CENTENE Corporation

HCBS Value-Based Contracting: A Managed Care and LTSS Provider Partnership

December 8, 2021

Improving Delivery of Care and Quality through VBC

Challenges in providing HCBS services today

- Improving timely access to services
- Ensuring services provided are at a level of high quality
- Many HCBS providers have limited resources

Objectives

- Discuss incentive options for HCBS providers
- Focus on evidenced based, data driven programs
- Optimize the effectiveness of care management

Panelists

Mark Henry – Director of Contracting, Complex Care and Foster Care, Centene Corporation

Valerie Gates – Vice President of Operations, Superior Health Plan

Diane Kumarich – Senior Vice President Payer Innovations, Addus Home Care

Matthew Lippitt – Vice President Payer Contracting and Strategy| BAYADA Home Health Care

Agenda

- Overview of Centene – Mark Henry
- Minor Home Modification P4P – Valerie Gates
- High-Risk/High-Cost Community Care Model - Diane Kumarich
- Community Health Nursing Model – Matthew Lippitt
- Questions and Answers – Mark Henry

Centene Overview

Who We Are & What We Do

#24 *FORTUNE 500* 2021

#57 *FORTUNE Global 500*

St. Louis
Based company founded in Milwaukee in 1984

68,000+ employees

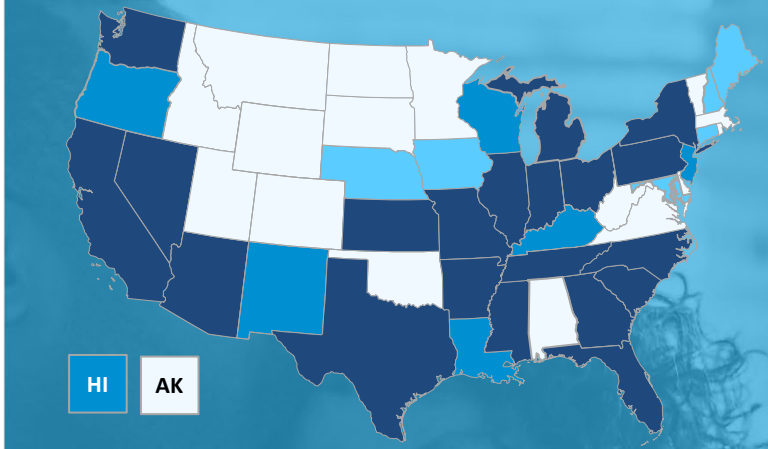
#127 Fortune Global 500 (2020)

#78 Fortune 100 Fastest Growing Companies (2019)

1 in 15
Americans across all 50 states

Centene offers affordable and high-quality products

QUALITY means going above-and-beyond to make sure our members get appropriate preventive care to stay healthy, and that they receive the right care in the right place.



Medicaid (30 States)

Marketplace (21 States)

Medicare (31 States)

Correctional (17 States)

50 States with government sponsored healthcare programs

3 International Markets

25.4 million members
includes 2.9 million TRICARE eligibles

CENTENE® Corporation
Confidential and Proprietary Information

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS

Focus on the Individual

+

Whole Health

+

Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

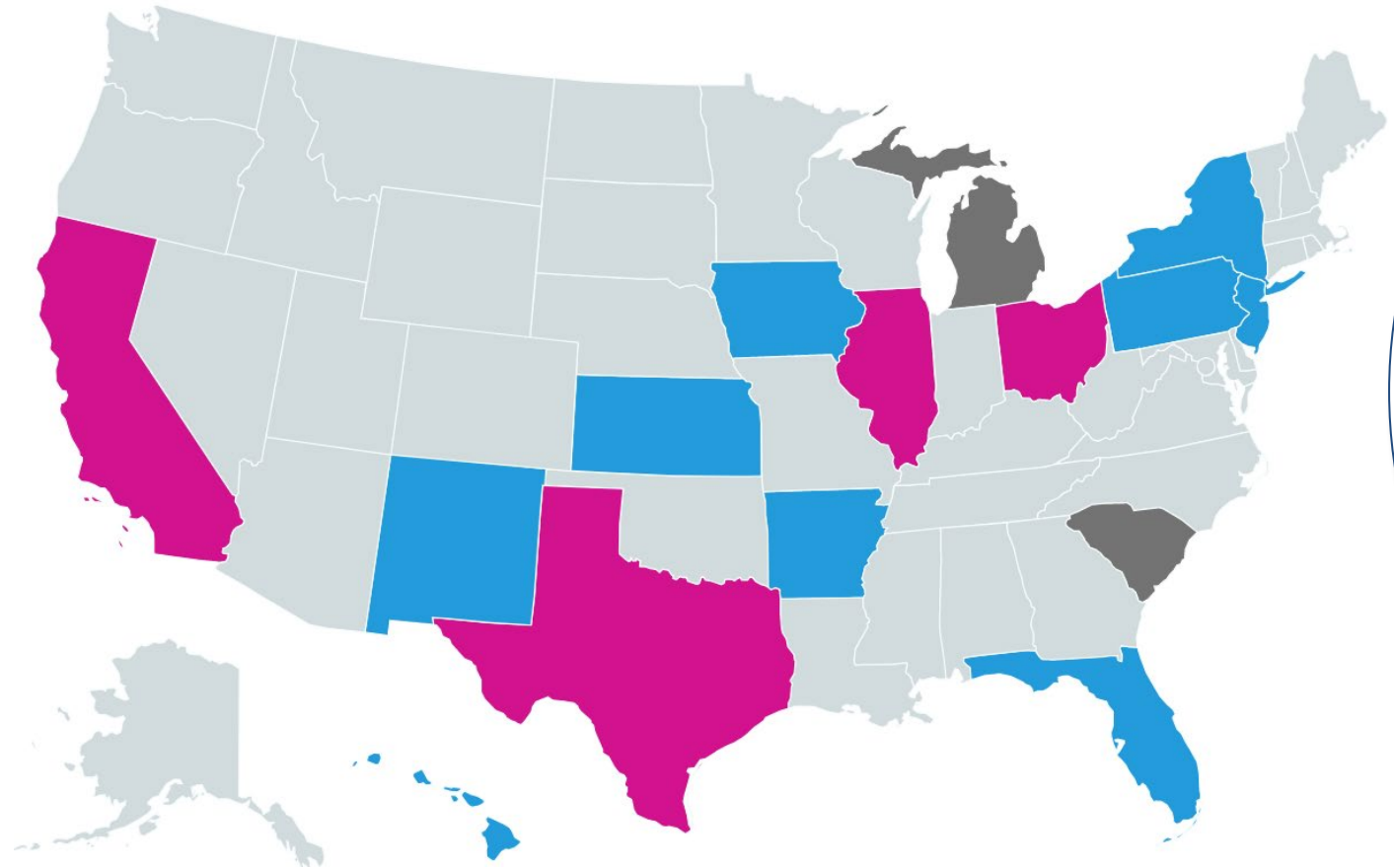
We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Centene's Long-Term Services and Supports & Medicare-Medicaid Plan Footprint



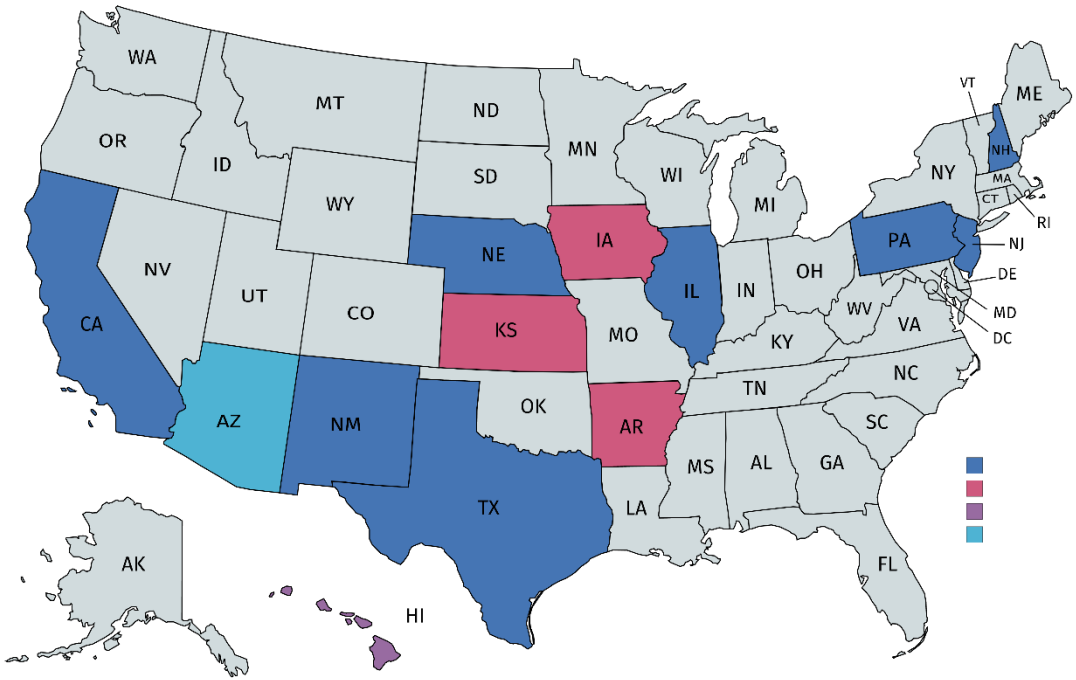
*409,000 members in 15 states; Largest MLTSS health plan in the U.S.**

Populations include: *Older Adults, Persons with Physical Disabilities, HIV/AIDS, Intellectual & Developmental Disabilities, Brain Injury, Serious & Persistent Mental Illness*

Color Key:
LTSS
LTSS & MMP
MMP

*November 2020 data

Centene's Intellectual & Developmental Disabilities (IDD) Footprint



Affiliates with Designated Programs:

Full benefits (Medical, Behavioral, LTSS)

Medical & Habilitation*

Behavioral Health

Medical, Behavioral, and Care Management

Total Footprint: Centene supports over 193,000 members with a primary diagnosis of an IDD, across all products, based on CMS definitions

*TX only: Habilitation through Community First Choice Waiver; *November 2020 data. Source: Population Health IDD Dashboard. Legacy Wellcare membership not included, except for Hawaii (self-report).

Minor Home Modification P4P

superior healthplan™

Superior HealthPlan

Top-Rated

Superior is among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the National Committee for Quality Assurance's (NCQA) Medicaid Health Insurance Plan Ratings 2019-2020.

Largest Medicaid Plan

Superior is the largest Medicaid health plan in Texas, serving all 254 counties. In addition to Medicaid and CHIP, Superior offers coverage through Medicare and the Health Insurance Marketplace for a combined total of more than 1.7 million members.

Provider Network

With a combined 86,000 hospitals, clinics, doctors and specialists, Superior has an expansive provider network.

Statewide Presence

Superior has more than 4,000 employees across 8 offices across Texas.

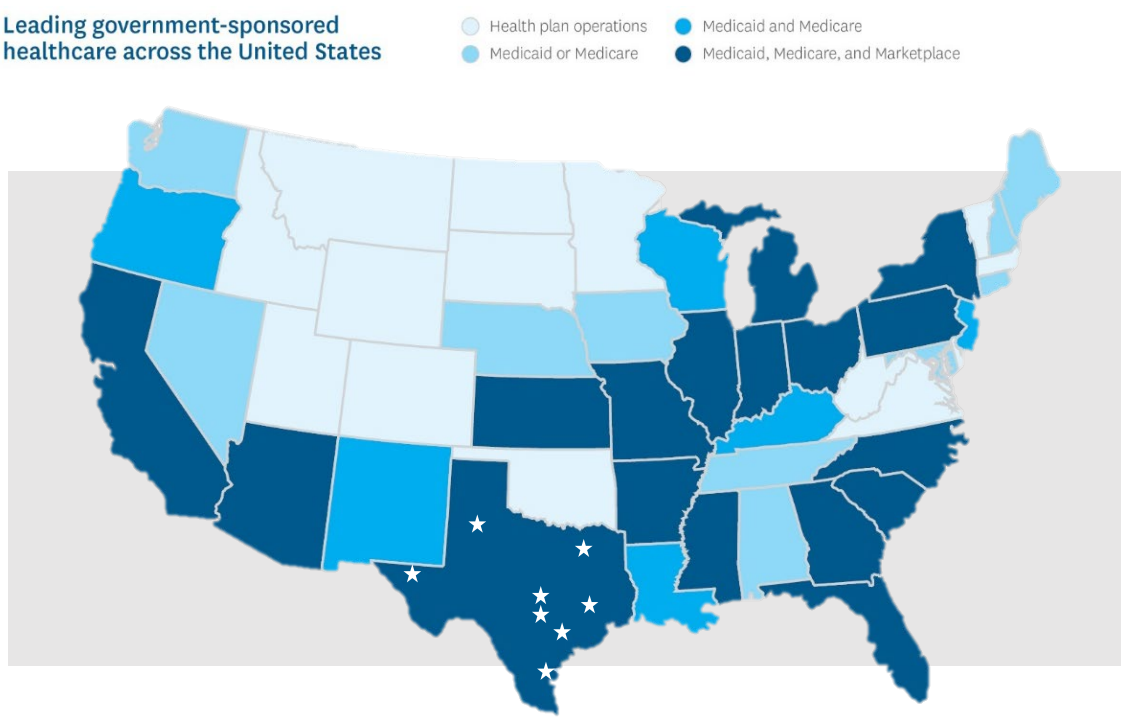
Giving Back

In 2020, Superior and its employees gave back $1 million to community-based organizations, including $400,000 to help assist communities in addressing the COVID-19 pandemic.

SuperiorHealthPlan.com

Superior at a Glance

1.7 million managed care members



8 products

- STAR (Medicaid)
- STAR Kids (Medicaid)
- STAR Health (Medicaid)
- STAR+PLUS (Medicaid)
- STAR+PLUS MMP
- CHIP
- Medicare
- Ambetter (Commercial)

3,800+ employees

8 TX offices

86,000 providers

SuperiorHealthPlan.com

Program Description

- Established to address challenges experienced with locating providers who can serve members in an efficient manner while providing high quality service
- Incorporates contracts with providers to ensure timely access and prioritization of our members who need minor home modifications (MHM)
- High-performing providers are placed on retainer and earn a bonus for quick turnaround
- Value based providers MHM activity is tracked and monitored closely
- Dedicated MHM Team to support our value-based MHM providers

Program Components

- Superior HealthPlan conducts a monthly performance review with service providers for total members served. The criteria below is measured on completed projects:

  - Referral to bid TAT
    - 10 business day TAT
  - Authorization to Work Completion TAT
    - MHM cost of $999 or less
      - 30 business day TAT
    - MHM cost of $1000 or greater
      - 45 business day TAT
  - Member survey conducted upon work completion
    - Member satisfaction
    - Quality of work
    - Provider's level of cleanliness
    - Customer Service
    - Would Provider be selected for future projects

Program Reporting

- A detailed report is submitted weekly to service providers participating in this program listing the following information:

  - Authorizations created during the week
  - Pending bids
  - Members pending MHM work completion

Incentive Calculation

- Contractual provisions are used to calculate incentives. As an example:

Provider must meet all of the following guidelines to qualify for the incentive

- Complete at least 1 MHM per month
- 100% Referral to BID TAT
- 100% Authorization to Work Completion TAT
- Provider provides documented proof of work completion, including photos and Documentation of Work Completion signed by member

Incentive Calculation

- Additional performance incentives are calculated based on:

- Service provider has the ability to earn an additional incentive for completing a minimum 10 members and achieving the following incentive measurement:
  - Average percentage of both BID to Referral and Work Completion TAT
  - All survey questions must be at 100% to qualify for highest tiers, if one question is less than highest rating, then considered 2nd tier. Anything less does not meet measure.

- Incentive amounts are processed via check by Finance department to Service Provider

High-Risk/High-Cost Community Care Model –

An Innovative Value-Based Care Program

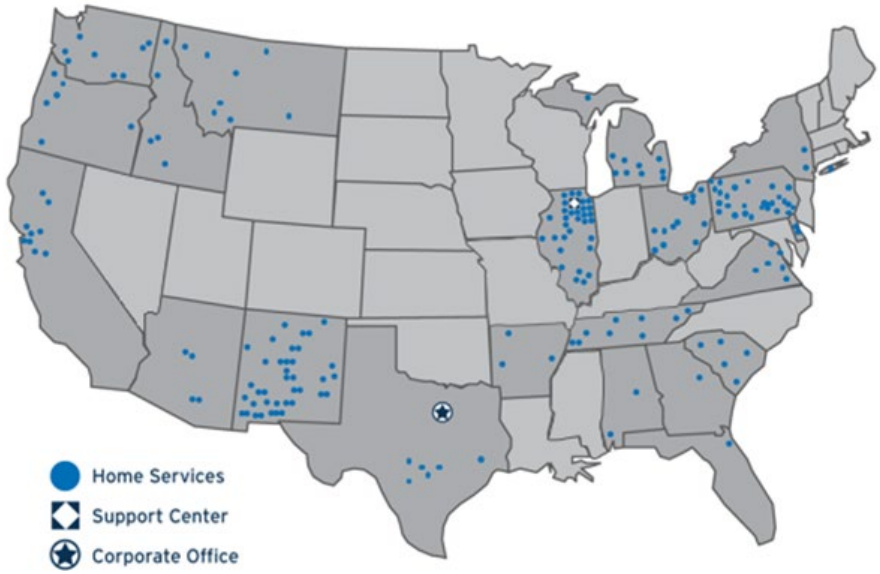
Giving people the freedom to remain at home

ADDUS HOMECARE

Addus Snapshot

- Since 1979 Addus has been a leading provider of home and community based personal care services
- Operates over 212 locations in 21 states with over 30,000 employees
- Serves approximately 44,000 patients - typically elderly, chronically ill or disabled and at risk of hospitalization or institutionalization
- Provides personal care (non-medical services) on a long-term continual basis, with an average duration of approximately 26 months per consumer
- A home care services provider for personal care, home health and hospice services.

Geographic Footprint



Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

High-Risk/High-Cost (HRHC) Community Model

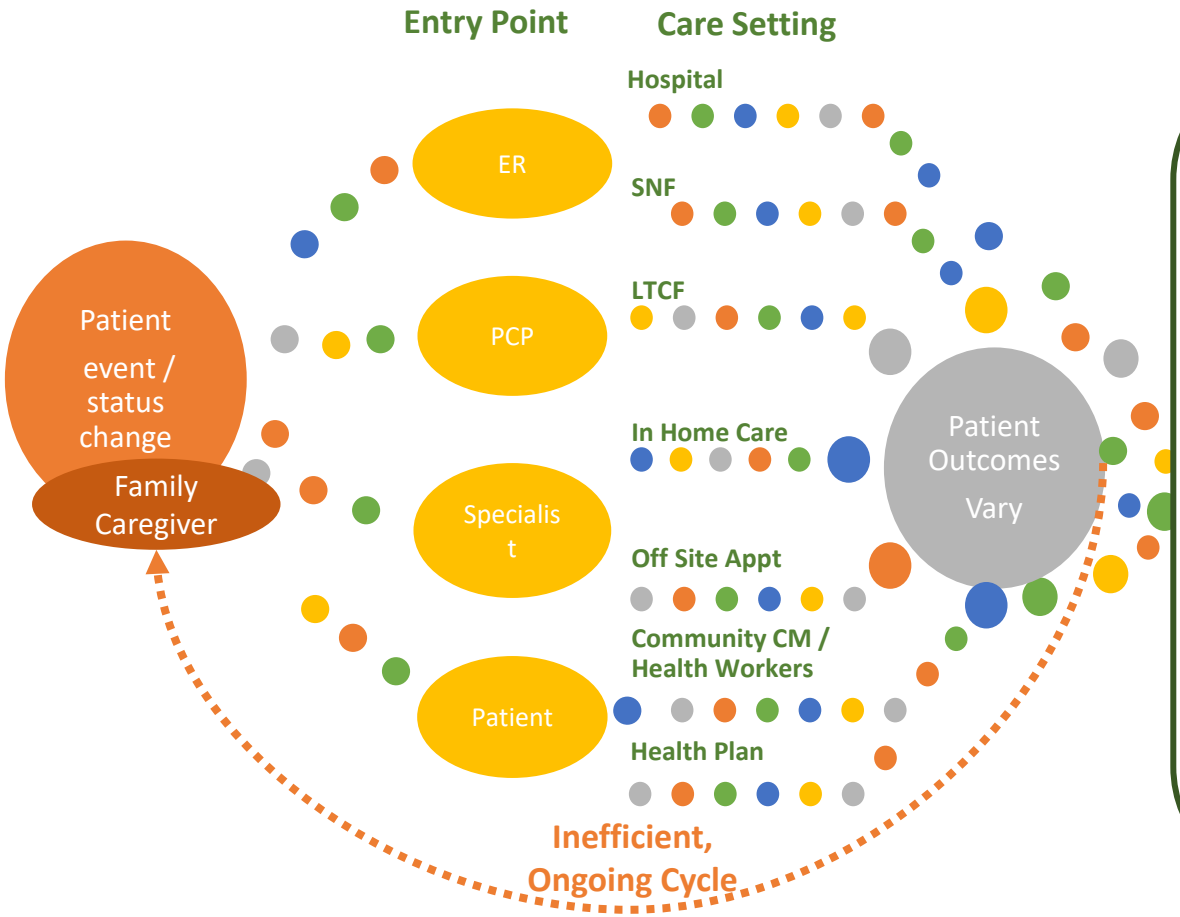
Program Statement

ADDUS is committed to advancing the effectiveness of several key trends in value-based healthcare delivery models (i.e., emphasis on high-risk/high-cost individuals; integration of clinical and social support services; and at-home healthcare).

Through this approach, we will improve the timely monitoring of changes in condition, optimize member self-management and self-sufficiency, ensure appropriate access to and use of the most aligned care delivery and social support services, and advance the use of life directives to ensure member wishes and care deployment is aligned during late-stage care.

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Current State Patient Experience *Without* an HRHC Model

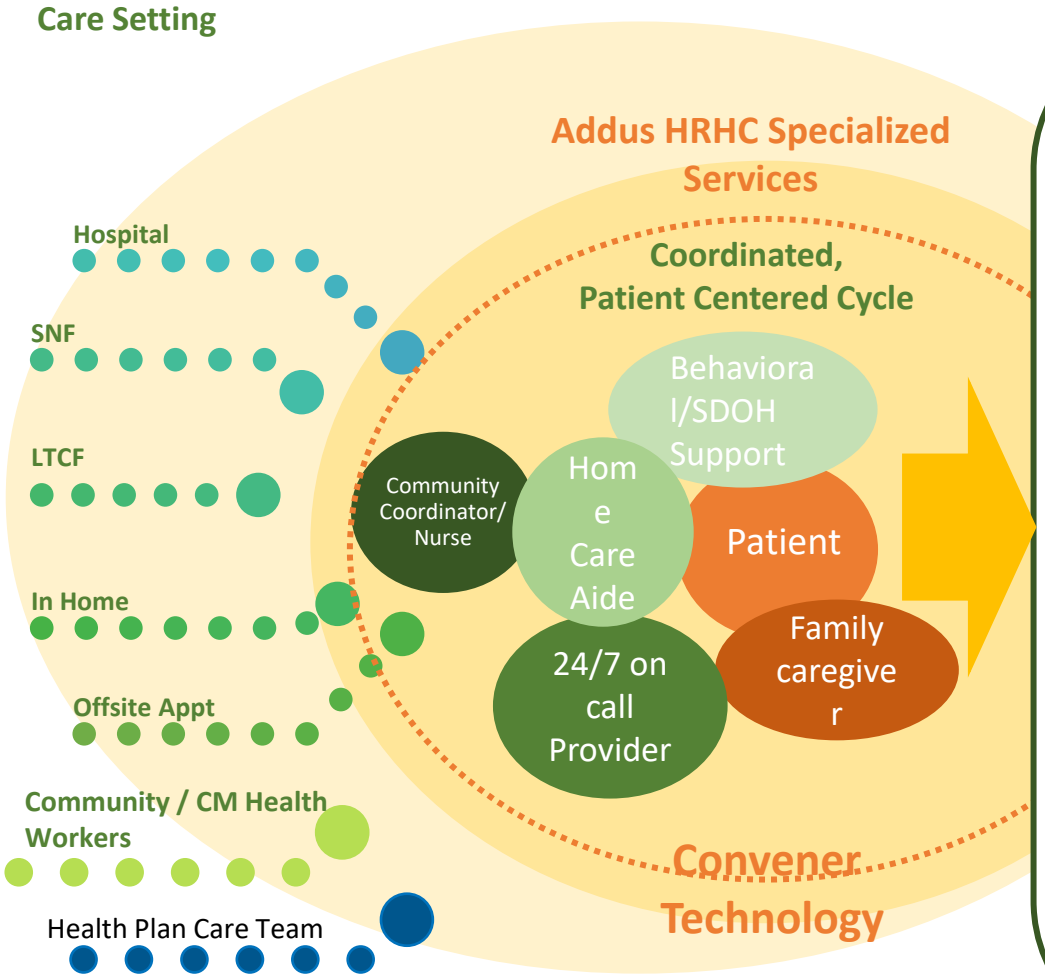


Outcomes

- **Cost of Care –** Highly variable
- **Admin Expense –** Varies; process inefficiencies
- **Care –** Uncoordinated; reactive; **no end-to-end care plan; likely lacks consistent RN / Aide relationships**
- **Tech –** Fragmented
- **Measurement –** Limited; challenges proactively tracking and closing metrics (e.g., STARS)
- **Care Visibility –** Often limited until prior auth and / or claim is submitted

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Future State Addus HRHC Model



Outcomes

- **Cost of Care –** Optimized; Care plan driven
- **Admin Expense –** Reduced due coordinated, streamlined and outsourced approach
- **Care –Proactive, end-to-end care plan; relationship based; culturally competent**
- **Tech –** Consistent platform; ability to scale and connect
- **Measurement –** More data sooner in process; improved ability prevent gaps in care (e.g., STARS)
- **Care Visibility –** At point of admission and ongoing
- **Risk Mitigation –** Fewer supplier relationships; trusted partner with deep expertise

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Addus HRHC Community Care Models

Addus is committed to advancing value-based care models for high-risk/high-cost (HRHC) individuals, that integrate clinical and social support services, optimizing the effectiveness of care management

Models are designed to address immediate needs and outcomes of the at-risk provider/payer

- SNF at Home
- LTCF Transition
- Post Acute Transition
- Gap Closure
- End of Life Management

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Post Acute Transitions

Patient Population

Patients with chronic disease who experience frequent exacerbation and re-hospitalization
- CHF with one re-hospitalization within 30 days
- All patients will more than 2 re-hospitalizations in less than 30 days over the past 6 months

Care Model

A Comprehensive pre-discharge evaluation will aim to identify gaps in care or barriers to compliance, which may result in re-admissions and/or are required for patient to remain at home with out SNF placement. In addition to traditional home health, the program includes provision of: In home nursing and personal care services the day of discharge; management of post discharge medications, medical supplies and services; non clinical support with ADL's; intensive patient education; and, tele-health/tele-monitoring.

Top Level Case Management supported by a 24/7 Command Center

Able to assess and deploy needed staff and services to the home

Provides avenue for continuous daily monitoring and communication with patient/caregiver and agency personnel

Operational Infrastructure

Technology
- Ongoing patient risk eval
- EVV with CIC
- Install RPM/PERS
- Deploy telehealth applications

Supply / Support
- DME as needed
- Access additional support services (i.e., meals, transportation)
- Health literacy support
- SDOH evaluation

Personnel
- HH services to support clinical interventions and intensive therapy
- Dedicated trained HCAs doing regular CIC reporting and ADL support
- Deployed clinical support to include telehealth, local EMS

Financial Model

Medicare/Medicaid and MA : HH, pharmacy, labs, EMS, DME
Medicaid Waiver: Personal Care, PERS, Transport**
Area Agency: Meals, Housing Stability
Hospital: Success payments, indigent coverage

** Patients not eligible for Medicaid or indigent care funded privately by patient

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

ADDUS HOMECARE

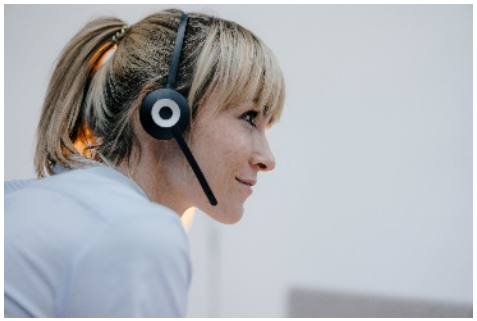
Here Is A “Real World” Example Of How Addus’s Personal And Face-to-face Care Model Makes A Difference

Meet Rose

- 6+ chronic health conditions
- Dual eligible
- Happily married; her husband is her primary caregiver
- Receives in home care support from Addus
- Resides in a subsidized apartment home
- Requires oxygen to get around

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Meet Rose's Care Team Who Acted On Her Behalf



Meet Claire, Rose's Health Plan CM

- Registered Nurse
- Connects with Rose monthly via phone; wishes she could check-in more frequently
- Because she can only connect telephonically, Claire lacks visibility into Rose's environment limiting the in-depth interventions she would like to provide

Meet Brian, Rose's Addus Personal Care Worker

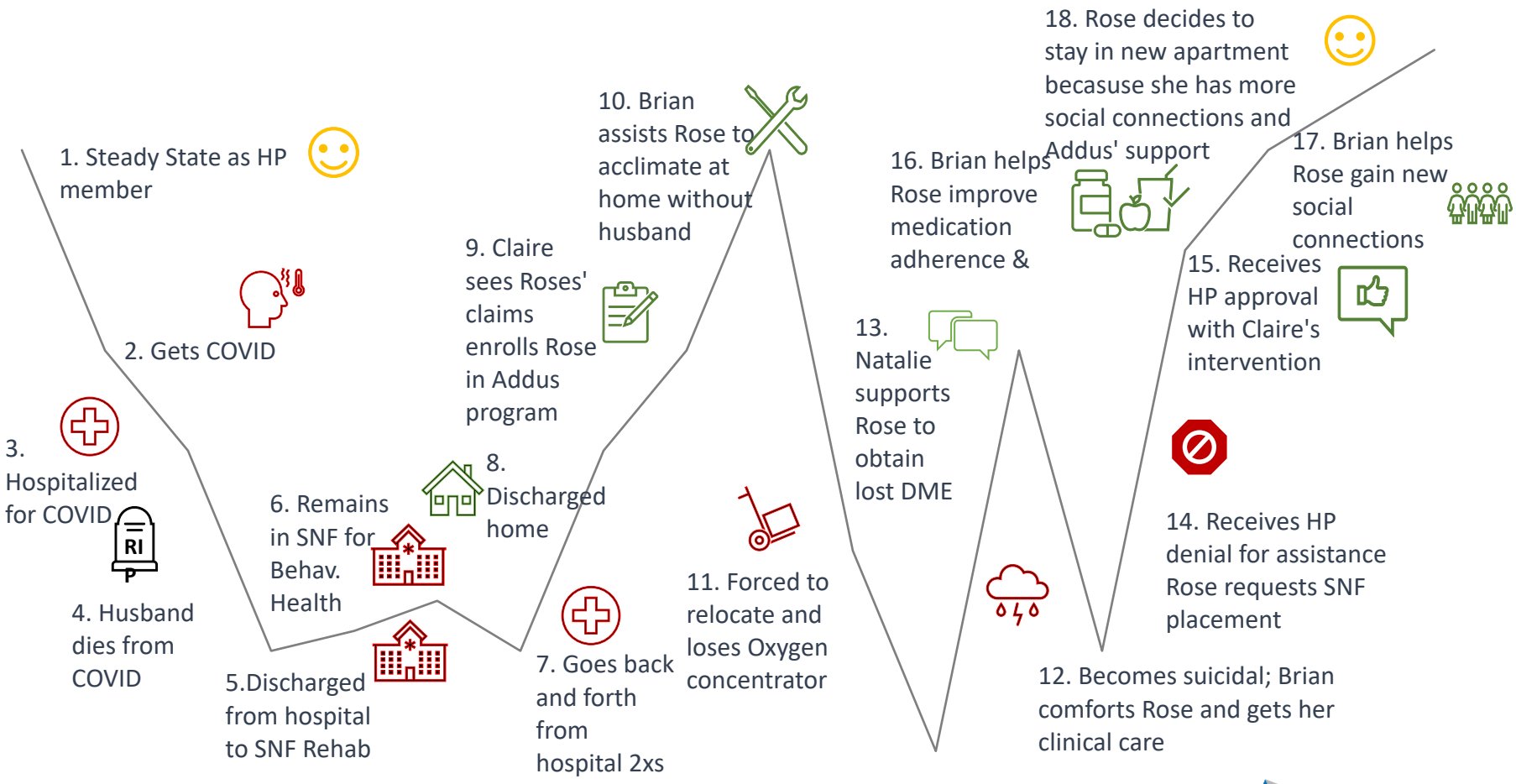
- Knows Rose and her former husband prior to joining Addus because he lives in the same neighborhood
- Has been trained on how to meet ADL needs and additional training on Rose's specific medical needs
- Deep understanding of community supports

Meet Natalie, Rose's Addus Nurse

- Licensed Practical Nurse
- Connects with Rose during her second re-hospitalization from SNF
- Develops a deep understanding of Roses needs during home care visits

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

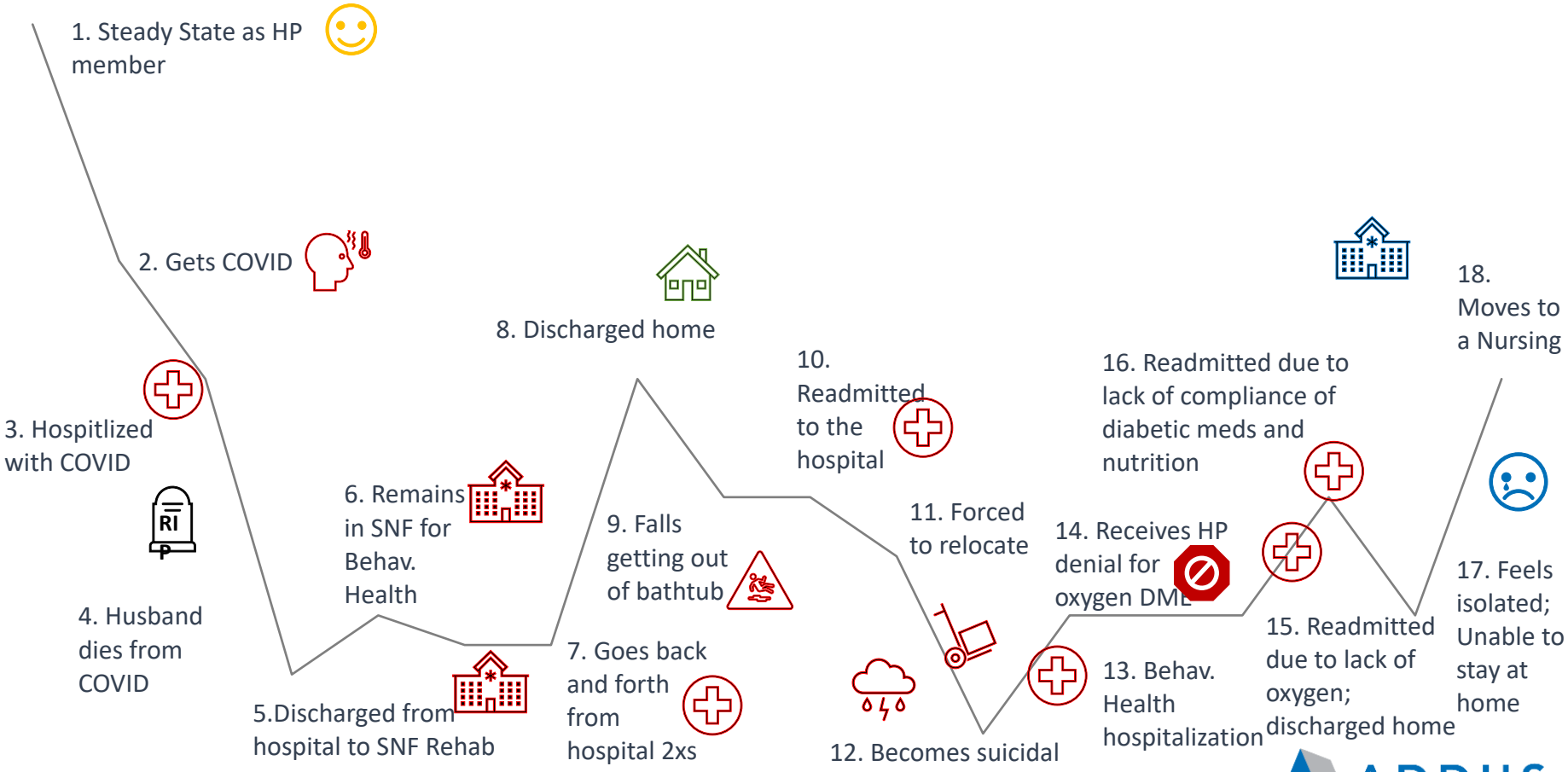
Rose's Care Team Agrees Addus' Understanding of Rose's Home Environment Helped Avoid Four Re-Hospitalizations And A Move To a Nursing Home While Improving Her Care Plan Adherence



Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

What Rose's Journey May Have Looked Like Without Addus

- Given the Health Plan's Care Management Model, Claire could not truly understand Rose's unique situation and intervene on her behalf



Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

Initial financial model includes contracted FFS rates for home services, incentives for successful fulfillment of task related metrics, and gain share for avoidable events versus control groups

VBC Initiative #1 – Post-Acute Care Transitions			
	Performance Objectives	**Data Requirements**	**Addus Experience (Test Markets)**
PRIMARY	Reduced readmission rates	• Claims data (retrospective and prospective) • Addus enrollees EMR data • Control group	• Addus – 8% (30 day readmit rate) • Control – 16% (30 day readmit rate)
	Reduced need for SNF admissions/LOS		
	Reduced admits to LTCFs for S/T rehab		• 1 of 52 (2%) clients admitted to SNF
SECONDARY	Adherence to med regimen/STARs	• Claims data (retrospective and prospective) • HCA generated Change in Condition Reports • Control group	• Assisted 50% of clients with open gaps to complete PCP visit
	Support with appointments		
	Self-commitment to nutrition/diet adherence		
	Identification of behavioral changes		• Receive and process over 1600 CIC reports monthly
	Identification of environmental/SDOH changes		
	Reduced unnecessary ED visits		

Confidential property of Addus HomeCare. Do not distribute or reproduce without express permission from Addus HomecCare.

BAYADA®

WE LOVE WHAT WE DO

BAYADA

Continually Innovating to Improve Care

About BAYADA

BAYADA
WE LOVE WHAT WE DO

BAYADA has a **legacy of more than 45 years** of industry leadership, high **quality care,** and growth in **impact**

Founded in 1975 by Mark Baiada in Philadelphia

A private, family-owned home health provider that transitioned to nonprofit

Headquartered in Moorestown, New Jersey

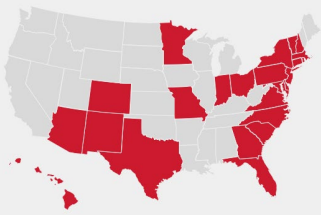
23,000 field clinicians
34,400 clients/week

3,000 full time office employees

$1.4 billion in annual revenue

1,000 hospital/SNF collaborations and **5,000** physician partners nationwide

More than 1,000,000 clients cared for since 1975



More than **360 organically developed local offices** provide nurses, home health aides, therapists, and social workers to 150,000+ clients per year

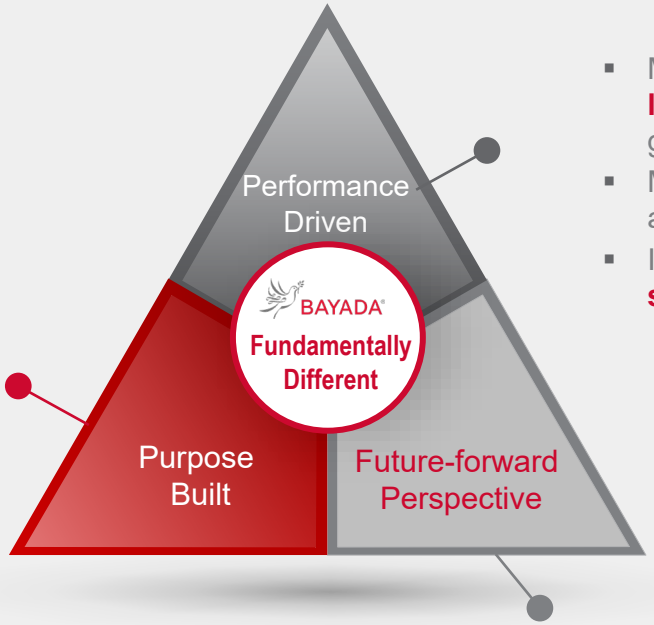
PAYOR PARTNER BENEFITS

- Best-in-class provider reputation **enhances network quality** and CMS Star ratings
- **Scale of services** to be a **comprehensive partner** for large networks
- Growth-oriented partner **empowered to innovate home-based care** models
- **Provider** partnerships ensure cross-continuum **care coordination**

About BAYADA

BAYADA
WE LOVE WHAT WE DO

- **BAYADA Way** value system fuels the **highest talent satisfaction** in the industry
- **10 BAYADA services** provide a comprehensive care continuum
- **Not-for-profit status** ensures BAYADA is **built to last** and has the flexibility to serve a more **diverse patient mix**

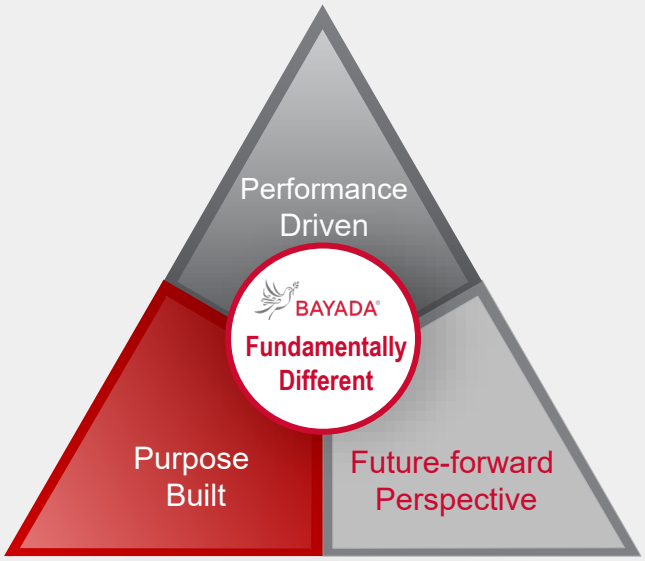


- More than **45 years** of industry **leadership**, high **quality care,** and growth in **impact**
- Market leading **training**, **compliance,** and **quality accreditations**
- In-house **clinical and personal care services** to **manage risk** over time

- Investment in **innovation** and **higher acuity models of care** to manage complex patients in the home
- Growing portfolio of **health system joint ventures** to build home-based care expertise as a **population health strategy**
- **Success in value based contracting models** that improve health outcomes and reduce total costs of care

About BAYADA

BAYADA®
WE LOVE WHAT WE DO



PAYOR PARTNER BENEFITS

- **Improve health outcomes**
- **Create opportunities for early intervention to reduce MLR**
- **Expand access to data on social determinants of health**
- **Enhance member experience and retention**
- **Accelerate value creation through home-based care**

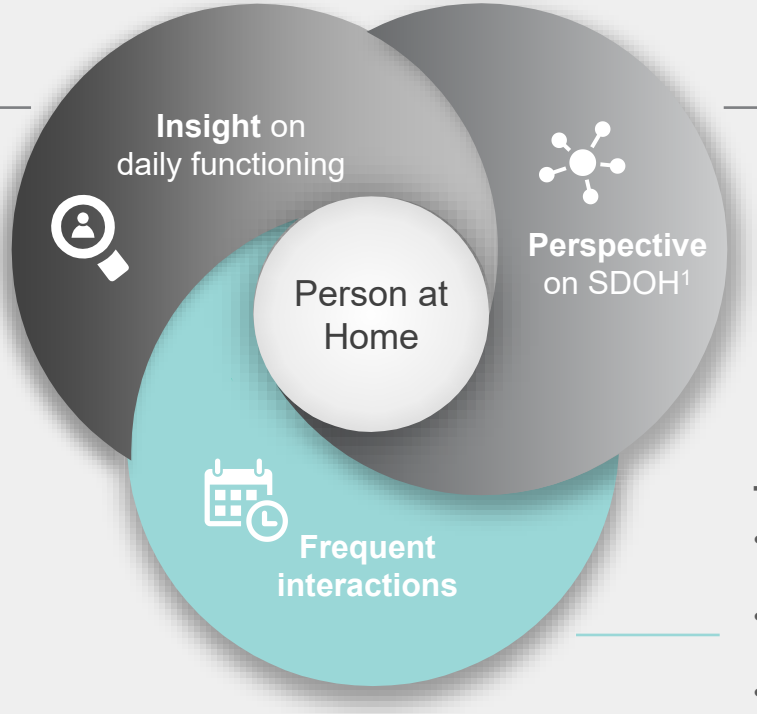
Medicare & Medicare Advantage | **Medicaid & Dual Eligible** | **Commercial**

Home-based care is an unmatched opportunity to maintain wellbeing and provide proactive care

BAYADA®
WE LOVE WHAT WE DO

The foundational benefit

- How is the person functioning in the home?
- How much support do they need with ADLs?
- Should we deliver a shower bar or a walker?



The broader perspective

- How robust is the person's social support system?
- Is the home located near public transit, grocery stores, and safe outdoor spaces?
- To which social services should we refer this person?

The timely intervention

- How is the person doing compared to our visit last week?
- How is their physical and mental health trending?
- Does the person need an appointment with their PCP this week?

1. Social determinants of health.

BAYADA's Community Health Nursing model

BAYADA
WE LOVE WHAT WE DO

- BAYADA's Community Health Nursing model was established to support the most vulnerable, high -risk populations by designing a comprehensive healthcare plan to keep these underserved clients safely in their community with maximum independence.
- Our Clinical Managers are engaged to assess clients, inform care planning, recommend, and assist with access to resources, and periodically reassess to identify any changes in condition.
- A digital tracking system provides a longitudinal health profile. Evidenced based analytics predict risk and guides potential interventions to ensure clients remain safely in the community - minimizing hospitalizations, readmissions, and ER visits, and reducing total cost of care.

- Operating Model:
  - Utilizing evidence-based risk stratification – driving frequency of intervention and touch points based on individual client needs
  - Collaborative model driven by case conference
  - Resolving clinical and SDOH care gaps by referring to appropriate services
  - Assisting with end-of-life transitions to community Hospice

Our Advanced Care Management Process

BAYADA®
WE LOVE WHAT WE DO

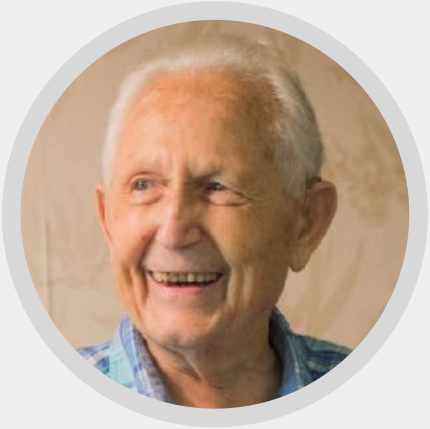
	Observe	Report	Inquire and Validate	Assess and Respond	Notify / Refer / Engage Community Resources and Partners
On-Demand	 Member: Stewart R. BAYADA Home Health Aide		BAYADA Office Team 25% Report was a mistake or non-issue	BAYADA RN / Clinical Manager	25% BAYADA State's and MCO's
Clinical Snapshot	 Member: Stewart R. BAYADA RN / Clinical Manager	BAYADA® ADA Proprietary assessment	AI Clinical decision support	Details of reported issue sent to available RN / Clinical Manager or BAYADA Care Management Team	

BAYADA

WE LOVE WHAT WE DO

BAYADA

WE LOVE WHAT WE DO



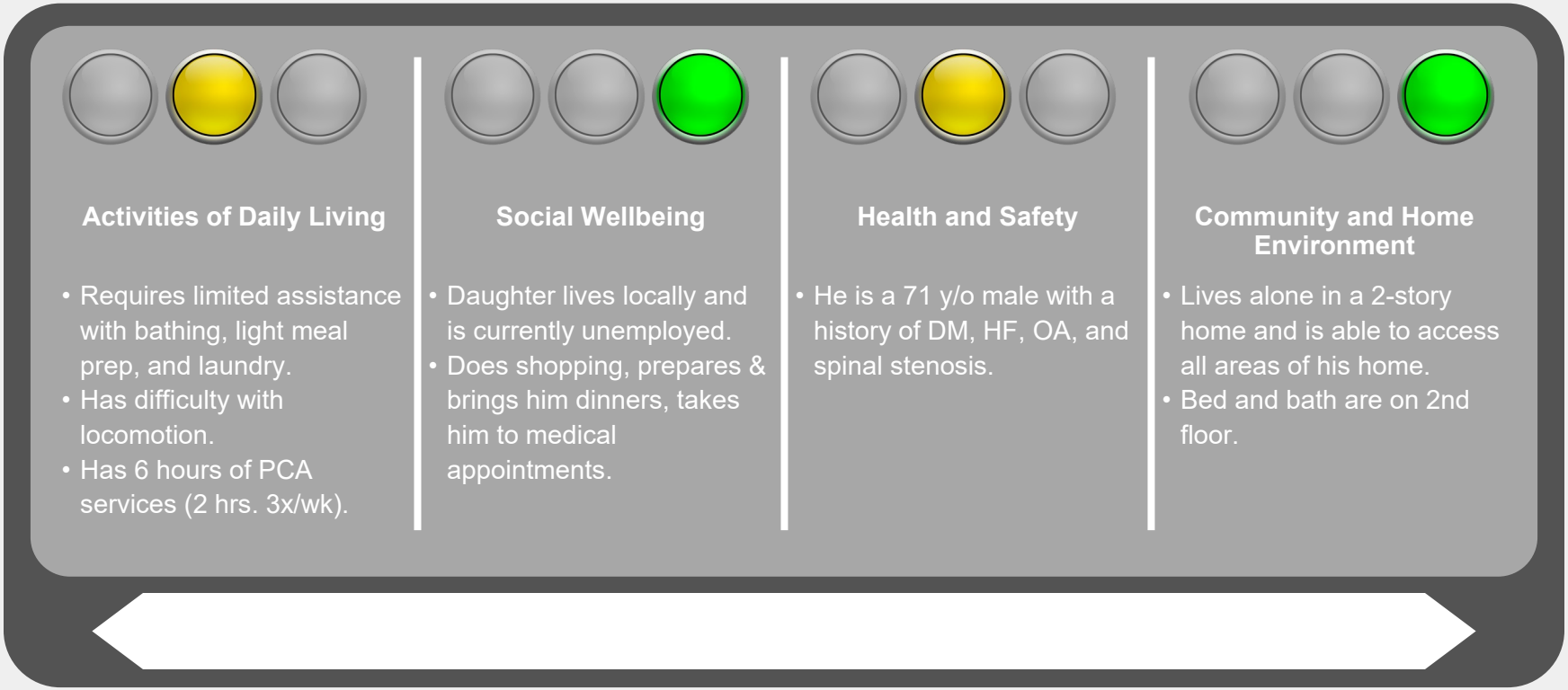
Stewart R.

Case Study:

15-month Review of Clinical Assessment and Real-time Change in Condition Monitoring

The Admission: January 2020

BAYADA
WE LOVE WHAT WE DO



Activities of Daily Living

- Requires limited assistance with bathing, light meal prep, and laundry.
- Has difficulty with locomotion.
- Has 6 hours of PCA services (2 hrs. 3x/wk).

Social Wellbeing

- Daughter lives locally and is currently unemployed.
- Does shopping, prepares & brings him dinners, takes him to medical appointments.

Health and Safety

- He is a 71 y/o male with a history of DM, HF, OA, and spinal stenosis.

Community and Home Environment

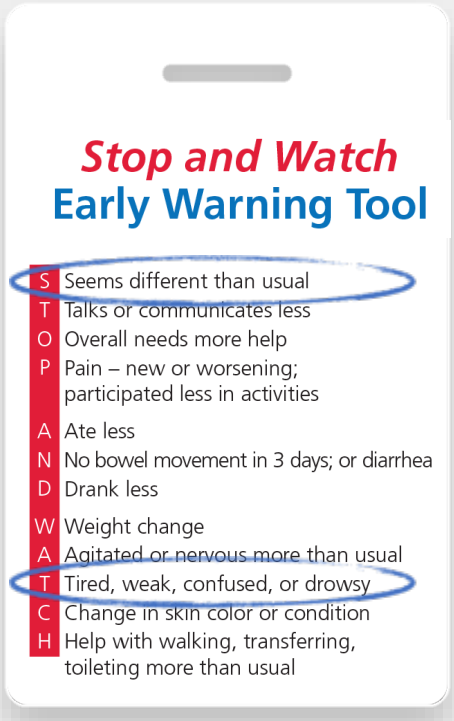
- Lives alone in a 2-story home and is able to access all areas of his home.
- Bed and bath are on 2nd floor.

Likely intervention needed No imminent risk Stable, no needs

Real-time Change in Condition Alert

BAYADA
WE LOVE WHAT WE DO

FEBRUARY 19th 2020



BAYADA RN follow up reveals:

- History of UTIs
- Increased frequency of urination
- Confirmation of change in condition

Action Taken

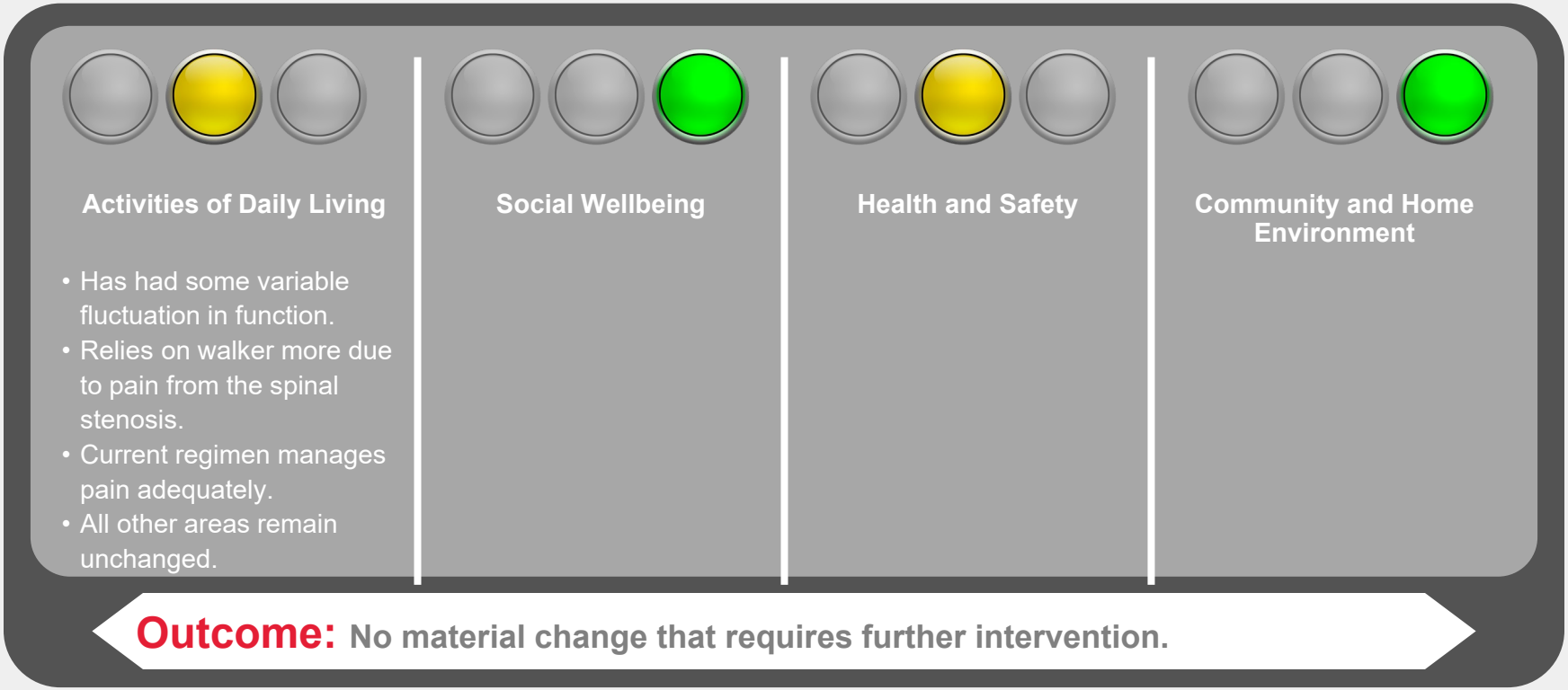
- Call to daughter
- MD facilitates same-day appointment
- Stewart R. treated with antibiotic therapy
- RN does telephone f/u to monitor for change

Outcome

- Stewart R. averts an admission

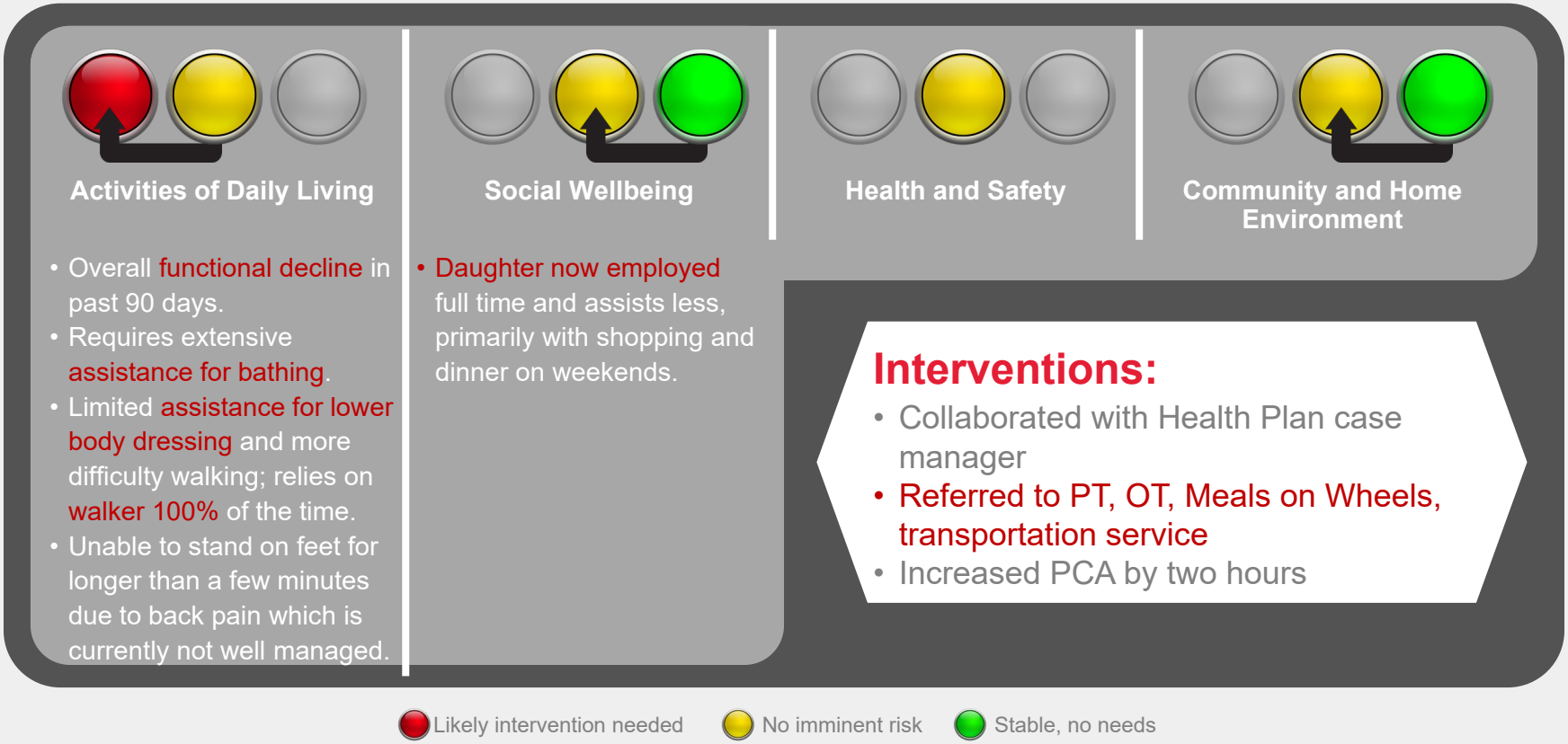
3-Month Progress Assessment: April 2020

BAYADA
WE LOVE WHAT WE DO



6-Month Reassessment: July 2020

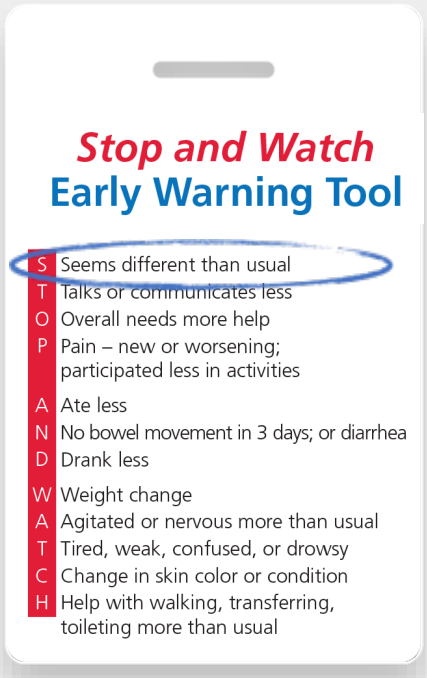
BAYADA
WE LOVE WHAT WE DO



Real Time Change in Condition Alert

BAYADA
WE LOVE WHAT WE DO

September 9th 2020
Shortness of breath



BAYADA RN follow up reveals:

- Client unable to lie in bed and sat in his recliner all night due to shortness of breath
- Shortness of breath during morning routine with aide
- Aide reports shoes are tighter than usual
- Confirmation of change in condition
- Client ate hot dogs and chips at Labor Day labor picnic

Action Taken

- Call to daughter
- Facilitates appointment
- MD called client and daughter and instructed to increase his diuretic same day and follow-up in the office the next day

Outcome

- Early intervention avoided the need for in-patient admission

12-Month Reassessment: January 2021

BAYADA
WE LOVE WHAT WE DO

15-month Progress Report: April 2021

BAYADA
WE LOVE WHAT WE DO

Activities of Daily Living

- Able to bathe in shower again with extensive assistance.

Social Wellbeing

- Depression scale below cut-off for risk.

Health and Safety

Community and Home Environment

- Able to access bed and bathroom on 2nd floor with installation of motorized stair glide chair.
- Transported one day a week to local daycare for socialization and activity.

Outcome: Continue to monthly monitor.

Likely intervention needed No imminent risk Stable, no needs

CENTENE® Corporation

HCBS Value-Based Contracting

Questions?

Thank you!

Mark Henry – Director of Contracting, Complex Care and Foster Care, Centene Corporation, Mark.Henry@wellcare.com, 615-987-2380

Valerie Gates – Vice President of Operations, Superior Health Plan, Valerie.Gates@superiorhealthplan.com, 512-410-9432

Diane Kumarich – Senior Vice President Payer Innovations, Addus Home Care, DKumarich@addus.com, 847-212-4032

Matthew Lippitt – Vice President Payer Contracting and Strategy| BAYADA Home Health Care, mlippitt@bayada.com, 908-377-7101