<td>21.8</td>
<td>23.7</td>
<td>25.4</td>
<td>25.8</td>
<td>24.0</td>
<td>TBD</td>
<td>10% Decrease</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>ED Visits/1,000(^2)</td>
<td>378</td>
<td>603</td>
<td>432</td>
<td>244</td>
<td>372</td>
<td>184</td>
<td>TBD</td>
<td>222(^3)</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>PCP Visits/1000(^2)</td>
<td>4,657</td>
<td>3,739</td>
<td>4,147</td>
<td>5,199</td>
<td>5,193</td>
<td>5,266</td>
<td>TBD</td>
<td>3,626(^3)</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>All Cause 30-Day Readmits/1,000(^2)</td>
<td>59</td>
<td>53</td>
<td>59</td>
<td>75</td>
<td>70</td>
<td>48</td>
<td>TBD</td>
<td>TBD</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
<tr>
<td>Medical Cost of Care PMPM(^4)</td>
<td>$903</td>
<td>$839</td>
<td>$869</td>
<td>$975</td>
<td>$944</td>
<td>$932</td>
<td>$916</td>
<td>$601(^3)</td>
<td>Outcome</td>
<td>Monthly</td>
<td>MECA-SPARC</td>
</tr>
</tbody>
</table>

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\(^1\) Source: CMS or CMMI defined primary care providers having at least one attributed beneficiary

\(^2\) Source: CCLF claims in MECA-SPARC from 01/01/2016 - 11/30/2016, paid through 12/31/2016

\(^3\) Source: Milliman Well Managed National Average Benchmark, 7/1/2014

\(^4\) Source: CCLF claims in MECA-SPARC from 01/01/2016 - 11/30/2016, paid through 12/31/2016, including completion factor and estimations for OPT-OUTS
Collaborative Model
We propose a collaborative Track 3 ACO to facilitate participation in AAPMs. This ACO is built upon principles used with Trinity Health ACO.

- Health care is inherently local
- There are things that can be performed centrally that can ease administrative burden and simplify implementation
- All of us can move down this path faster and more effectively together than we can separately
Participation in a collaborative AAPM provides a number of strategic and operational advantages.

AAPM Bonus
- **Starting in 2019:** Providers participating in 2017 could be eligible for a 5% lump sum bonus for total Part B Medicare payments
- Qualifying AAPM participants avoid participation in MIPS

MSSP Track 3 vs Track 1
- **Providers:** No financial risk
- **Sharing Rate:** 40% to 75%
- **Attribution:** Beneficiaries are prospectively attributed each year
- **Advanced Alternative Payment Model:** Yes
- **Waivers:** Can participate in 3 day SNF Waiver

The Collaborative ACO
- **Risk mitigation:** Size of patient pools are important in mitigating risk
- **Governance:** Each CIN will have representation on the Collaborative ACO Board
- **Optimized collaboration:** Structured to facilitate sharing of best practices in population health

Trinity Health Integrated Care, A collaborative MSSP ACO
The collaborative model will drive improved performance in achieving better health, better care and lower cost.

**Effective Trinity System Office Support:**
System office has responsibility for successfully deciphering regulations of MSSP and creating turn-key products which reduces administrative burden and allow local providers to focus on people centered care.

**Effective Local ACO/CIN Execution:**
System office will provide guidance and support, but healthcare will remain local.

**Collaboration drives improved performance:**
There is a shared accountability amongst the chapters. Facilitated by the system office, best practices are shared and barriers are removed together. **Our delivery of people centered care accelerates.**

**Shared Governance:**
The governing body of the ACO is comprised of chapters that represent local CIN participation in the entity.
MACRA
MSSP continues to evolve and will be driven further by MACRA.

This NAACOS ACO comparison chart details the main elements of the three tracks in the Medicare Shared Savings Program and the Next Generation ACO model.

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>TRACK 1</th>
<th>TRACK 2</th>
<th>TRACK 3</th>
<th>NEXT GENERATION ACO MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial program start year</strong></td>
<td>2012</td>
<td>2012</td>
<td>2016</td>
<td>2016</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>MSSP ACO Tracks 1 and 2 were included in the original MSSP. The program stems the Affordable Care Act and is designed to enhance care coordination and cooperation among healthcare providers with the overall goals of improved quality and patient outcomes as well as lower costs.</td>
<td>Same as Track 1</td>
<td>Track 3 was added to the MSSP beginning in 2016. This model takes successful aspects of the MSSP and Pioneer model to create a new MSSP Track with higher shared savings opportunities and greater risks.</td>
<td>Similar to the Pioneer Model with higher potential rewards and risk than the MSSP Tracks. NextGen ACOs must operate under outcomes-based contracts with other purchasers by the end of the first performance period.</td>
</tr>
<tr>
<td><strong>Number of 2015 organizations</strong></td>
<td>112</td>
<td>6</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td><strong>Length of contract</strong></td>
<td>2 years (may remain in Track 1 for 5 years)</td>
<td>3 years</td>
<td>3 years</td>
<td>3 years with option for 2 additional years</td>
</tr>
<tr>
<td><strong>FINANCIAL STRUCTURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sharing Rate</strong></td>
<td>Up to 50%</td>
<td>Up to 60%</td>
<td>Up to 75%</td>
<td>2 risk arrangement options. Arrangement A offers shared savings/losses of up to 80% in Years 1 through 3, then up to 85% in Years 4 and 5. Arrangement B offers shared savings/losses of up to 100%.</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR)</strong></td>
<td>2% to 3.9% MSR depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR. (2% MSR for ACOs with 60,000+ assigned beneficiaries. MLR not applicable.</td>
<td>ACOs have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0% symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)</td>
<td>Same as Track 2</td>
<td>Next Gen does not utilize MLR/MLRs. Instead, CMS applies a discount to the benchmark once the baseline has been calculated, trended, and risk adjusted. NextGen ACOs can achieve first dollar savings for spending below the benchmark and are accountable for first dollar shared losses for spending above the benchmark.</td>
</tr>
<tr>
<td><strong>Performance Payment Limit</strong></td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>First dollar sharing once MSR is met or exceeded</td>
<td>Same as Track 1</td>
<td>Same as Tracks 1</td>
<td>First dollar savings for spending below benchmark (which includes a discount)</td>
</tr>
<tr>
<td><strong>Shared Loss Rate</strong></td>
<td>Not applicable</td>
<td>First dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 60%</td>
<td>First dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%</td>
<td>First dollar losses for spending above the benchmark</td>
</tr>
<tr>
<td><strong>Limit on the amount of shared losses phases in over 3 years, starting at 5% in Year 1, 7.5% in Year 2, and 10% in Year 3 and beyond</strong></td>
<td>Not applicable</td>
<td>Limit on the amount of shared losses phases in over 3 years, starting at 5% in Year 1, 7.5% in Year 2, and 10% in Year 3 and beyond</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Benchmark in Initial agreement period</strong></td>
<td>Established based on three years of historical ACO costs, using risk-adjusted average per capita expenditures for Parts A and B Medicare FFS beneficiaries who would have been assigned to the ACO. Benchmark years are weighted 10% Year 1, 30% Year 2 and 60% Year 3. CMS applies a national average growth rate for the prior three years to account for inflation. Benchmarks may be adjusted</td>
<td>Same as Track 1</td>
<td>Same as Tracks 1</td>
<td>Established prior to each performance year and uses a hybrid approach to incorporate historical and regional costs. Initially, the prospective benchmark is established through the following steps: (1) determine the ACO’s historic baseline expenditures; (2) apply regional projected trend; (3) risk adjust using the CMS HCC model; (4) apply the discount, which is derived from one or more quality adjustments and two efficiency adjustments.</td>
</tr>
</tbody>
</table>
MACRA creates two options for physicians to choose from, one more advantageous than the other.

- Repeals the Sustainable Growth Rate (SGR) Formula
- Streamlines multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- Provides incentive payments for participation in Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS) OR Alternative Payment Models (APMs)

Source CMS:
Strategically participating in new payment models offers opportunity for optimal reimbursement.

Trinity Health ACO
- Affinia Health Network (Muskegon and Grand Rapids, MI)
- Mount Carmel Health System (Columbus, OH)
- LHS Health Network (Camden, NJ)
- Loyola Physician Partners (Maywood IL)
- Summit Medical Group (Berkeley Heights, NJ)*

*Independent group, not owned by Trinity Health

Trinity Health Integrated Care
- St. Joseph’s Health Accountable Care Organization (Syracuse, NY)
- Mercy Accountable Care (Conshohoken, PA)
- Select Health Network ACO, LLC (Mishawaka, IN)
- Saint Alphonsus Health Alliance (Boise, ID)
- Quality Health Alliance (Langhorne, PA)

CPC+ Participants
- Southeast Michigan/IHA
- SEPA/Mercy
The changes provide Trinity Health with opportunity to advance our partnerships with physicians.

Physicians across the spectrum are driving toward organized networks seeking partnership and further consolidation in the provider community.

Increased competition in many markets for physician alignment in AAPM’s

Our value proposition for physicians is to be the partner of choice in demonstrating their value and participating in models that reward value.
Physicians want to be part of a larger organization to take on risk

Nearly 40 percent of physicians report being more likely to accept risk-based compensation if they were part of a larger organization.

58% of physicians would opt to be part of a larger organization to bear risk collectively and/or have access to resources.

Of independent physicians, 1 in 4 prefer to be employed, while 75% would prefer to join a clinical network.

Source: Deloitte Center for Health Solutions 2016 Survey of US Physicians
The Triple Aim is producing the Quadruple Win

Better care, health and access for patients and families

Great experience for clinical and administrative staff

Success for an integrated health system

Lower costs and better outcomes for payers
We are positively impacting patient lives

Our Care
- Care manager took on case and identified behavioral health and socioeconomic components to Rodney’s illness
- Behavioral health specialists established relationship with Rodney
- Provided referrals for medical, behavioral health and pain management
- Educated him on anxiety disorder and coping mechanisms

Rodney, 54

Pre-Mount Carmel Health Partners
- 80 ER visits Jan.- Oct., 2015
- Pain, numbness
- Stroke-like symptoms
- Nausea
- Behavioral Health issues
- No transportation

Post-Mount Carmel Health Partners
- 2 ER visits Nov.- Dec., 2015
- Compliant with medications and appointments
- Owns a car and provides own transportation
- Understands his illnesses and utilizes coping mechanisms
Thank you.

Barbara.Walters@Trinity-Health.org
Questions & Discussion