PREMIER

National Best Practices in Value-Based Payment Innovation and Implementation

Joe Damore, Premier PHM

Greg Wojtal, Banner Health Network

Russ Mohawk, Inova

Dirk Clark, MPact Health

February 18, 2016

Today's agenda

- **Introductions/Purpose (Joe Damore)**
- **Overview of Value based payment models**
  - **Banner Health Network(Greg Wojtal)**
  - **Inova (Russ Mohawk)**
  - **MPact Health (Dirk Clark)**
- **Panel discussion**
- **Summary**

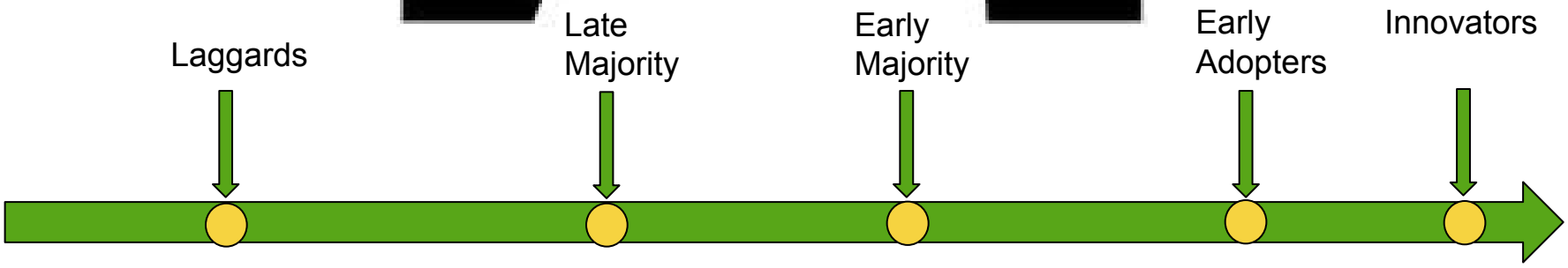
Transitioning to value based payment: A foot in two worlds

Pay for volume

- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Lack of outcome based metrics
- Duplication and waste

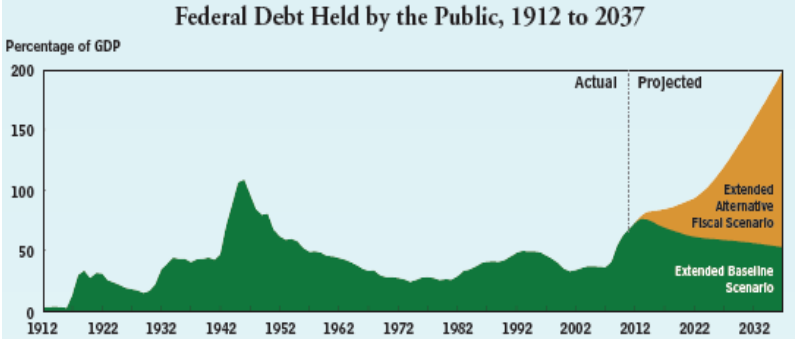
Pay for value

- Accountable care
- Coordinated care across the continuum
- Global payment
- Fostering wellness
- Payor partners
- Fully wired systems
- Right care, right setting, right time
- Triple Aim metrics



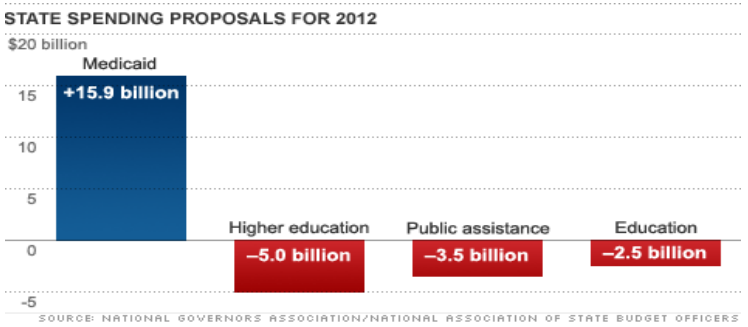
Market pressure

Federal

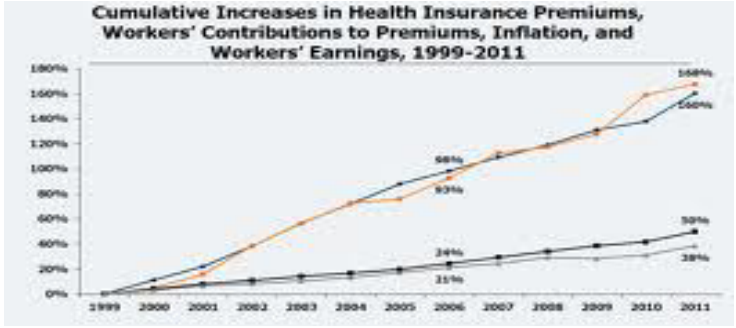


- Current Medicare enrollment is projected to increase from approximately 55M today, to 85M by 2035
- Dramatic projected growth of all major chronic diseases
- FFS payment reductions
- Value-based payment risk

State



Employee / Commercial



Government developments

National policy developments

- HHS Announcement (1/26/15) to increase speed of the transformation to value based payment
- New Oncology bundled payment program
- Next Generation ACO Model-21 new participants (1/1/16)
- MACRA bi-partisan approval of SGR fix with physician incentives to value based payment programs
- New MSSP rules approved/new target process announced 1/2016
- 100 new MSSPs announce for 1/1/16 (64 did not renew)
- 12% of Medicare ACOs now in two sided risk (2016)
- CJR required bundled payment participation in 67 markets (>750 hospitals) on 4/1/16

State reform developments

- SIM state planning grants (VA, MI, ID, MI, WV, etc.)
- Episodes of care model (AR, TN, OH)
- ACO model (OR, CO, AL, and proposed for NC)
- DSRIP model (TX, CA, NJ, NY)

HHS 2/15 goals:
Better Care. Smarter Spending. Healthier People

Volume to Value

	2016	2018
Track 1: Value-based payments	85% of all Medicare payments	90% of all Medicare payments
Track 2: Alternative payment models*	30% of all Medicare payments	50% of all Medicare payments

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Medicare Access & CHIP Reauthorization Act (MACRA) of 2015

Replaces the 1997 SGR formula, which capped Medicare physician per beneficiary spending growth at GDP growth rate

- Overwhelming bipartisan support.
- Provides new tools in implementing the payment reforms.
- Applies to MD, DO, PA, NP, Clinical nurse specialist, nurse anesthetist.
- 2021 includes therapists, psychologists, social workers, audiologists, and dieticians.
- Creates clear timetable and benchmarks.
- Provides two options for physicians
  - Merit Based Incentive Payment system (MIPS)
  - Alternative Payment Models (APMs)

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

Key commercial health plan trends

- **Consensus that the shift to value based contracting is underway**
- **Commercial payer value-based contracting strategies are still evolving**
- **Several payers are integrating with primary care physicians** (Humana, UHC/Optum, Highmark BC, etc.)
- **Data analytics and the IT infrastructure are critical in the shift to value-based contracting**: Current capabilities in this area fall short and require further development by payers and providers
- **Inconsistencies in quality measurement approaches and metrics must be addressed**: Variations among quality measurement programs and targets across payers is a significant challenge
- **Provider sponsored health plans are on the rise**
- **Payers are beginning to "pick partners",** reducing number of provider partners per geographic area (especially for exchange products)

Integrating care redesign and new payment models

Value Based Care Redesign

- Patient Centered Medical Home
- Clinical Integration
- Care Management
- Post-Acute Care
- Electronic Health Record
- Data analytics

Care redesign must not outpace changes in payment

New Value Based Payment Arrangements

- Care Transformation Costs
- Care Management Payment
- Shared Savings
- Episodes of Care Payment
- Global Payment

Population Health Transformation

Banner Health Network

National Best Practices in Value-Based Payment Innovation and Implementation

Greg Wojtal, VP/CFO BHN

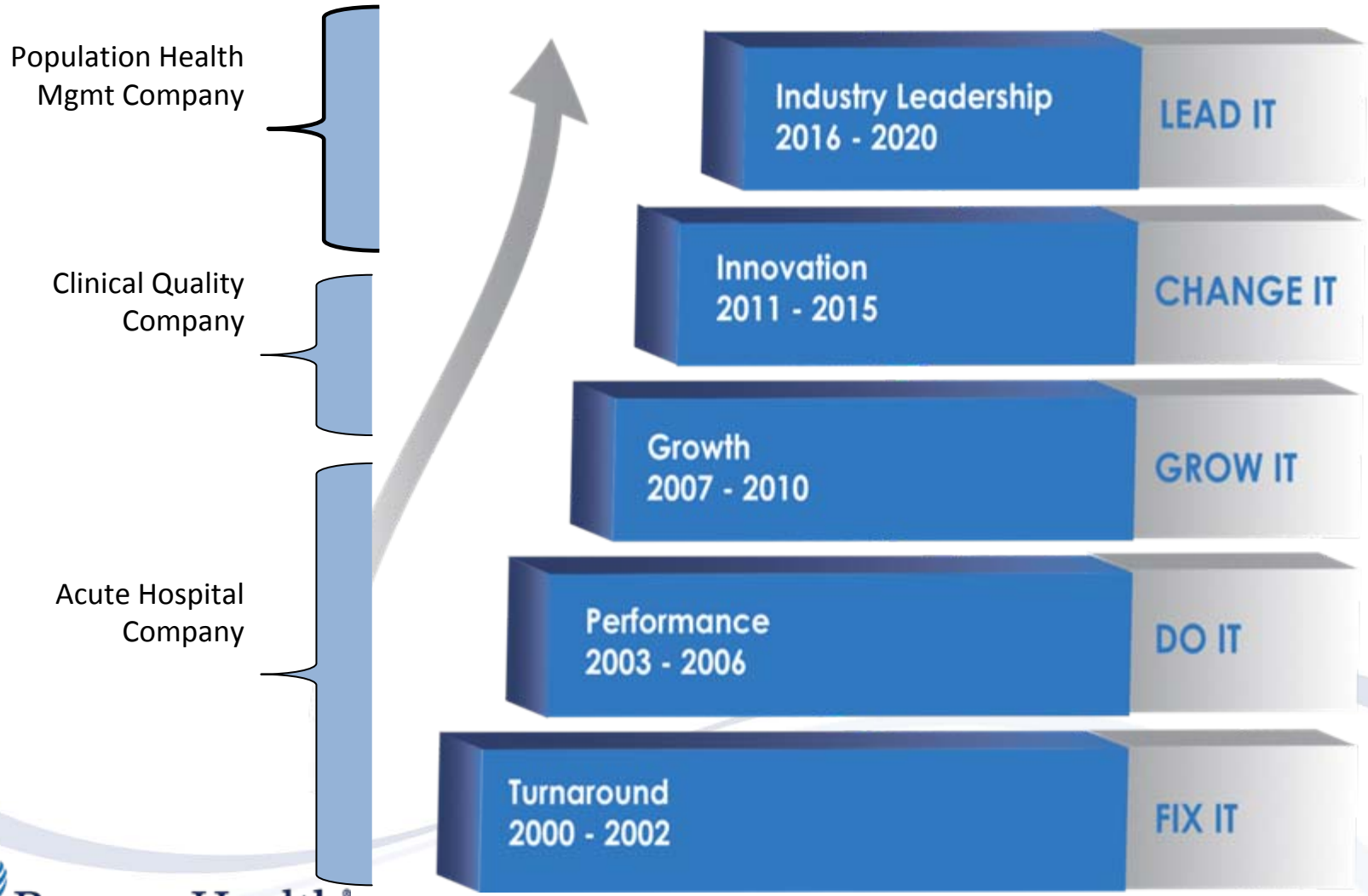
February 18, 2016

Banner Health

- 29 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group With More Than 1,500 Physicians and Advanced Practitioners and More Than 200 Banner Health Centers and Clinics
- Outpatient Surgery
- Banner – University Medicine Division
- $5.4 Billion in Revenue, 2014
- AA – Bond Rating
- $457 Million in Community Benefits, Including $84 Million in Charity Care, 2014

Banner Health®

Banner's 2020 Vision
"Our steps to the Future"



Banner Health

Assumptions

1. The ***growth of risk-based lives*** with Banner responsibility will grow rapidly.
2. The ***"retailization"*** of healthcare purchasing facilitated by the insurance exchange structure of January 1, 2014, will continue to expand.
3. ***Price*** will be an increasingly dominant feature for a large segment of the population served.
4. Clinical excellence will be a primary cost improvement driver, but the ***patient/member experience*** will be the tangible "product differentiator."
5. To maximize efficient and reliable clinical management, ***tactics and services targeted at patient management are best "embedded" within the delivery system.***

Banner Health®

The Who:
Banner Health Network

Banner Health Network Vision:
To be the health system of choice in markets we serve for those that entrust their health and wellbeing to us.

- **Arizona Integrated Physicians**
- **Banner Physician Hospital Organization**
- **Banner Medical Group**
- **Banner Health**

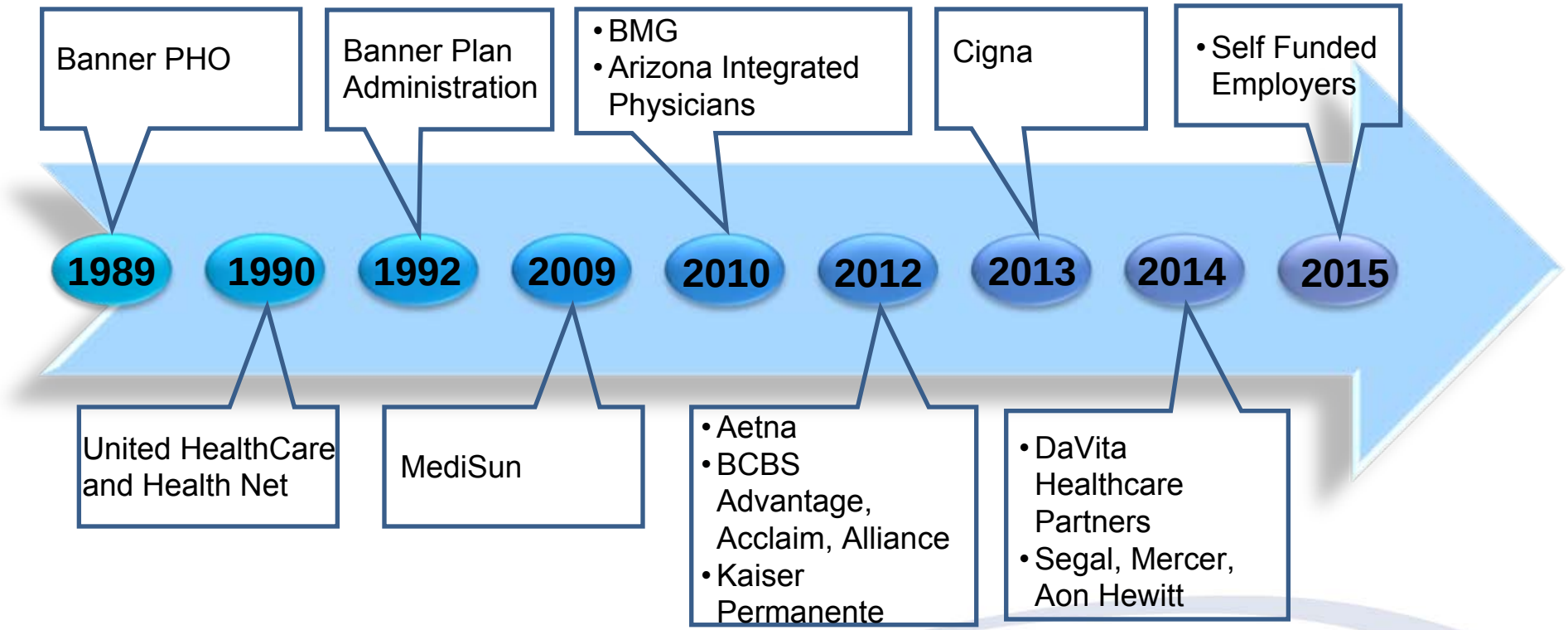
BHN Members

Triple Aim Goals:

1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing the per capita cost of health care

Banner Health®

Evolution of Our Journey



Banner Health®

BHN Pioneer Performance

PY1 2012	PY2 2013	PY3 2014	PY4 2015
876 providers	1,623 providers	1,340 providers	1,198 providers
50,500† aligned beneficiaries	55,500† aligned beneficiaries	61,250† aligned beneficiaries	86,700† aligned beneficiaries
4% shared savings $19.1M	2.8% shared savings $15.1M	5.0% shared savings $29.0M	TBD
Pay for Reporting 62.19%* Quality Score	Pay for Performance 81.18%* Quality Score	Pay for Performance 87.58% Quality Score	TBD
$13,369,201	**$9,038,408**	**$18,698,004**	TBD

*: Quality Scores per our official Settlement/ may differ from what was reported by CMS. This is because of a post-settlement adjustment in PY1 and PY2.

†Note: Beneficiary number is as of January; numbers decrease throughout year

Banner Health Network

Success – Commercial Market Place

aetna

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Banner Health Network

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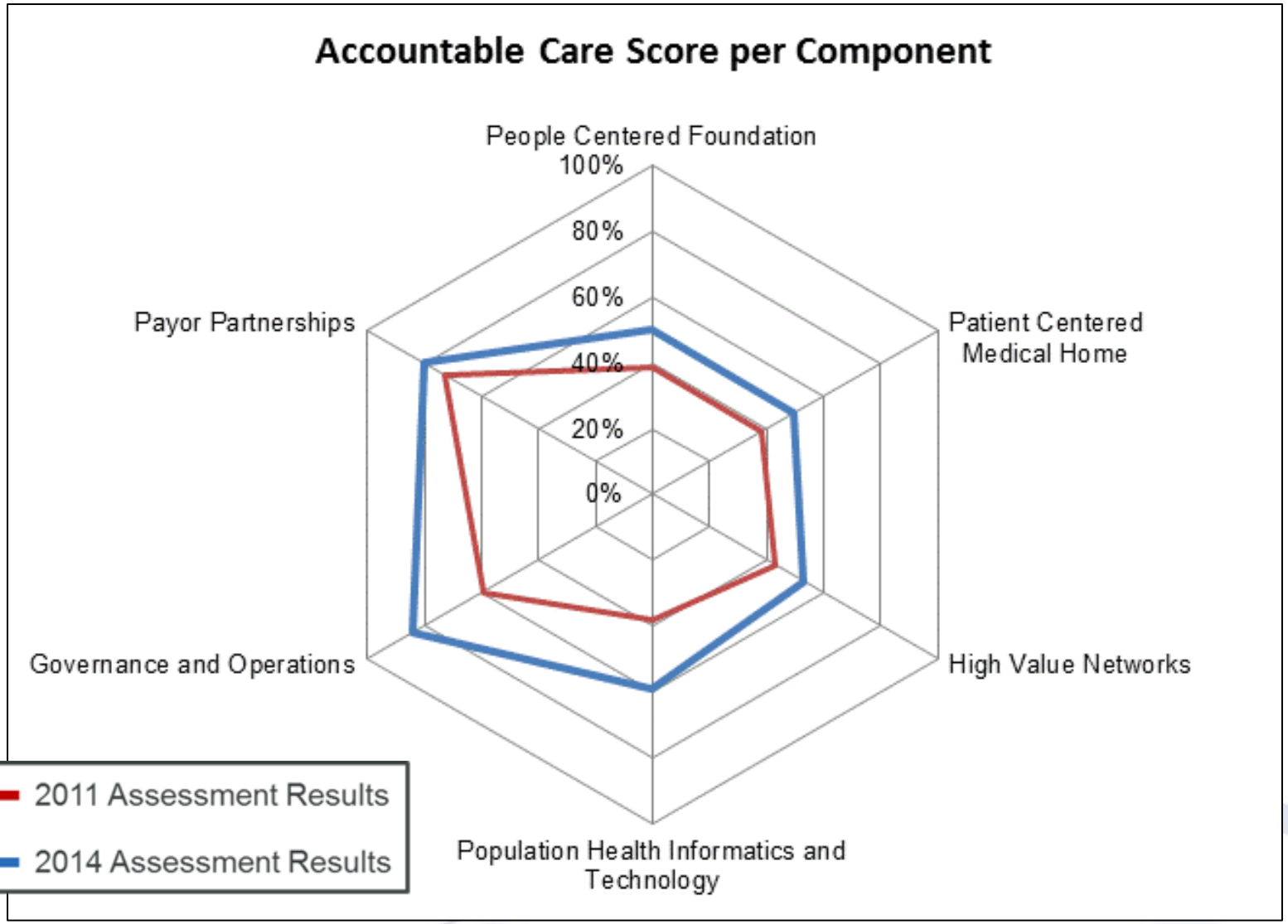
News Release

LOWER COSTS, MORE PROACTIVE CARE IN AETNA AND BANNER HEALTH NETWORK ACCOUNTABLE CARE COLLABORATION

-- Hospital admissions decline; quality measures improve --

PHOENIX, August 26, 2014 — Aetna (NYSE: AET) and Banner Health Network (BHN) today announced that their accountable care collaboration resulted in a shared savings of approximately $5 million on Aetna Whole Health fully-insured commercial membership in 2013 and a five percent decline in average medical cost on the members. At the same time, Aetna and BHN improved cancer screening rates, blood sugar management in diabetic members and reduced avoidable hospital admissions. The results demonstrate that patients benefit when physicians and health plans share resources and work together in accountable care models. Further, Aetna and BHN saw savings and improved medical cost trend on additional membership outside the Aetna Whole Health product.

ACO Assessment (Re-visited)



Note: Capabilities Framework has been updated three times since 2011 Assessment and the majority of the team that completed the 2014 assessment were not present in 2011. This analysis is not an exact comparison, but it is directionally accurate.

Keys to BHN Success

- Joint Operating Committee (well attended regular meetings)
- Information (data exchange)
- Care Management (created DOCR)
- Trust (plan design, sales/broker network, actuary services, etc.)
- Price Concessions – Volume Growth
- Joint Marketing / Branding
- Consumer Touch Points
- Quality Measures
- Financial Models

Plan Growth Project Assumptions

Value-based care is likely to stay

Government payer mix likely to grow

Commercial payer mix improvement requires additional payer, provider and consumer tactics

Where We Have Opportunities

- Identification of member needs
- Care management programs matched to member needs
- Moving faster
- Data and analytics to continually improve

Banner Health®

What We Aspire to Become….

Trusted Advisor, Health Steward

Banner Health's Senior Leadership Team envisions a Population Health Management Company – a clinically integrated network caring for whole communities and thriving under global reimbursement models

Banner Health®

Manufacturing Metaphor for New Accountabilities

Banner Health Network

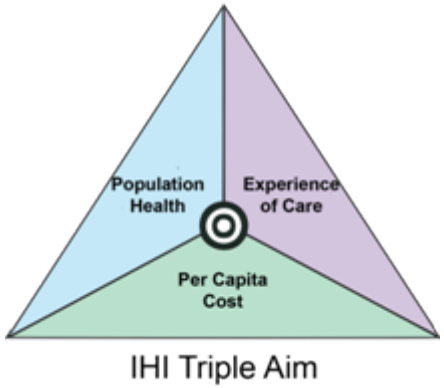
Health Mgmt/ Corp Svcs

Delivery System

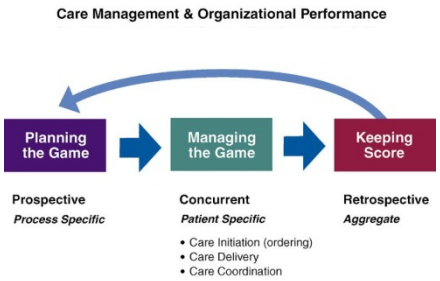
"Sales"

"Engineering"

"Manufacturing"



IHI Triple Aim



Corporate Support Services

Inova

Inova's Population Health Journey

Russ Mohawk
CEO Inova Health Plan and Population Health
February 18, 2016

Inova Health System Today

- Not-for-profit health care system providing a full array of services for the growing, and well-educated Northern Virginia region (2.4M Population) within the Washington, D.C. metropolitan area
- Net Revenue: $3.2B in 2014
- Key Facts:
  - 5 acute care campuses (1,700+ acute care beds)
    - Inova Fairfax Hospital (833-bed)
    - Inova Alexandria Hospital (318-bed)
    - Inova Fair Oaks Hospital (182-bed)
    - Inova Loudoun Hospital (183-bed)
    - Inova Mount Vernon Hospital (237-bed)
  - **Sites of Care**: 93 strategically located ambulatory & non-acute care
  - **Physicians**: 4,500 Community MD's & Inova Medical Group (450+)
  - **Health plans**: InTotal – Managed Medicaid Plan (60K Lives) & Innovation Health Plan – Commercial Plan JV with Aetna (180K Lives)
  - **MSSP –** Signature Partners (32K Beneficiaries)

Decision to Partner with Payer & Key Selection Criteria

INOVA™ Join the future of health.

Assessing Strategic Options

- ✗ **Do Nothing / Status Quo**
- ✗ **Contract Directly with Employers/Payers**
- ✗ **Build and Market Own Health Plan**
- ✓ **Partner & Joint Venture New Health Plan**

Health Plan Partner Attributes

- *State of the art data & information systems*
- *Capacity for scale in management & operations*
- *Innovator in physician integration*
- *Multi-year track record of high level performance*
- *Experience in Commercial, Medicare & Medicaid*
- *Agile—able to adapt and change quickly*
- *Common mission/mutual goals and objectives*

Innovation Health

INOVA™
Join the future of health.

Since September 2013 -
Over 1729+ customers have chosen Innovation Health

Nat'l Accounts	17
Public & Labor	2
Federal Employee Plan	1
Middle Market	28
Small Group	1,634
Total	**1,729**
IVL (On/Off-Exchange)	48,000

180,000+ members

Leading Innovations

Pioneering networks and plan design
Transparency tools
Distribution disruption

Serving all segments

Individual Exchange
Small Group-2-100
Middle Market- 101-3,000
National Accounts -3,000+
Public Sector
Federal Employee Plan

Lessons Learned

- ✓ Filing process with state Insurance regulators is much longer due to ACA oversight
- ✓ Hire strong management team to run JV
- ✓ Develop robust ”hands on” care coordination to compliment carrier’s remote legacy programs
- ✓ Assume the need the to develop internal analytical capability to manage utilization and care coordination
- ✓ Create effective communication and oversight process to monitor JV’s progress towards defined organizational goals
- ✓ Learn how to work with a highly matrixed organization
- ✓ Celebrate Successes
  - ✓ Shared Savings with Local Employer with 8500 Members
  - ✓ Bent the Cost Curve ↓5% Spend YoY
  - ✓ Risk-Stratification Identified High-Utilizers → Targeted Care Management to Improve Health and Reduce Spend

Signature Partners

INOVA™
Join the future of health.

- Clinically integrated network of physicians and hospitals in Northern Virginia who work together to provide high quality, lower cost care by integrating and coordinating clinical

SIGNATURE
PARTNERS

Providers
Together, we are transforming healthcare.

Patients
Better outcomes for an enhanced patient experience.

Payers
Finding solutions that make healthcare more affordable.

Employers
Healthy employees means greater productivity.

MSSP
Improved Care for Medicare Beneficiaries.

Care Management

INOVA™
Join the future of health.

Enhanced Care Coordinators

- Aetna & Signature Care Coordinators who engage members and place in appropriate care management program: Disease Management, Coaching, etc.
- Daily EPIC-Driven Alert to Identify IH members within Inova System

Post-Acute Care

- Transitional Care Management (TCM) program, post-discharge community placement, medical home (30 day) for high risk for readmission
- "SNF-ist program" at each SNFwe have significant discharges
- Select high performing SNFs for our network.
- Enroll High Risk patients in Care Management Programs when at a Post Acute Facility

High Risk / Complex Outpatients

- High risk Innovation Health Members are identified through pulse and Aetna opportunity scores
- Advanced Illness Model – Complex Geriatrics Program
- Increase Remote Monitoring
- Increase Palliative/Hospice Referrals, Advance Directives and Care Planning

Gain Share and Pay-for-Performance

INOVA™
Join the future of health.

MSSP

- One-sided model with 60% of earned savings distributed to providers; allocation based on attribution and compliance with a single measure – advance care planning

Innovation Health

- “Guaranteed” P4P payment based on attribution and performance on 10 measures comprised of 3 network measures and 6 provider measures
- “Variable” gain share based on savings in excess of the guaranteed payment

Medicare Advantage

- Negotiating collaborative agreement with Aetna for PMPM care coordination fee (risk adjusted) + PMPM P4P based on performance

Employer Direct Gain Share

1 National Accounts	Be a National Accounts plan sponsor
2 Membership	Have at least 3,000 * members in our Service Area
3 Steerage	Agree to some form of steerage
4 Risk Share	Agree to risk share arrangement

Inova – Employer Direct Risk Sharing Contracts

INOVA™
Join the future of health.

- At risk for members in our catchment Area
  - Approximately 25,000 members
  - 50/50 risk sharing up and down
  - Risk corridor of 15% up and down
  - Target PMPM medical cost based on:
    - ✓ Previous 12 months claims experience
    - ✓ Less Catastrophic claims and
    - ✓ Less network pricing impact
    - ✓ Medical inflation/trend
    - ✓ Seasonality

Inova Employer Risk Sharing Lessons Learned

- ✓ Have access to an experienced underwriter/rate development SME
- ✓ Request most recent 12 months claims experience to conduct risk stratification
- ✓ If claims experience is not available require members to complete a health Risk Assessment to perform risk stratification
- ✓ Identify and engage high risk members early on
- ✓ Monitor financial performance on a monthly basis
- ✓ Require, at a minimum, benefit steerage into ACO/CIN

National Value-Based Payment and Pay for Performance Summit

February 18, 2016

MPactHealth

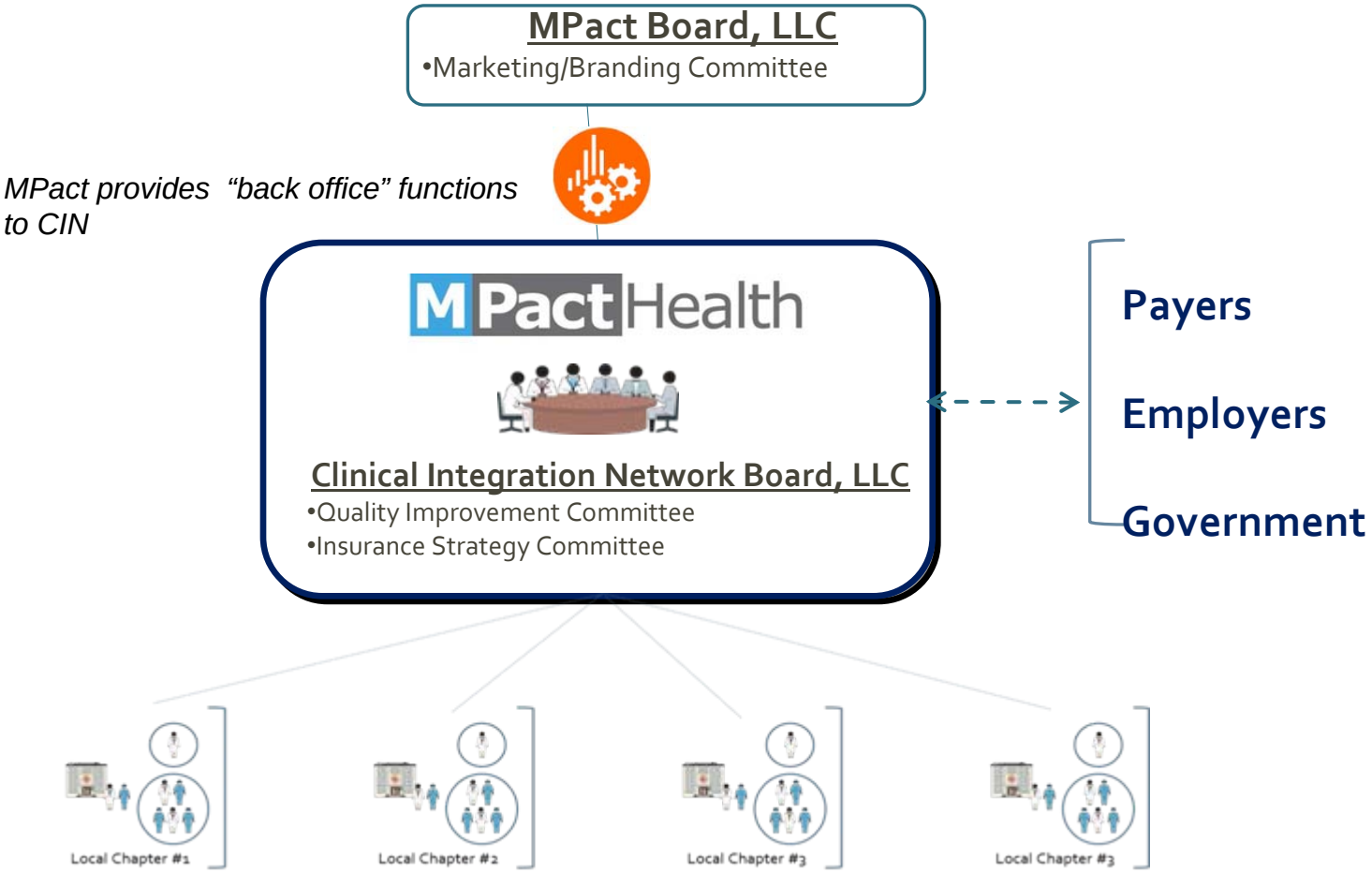
Mosaic Standard VBP Agreements

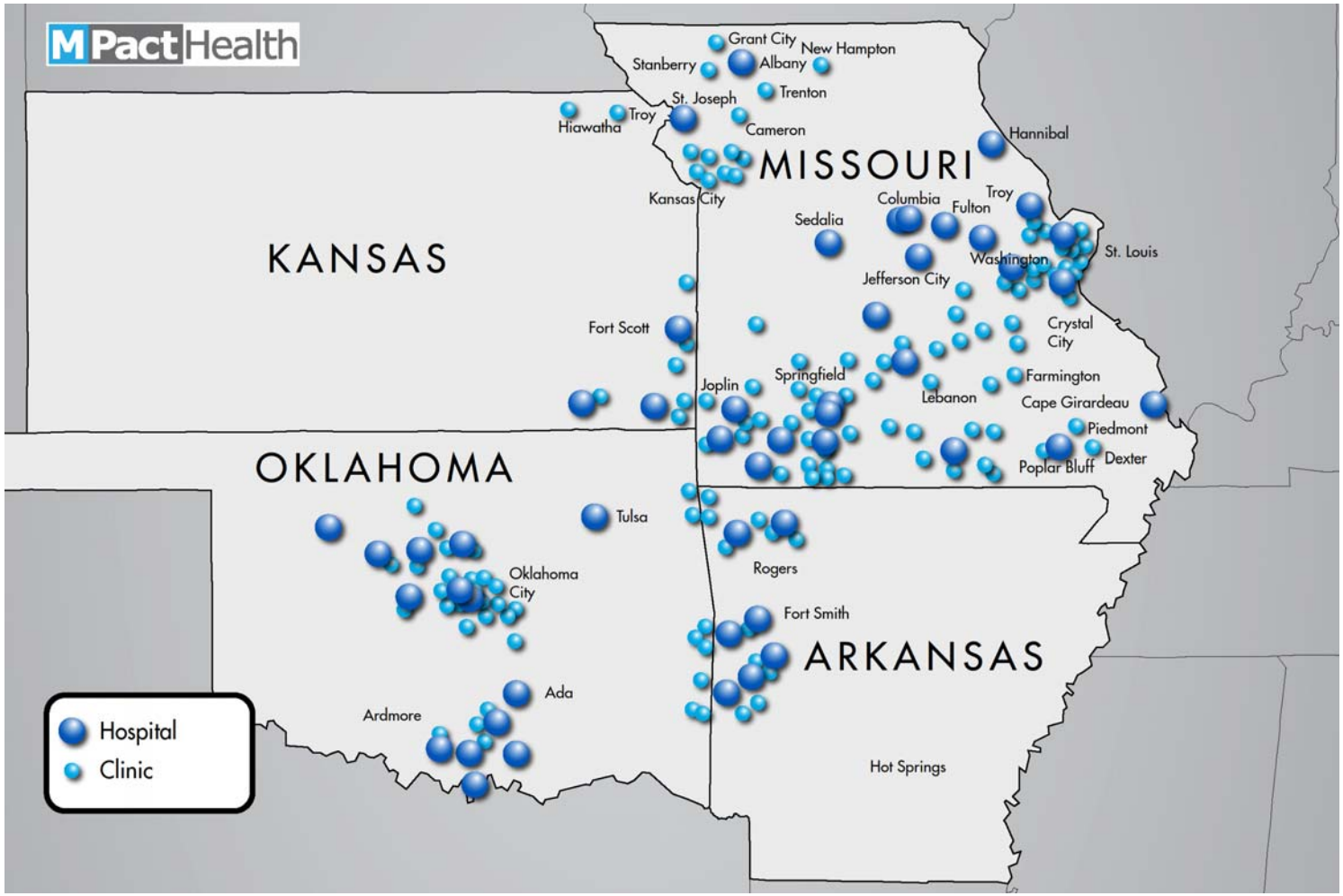
- Entering fourth year
- Must meet Quality targets to get payout
- Payer sets risk adjusted targets
- 50/50 upside risk only
- Earned risk share 2/3 years

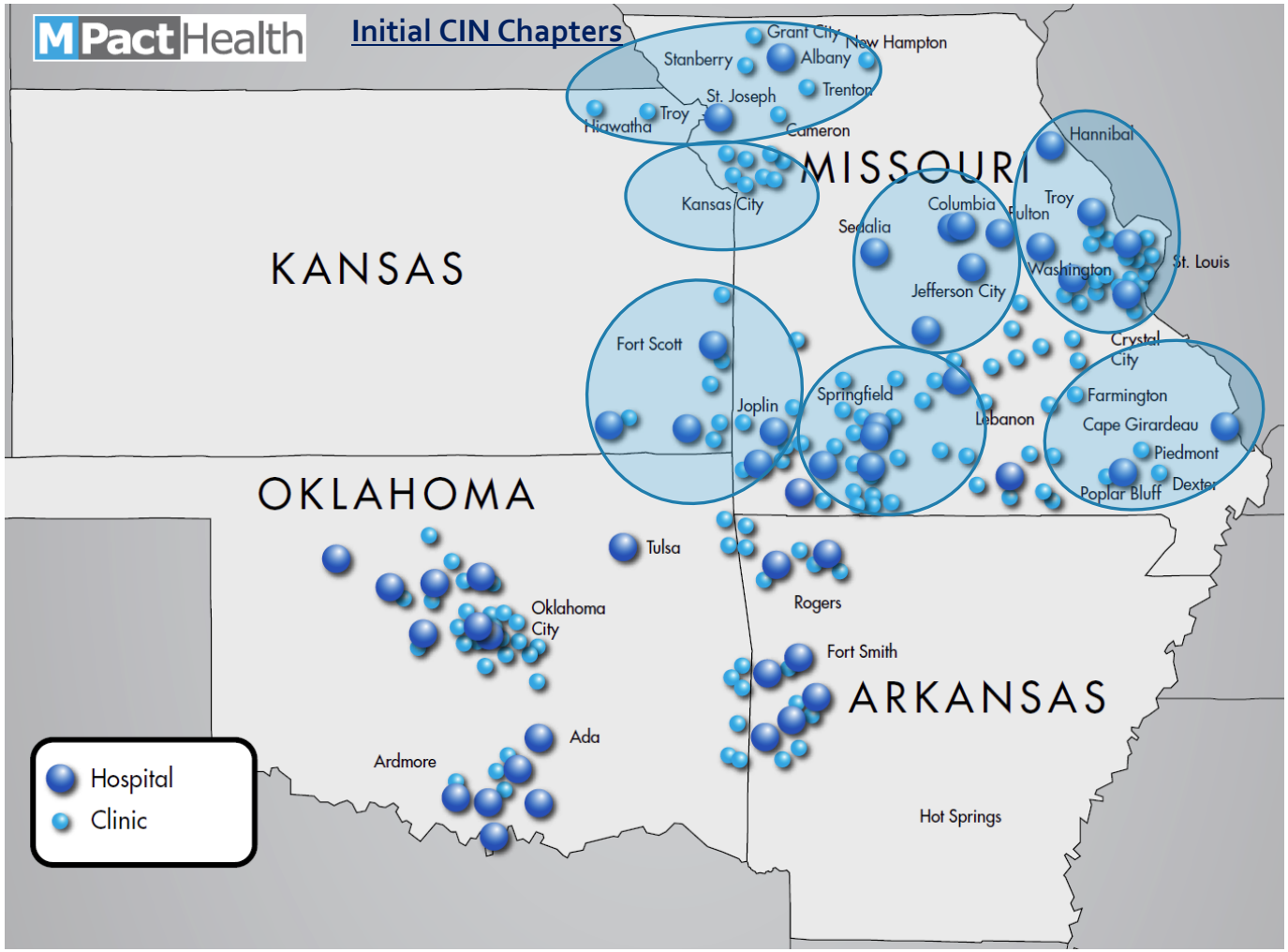
Now adding MPact Health

- Mosaic, Mercy, University of Missouri Health Care
- Multi-state Clinically Integrated Network (CIN)
- Meets the FTC and DOJ definitions of clinical integration.
- Single-signature value-based contracting
- “Chapter-Centric” CIN

Organizational Structure




MPactHealth
Grant City
New Hampton
Stanberry
Albany
Trenton
St. Joseph
Troy
Hiawatha
Cameron
Hannibal
MISSOURI
Kansas City
Columbia
Fulton
Troy
Sedalia
Washington
St. Louis
KANSAS
Jefferson City
Fort Scott
Crystal City
Springfield
Farmington
Joplin
Lebanon
Cape Girardeau
Piedmont
Poplar Bluff
Dexter
OKLAHOMA
Tulsa
Rogers
Oklahoma City
Fort Smith
ARKANSAS
Ada
Ardmore
Hot Springs
Hospital
Clinic


MPactHealth
Initial CIN Chapters
Grant City
New Hampton
Stanberry
Albany
Trenton
St. Joseph
Troy
Hiawatha
Cameron
Hannibal
MISSOURI
Kansas City
Columbia
Fulton
Troy
Sedalia
Washington
St. Louis
KANSAS
Jefferson City
Fort Scott
Crystal City
Springfield
Farmington
Joplin
Lebanon
Cape Girardeau
Piedmont
Poplar Bluff
Dexter
OKLAHOMA
Tulsa
Rogers
Oklahoma City
Fort Smith
ARKANSAS
Ada
Ardmore
Hot Springs
Hospital
Clinic

Data and Analytics Platform

- All providers now electronically connected
  - 3,000 physicians
- Analytics currently Cerner, moving to Optum
- Everyone keeps their own EMR and EDW

Quality Improvement
Where We Started

MPactHealth At Risk Population

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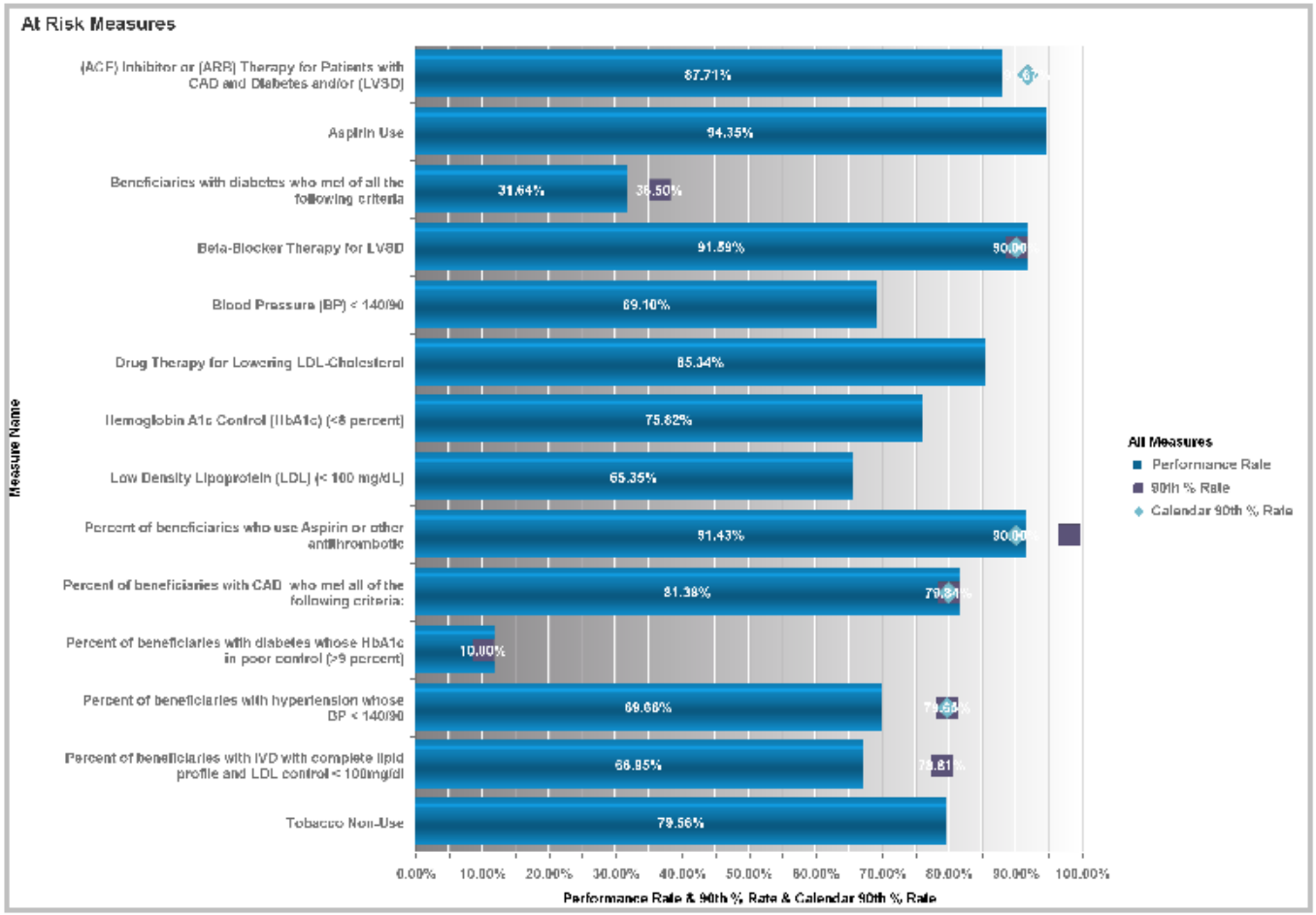

Quality Improvement
Where We Started

MPactHealth At Risk Population by Org

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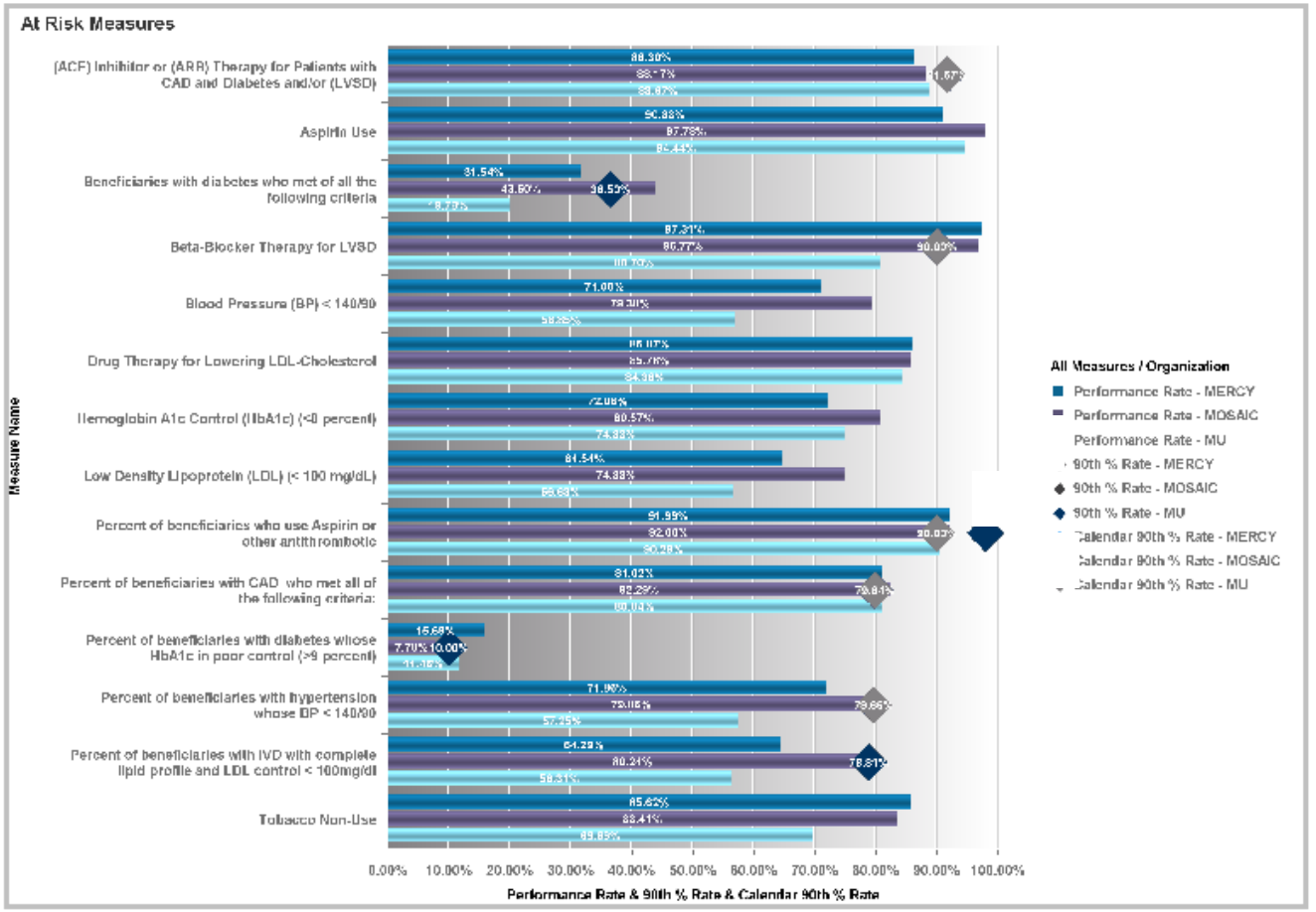

Work of the Chapters

- How does our Chapter's Quality metrics compare to MPact overall and to the national benchmarks?
- Which metrics are weakest to target the QI work?
- Do we have providers not meeting the Quality threshold?

MPact Health

As the CIN is Finalized, CI Work Continues

- Mercy Boeing direct contract
- Mosaic and Mercy MSSP (#2, 10)
- Mercy COE center with Wal Mart, Lowes, PBGH
- MU narrow network option for University of Missouri employees

MPactHealth

Summary

Summary

- **Both major political parties support this movement to value based payment**
- **The early results of these changes appear positive and promising**
- **Innovative value based care models are currently being developed and implemented**
- **Commercial payors have joined the transformation to value based payment**
- **The pace of this transformation varies widely by community based on several key factors**
- **The roles of organizations (e.g. CVS, hospitals, etc.) are changing and new entrants are developing innovative approaches to value based care**
- **Scale is important in building value based payment and risk arrangements**

THANK YOU