Mini Summit: Advanced Case Studies in Successful Hospital Value-Based Payment Initiatives

Banner Health Network
Inova
MPACT Health

February 18, 2016
Today’s agenda

Introductions/Purpose (Joe Damore)

Case Studies
  • Banner Health Network (Greg Wojtal)
  • Inova Health System (Russ Mohawk)
  • MPact Health (Dirk Clark)

Discussion (All)

Questions

Summary (Joe)
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
Value based payment arrangements/success

Full Risk (Clinical & Actuarial Risk):

Bundled Payment:

Shared Savings: (Medicare/Commercial)

Direct contracts

Pay for Performance/Bonus (Medicare VBP):

TOTAL COVERED LIVES:
Market pressure

- 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
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**

**Track 1:**
**Value-based payments**
- **2016:** 85% of all Medicare payments
- **2018:** 90% of all Medicare payments

**Track 2:**
**Alternative payment models***
- **2016:** 30% of all Medicare payments
- **2018:** 50% of all Medicare payments

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| **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.
# Prior law and MACRA reform timeline

(Medicare Access and CHIP Reauthorization Act of 2015)

### Physician Quality Reporting System Penalty

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2016 &amp; beyond</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2019 &amp; beyond</td>
<td></td>
</tr>
</tbody>
</table>

### Meaningful Use Penalty (up to %)

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019 &amp; beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%?</td>
<td>-5.0%?</td>
</tr>
</tbody>
</table>

### Value-based Payment Modifier penalty (up to %)

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018 &amp; beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>???%</td>
</tr>
</tbody>
</table>

### Sunset of existing quality value penalties under PQRS, VBM, EHR 12/31/2018

### Permanent repeal of SGR

### Updates in physician payments

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>0.5% (7/2015-2019)</td>
</tr>
<tr>
<td>2019 &amp; beyond</td>
<td>0% (2020-2025)</td>
</tr>
<tr>
<td>2026</td>
<td>0.25% (2026)</td>
</tr>
</tbody>
</table>

### Merit-Based Incentive Payment System (MIPS) adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 &amp; beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS performance measurement</td>
<td>+/-4%</td>
<td>+/- 5%</td>
<td>+/- 7%</td>
<td>+/- 9%</td>
</tr>
</tbody>
</table>

### APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)

### MIPS exceptional performance adjustment; ≤ 10% Medicare payment (2019-2024)

### 0.75% update (2026)
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**
Advanced Case Studies in Successful Hospital Value-Based Payment Initiatives

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
Experience of Care

Population Health

Per Capita Cost

Triple Aim

Experienc e of Care
Value Proposition in an ACO Type Model

... while increasing quality and member experience
# BHN Pioneer Performance

<table>
<thead>
<tr>
<th></th>
<th>PY1 2012</th>
<th>PY2 2013</th>
<th>PY3 2014</th>
<th>PY4 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>876</td>
<td>1,623</td>
<td>1,340</td>
<td>1,198</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>50,500†</td>
<td>55,500†</td>
<td>61,250†</td>
<td>86,700†</td>
</tr>
<tr>
<td>Savings</td>
<td>4% shared savings $19.1M</td>
<td>2.8% shared savings $15.1M</td>
<td>5.0% shared savings $29.0M</td>
<td>TBD</td>
</tr>
<tr>
<td>Reporting Pay</td>
<td>Pay for Reporting 62.19%* Quality Score</td>
<td>Pay for Performance 81.18%* Quality Score</td>
<td>Pay for Performance 87.58% Quality Score</td>
<td>TBD</td>
</tr>
<tr>
<td>Total</td>
<td>$13,369,201</td>
<td>$9,038,408</td>
<td>$18,698,004</td>
<td>TBD</td>
</tr>
</tbody>
</table>

*:* 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.
Success – Commercial Market Place

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.
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
BHN Membership

**Full Risk**
Typically these are fully or partially capitated arrangements. Banner is paid a PMPM or POP (percent of Premium) for a set of services defined in a DOFR (Division of Financial Responsibility). Banner is fully at risk for providing those services and reimbursement is limited to the capitations.

**Shared Risk**
An “upside/downside” arrangement. Typically a PMPM cost target is established and Banner would receive a share of any saving that occurred if medical cost fell below the target but would also be at risk for a share of the “losses if costs exceeded the target”. Targets are either against a trend, developed as part of a premium build-up, or a combination of the two.

**Shared Savings**
An “upside” arrangement. Typically a PMPM cost target is established and Banner would receive a share of any saving that occurred if medical cost fell below the target. Banner would not be at risk if costs exceeded the target. Targets are either against a trend, developed as part of a premium build-up, or a combination of the two.

**Care Coordination**
Banner is paid a PMPM for providing a pre-defined set of Care Management services. The amount might be adjusted based on Banner meeting certain quality or performance Targets. However, Banner is not directly at risk for cost performance of the product.
The What: Key Market Segments

- Medicare FFS: 300,000
- Medicare Advantage: 75,000
- Medicaid/AHCCCS: 64,000
- Individual: 130,000
- Small Group: 5,000
- Middle Market: 600,000
- Large Account, State, Local Government: 1,000,000

AZ Estimated Addressable
BHN Current Membership
University Family Care Membership
Focused on New Value-Based Models of Care
Health Care System

Financing
- Employers
- Government
- Individual

Insurance
- Risk Contracts
- Joint Ventures
- U of A Health Plan

Payment
- Banner Plan Administration
- PHSO

Delivery
- Provider Integration
- Health System Integration
- Future Healthcare

Infrastructure
- Population Health Platform
- Enterprise Data Warehouse
Banner Health Network Senior Leadership Team

- John Hensing, MD
  Exec VPCMO
- Chuck Lehn
  Sr VP/CEO BHN
- Dennis Dahlen
  Sr VP/CFO

- David Ledbetter
  VP Ethics & Compliance
- Charlie Agee, MD
  VP Clinical Stewardship
- Lee Lemelson
  VP Clinical Apps
- Tracy Tannenbaum
  VP Service Excellence
- Bill Byron
  VP Public Relations

- Robert Groves, MD
  VP Health Mgmt
- Kathy Harris
  BHN Compliance Sr Dir
- Vacant
  Care Coord Sr Dir
- Lisa Stevens Anderson
  COO
- Vacant
  Svc Excellence Prog Dir

- Mindy Camden
  RN Case Mgmt Svcs Sr Dir (Acute)
- Vacant
  Care Coord Sr Dir
- Jamie Ferguson
  IT Ops Dir
- Lori Andersen
  Sr Dir Mgd Care Ops Interim
- Vacant
  Svc Excellence Sr Dir

- Judy Reddie
  RN Case Mgmt Svcs Sr Dir
- Bill Pomeleau
  IT Ops Dir
- Patricia Robinson
  Network Mgmt Sr Dir
- Carri Kelly
  BPA Sr Director
- Judy Reddie
  RN Case Mgmt Svcs Sr Dir

- Sarah Fernandez
  Accreditation Consultant
- Vacant
  Care Coord Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir

- Donna Siemens
  RN Case Mgmt Svcs Sr Dir
  (Ambulatory)
- Vacant
  Care Coord Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir

- Carol Cherry
  Health Management Sr Director
- Linda Steward
  BHN Compliance Sr Consultant
- Vacant
  Care Coord Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir

- Connie Dohner
  VP Practice Mgmt
- Jennifer Jackson
  IT Bus Apps Sr Dir
- Vacant
  Care Coord Sr Dir
- Vacant
  Svc Excellence Sr Dir
- Vacant
  Svc Excellence Sr Dir

- Dennis Dahlen
  Sr VP/CFO
- Sandra Herr
  CHRO Corporate
- Greg Wojcik
  CFO
- Mysti Kocher
  CHRO
- John Neuner
  Sr Dir Mgd Care Contracts
- Jessica Potts
  HR Consultant
- Mike Tullo
  Finance Dir BHN
- Mohammad Khaksari
  Business Analytics Dir
- Vacant
  Dept Apps Dir
- Vacant
  Dept Apps Dir
- Vacant
  Dept Apps Dir
- Vacant
  Dept Apps Dir
- Vacant
  Dept Apps Dir
Managing Risk for a Population

High Intensity

Mid Intensity

Low Intensity

5% of Americans account for 45% of healthcare spending ($1.2 trillion by 15 million Americans)

20% of American account for 35% of healthcare spending ($910 billion for 60 million Americans).

Employ evidence-based protocols and patient-centered medical homes

For the remaining 75%, improve overall health, and increase consumer engagement
Case Management Practice Settings

Support Services

- Resource Stewardship
  - Status verification, utilization management, prior authorization and concurrent review

- Social Services
  - Psychosocial, behavioral, financial, legal and ethical health issues

- Case Management Assistance
  - Navigation & Health Coach
  - Clerical support

- Condition Management
  - Coaching
  - Education

- Registry and data management

Acute & Sub-acute Case Management
- Hospital based case management
- SNF and Rehabilitation based case management

Ambulatory Case Management
- Telephonic case management
- Home based case management

Office Based Case Management
- Physician office based case management

Specialty Based Case Management
- Maternity, Infertility, ESRD, Clinic without Walls, IAC, Palliative care
Clinical Decision Support at the Point of Care

**Care Engine**

- Evidence-based standards of care
- Pharmacy data
- Lab data
- Payer claims data
- Physician EMR data
- Inpatient EMR data
- Patient reported data

**Care Considerations and Quality Measures:**
Identify and act on clinical opportunities

**Data Analytics and Reporting:**
The right information to the right clinician...right away

**Care Team:**
Total Population Management and Individual Patient Action

**MyActive Health:**
Patient Self Management

- Improves Care & Quality
- Enables Meaningful Use
- Meets CIN, PCMH, ACO requirements
- Allows quality and cost management
### The How: Improving Health and Lowering Costs

<table>
<thead>
<tr>
<th>Focus #1</th>
<th>Grow Banner Ambulatory Palliative Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus #2</td>
<td>Reduce Admits/1000 Management of the 5% High Intensity Members, Reduce Readmissions</td>
</tr>
<tr>
<td>Focus #3</td>
<td>Decrease ED Visits/1000</td>
</tr>
<tr>
<td>Focus #4</td>
<td>Post-Acute Care</td>
</tr>
<tr>
<td>Focus #5</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Focus #6</td>
<td>Improve Performance on Contract Performance Measures</td>
</tr>
<tr>
<td>Focus #7</td>
<td>Focus on Determinants of Health to develop Employee Wellness Program</td>
</tr>
<tr>
<td>Focus #8</td>
<td>Develop High Value Network</td>
</tr>
<tr>
<td>Focus #9</td>
<td>Provide Value to PCPs in BHN Network</td>
</tr>
</tbody>
</table>

**Focus Area:**

- Focus #1
- Focus #2
- Focus #3
- Focus #4
- Focus #5
- Focus #6
- Focus #7
- Focus #8
- Focus #9
# Physician Scorecard

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>% of Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENGAGEMENT</strong></td>
<td></td>
</tr>
<tr>
<td>A. PCP Engagement Meeting Attendance</td>
<td>20%</td>
</tr>
<tr>
<td>• Minimum 6 meetings</td>
<td></td>
</tr>
<tr>
<td>B. Office Manager Meetings</td>
<td></td>
</tr>
<tr>
<td>• Minimum 6 meetings</td>
<td></td>
</tr>
<tr>
<td>C. BHN Quality Team meeting</td>
<td></td>
</tr>
<tr>
<td>• Required 2 Meetings</td>
<td></td>
</tr>
<tr>
<td><strong>RISK ADJUSTMENT PARTICIPATION</strong></td>
<td>40%</td>
</tr>
<tr>
<td>A. Monthly Education/Training Attendance</td>
<td></td>
</tr>
<tr>
<td>• Minimum 5 meetings p/year</td>
<td></td>
</tr>
<tr>
<td>B. Patient Assessment Forms (PAF) completed</td>
<td></td>
</tr>
<tr>
<td>• Minimum 70% submission of provider PAF forms</td>
<td></td>
</tr>
<tr>
<td><strong>IN NETWORK UTILIZATION</strong></td>
<td>10%</td>
</tr>
<tr>
<td>1. +5% reduction in OON spend over 2013 (Pioneer)</td>
<td></td>
</tr>
<tr>
<td><strong>QUALITY</strong></td>
<td>30%</td>
</tr>
<tr>
<td>A. Members Without an Office Visit</td>
<td></td>
</tr>
<tr>
<td>1. Medicare Advantage:</td>
<td></td>
</tr>
<tr>
<td>• Minimum 10% MWOV</td>
<td></td>
</tr>
<tr>
<td>2. Pioneer: 5% MWOV</td>
<td></td>
</tr>
<tr>
<td>B. High risk (HR) care plans</td>
<td></td>
</tr>
<tr>
<td>1. 80% MA HR pts. w/ care plan</td>
<td></td>
</tr>
<tr>
<td>2. 80% Pioneer HR pts. w/ care plan</td>
<td></td>
</tr>
</tbody>
</table>

- B. MA Membership: 90% A, 80% B, 70% C
- Weighted by Membership: 5%

- A1. MA MWOV: 5%=A, 7.5%=B, 10%=C
- A2. Pioneer MWOV: 95% seen
- B1. HR w/ care plan: 90%=A, 85%=B, 80%=C
Population Health Solutions

<table>
<thead>
<tr>
<th>Solutions</th>
<th>Care Delivery</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthe Care, Wellness, MyBanner, ecW portal, MEC, JTN Referrals Management, Doc on Demand</td>
<td>Care Management Coordination • Medical Management Member Engagement • Clinical Decision Support • Virtual Care • Care Transitions</td>
<td>Integrated Consumer web and mobile tools, Eviti, Consumer Engagement Management</td>
</tr>
<tr>
<td>Impact, Avidity, Emdeon, Buck Solutions, Lexis Nexis, P2P, BHN.com, Morrissey, IVR, RAF, McKesson</td>
<td>Enrollment • Eligibility • Claims Processing Services</td>
<td></td>
</tr>
<tr>
<td>Healthe Registries, Clinical Performance Tracker, Scorecards &amp; Dashboards, Crimson</td>
<td>Risk Stratification • Identify Gaps in Care • Utilization Management • Network, Practice &amp; Provider Comparisons</td>
<td>Standard Reporting and Analytical tools, Predictive Analytics, Cerner Analytics, HCC Intelligence</td>
</tr>
<tr>
<td>Cerner, eCW, other EHRs, Healthe Intent, Teradata, State HIE</td>
<td>Population Health Platform • Enterprise Data Warehouse • Master Data Management • Identity Management • Healthcare Data Models</td>
<td>Social Media, Real-time clinical data, External benchmarks</td>
</tr>
</tbody>
</table>
Customer Engagement

Customer Experience Manager

- Enrollment
- Eligibility
- Auth/Referral Data
- Claims Status
- Benefits
- Credentialing
- Correspondence
- Billing/Fees
- Provider Directory
- Appeals & Grievances
- Clinical Decision Support Policies
Improving the Experience of Care:

- In-Patient BHN Members
  - Referral - Connect - Monitor

- Ambulatory Members
  - Any Complex Chronic Payer List
  - Monitor - Connect

- Triage
  - De-Escalate ED Admits & Frequent Re-Admits

- Health Management
  - And Member Experience Center

- Ambulatory Case Management
- iCare
- Home Care Palliative Care
- Providers Clinics
- Processes

- ✓ Check for Care Gaps
- ✓ for Annual Visit
- Complete Phone Screenings
- ✓ for Program Connectors
- Chart Prep for PCPs
- Chart Prep for PCP or Program
High Value Network Priorities

- Cardiology
- Oncology
- Nephrology
- Orthopedics
Banner’s Strategic Growth Agenda

Provider Network Strategies
- Acute Care Services
- Professional Services
- Home Care Services
- Ancillary Services
- Post Acute Services
- Retail Care Services

Premium Strategies
- Medicare (MA) at Risk Plans
- Medicaid at Risk Plans
- Commercial at Risk Plans
- Health Exchanges
- Self-Funded Plan Sponsored

Product/Service Strategies
- High Value Networks/Institutes
- High-end Quaternary Offerings
- Virtual Health 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)
Vision 2020 – Population Health
Strategic Goals & Objectives

Goal
Develop new capabilities and relationships to manage risk and population health

1. Population Health Management

- Develop capabilities to address payment reform change, including the assumption of financial risk
- Sponsor competitive value based (triple aim) health plans
- Build critical mass of covered lives in Inova Health Plans
- Create a shared savings construct with major payers
- Create new margin to replace ACA reductions.
- Broaden regional market share in our secondary service areas (covered lives and destination services)
Decision to Partner with Payer & Key Selection Criteria

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
Why Aetna?

• Inova performed an exhaustive search of many health plans nationwide to find the right fit, reputation, shared vision and core health plan capabilities.

• Inova did due diligence on several prospects both local, regional and national. And no matter how we ranked it, each time Aetna’s capabilities ranked at the top.

• Speed to market. Building our own health plan de novo would have taken a considerable amount of time. Aetna already had the back office capabilities’ distribution channels, and broad national provider network.

• It would have taken Inova years to develop a local provider network delaying our plans well beyond our expectations.

• The culture of two corporations is very compatible and had a good relationship prior to considering this joint venture.

• Aetna also had a strong desire and was willing to try innovative ways to become No.1 payor in Inova’s regional market.

Summary: The success we’ve had in the market with our Innovation Health products is proof that we made the right decision.
Since September 2013 -
Over 1729+ customers have chosen Innovation Health

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

17 Nat’l Accounts
2 Public & Labor
1 Federal Employee Plan
28 Middle Market
1,634 Small Group
Total 1,729

IVL (On/Off-Exchange) 48,000

180,000+ members
Early Results Indicators

**Pharmacy Rider and Medical Pharmacy per member per month (PMPM) trends**
- Less than 3%
  - Double digit trends are not uncommon in most health plans

**Generic prescribing rate**
- Increased 23 percent or 5 basis points
  - From 78 percent to 83 percent for all drugs**

**Admissions for C-sections**
- Decreased by 27 percent over the past year
  - C-sections per thousand have gone from 7.1 to 5.2**

**Transitional Care Management program**
- 0% 30-day readmission rate for members who complete or voluntarily partially complete the program. ***

**1,100 members** enrolled in care management programs.*
- Our unique Enhanced Care Coordinator model refers over 1,100 members a month to various disease management and care management programs.

**Members who are engaged by our complex case management nurses**
- Have risen from 20 percent to 68 percent.

Join the future of health
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
• 60,000 Virginia Medicaid members
• 80% of membership in N. VA, 20% in SW/FSW
• Over 15,000 providers in Virginia and bordering state
• Improved Operating Results by $6,000,000 or 3.3% (From 2014 to 2015)
• Implemented Major Initiatives in 2015
  • Renegotiated PMB Pricing
  • Optimized Risk Adjustment Scoring
  • Developed a Clinical Pharmacy Staff
  • 30 + Other Medical Management Initiatives
• Geriatric Ambulatory Services
  • Develop and Implement the following services in 2016:
    • SNFist – Hospitalists following Inova patients through the continuum to Nursing and Rehab centers
    • House Calls – Strengthening services in the community to ensure patients are able to improve/maintain wellness and prevent hospitalizations; long term care
    • Advance Illness Clinic – a center of excellence for providers to send chronic disease patients that need intense medical management
    • Geriatric Assessment Center – specialized assessments for patients that providers are unsure or need assistance with medical management
• 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
Care Management

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 SNF we have significant discharges
- Select high performing SNFs for our network
- Enroll High Risk patients in Care Management Programs when at a PostAcute 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

**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
Eligibility

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
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
Aetna Premier Care Network – Innovation Offering

- Allow National Accounts with <3,000 members in Jurisdiction 1
  - Employer Agrees to a risk share
  - Added to a risk pool of all NA with <3,000
  - Risk share does not kick in until pool reaches 3,000
  - A narrow network product offering of Inova’s CIN Signature Partners
  - Same parameters as >3,000 member accounts
    - 50/50
    - Pooled Claims $200K removed
    - Risk share Cap of 15%
    - Pool is individually risk adjusted
    - Annual reconciliation
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
VBP Innovation Case Study 1

Creating a CIN
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 CIN

- 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

MPact Board, LLC
• Marketing/Branding Committee

MPact provides “back office” functions to CIN

Clinical Integration Network Board, LLC
• Quality Improvement Committee
• Insurance Strategy Committee

Payers
Employers
Government

Local Chapter #1
Local Chapter #2
Local Chapter #3
Local Chapter #3
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
# Quality Improvement

Where We Started

## At Risk Population by Org

### At Risk Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Performance Rate - MERCY</th>
<th>Performance Rate - MOSAIC</th>
<th>Performance Rate - MU</th>
<th>90th % Rate - MERCY</th>
<th>90th % Rate - MOSAIC</th>
<th>90th % Rate - MU</th>
<th>Calendar 90th % Rate - MERCY</th>
<th>Calendar 90th % Rate - MOSAIC</th>
<th>Calendar 90th % Rate - MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ACE) Inhibitor or (ARB) Therapy for Patients with CAD and Diabetes and/or (LVSD)</td>
<td>16.5%</td>
<td>15.00%</td>
<td>15.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
</tr>
<tr>
<td>Aspirin Use</td>
<td>56.70%</td>
<td>55.00%</td>
<td>55.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
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<td>75.00%</td>
</tr>
<tr>
<td>Beneficiaries with diabetes who met all the following criteria</td>
<td>71.54%</td>
<td>70.00%</td>
<td>70.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
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<td>75.00%</td>
</tr>
<tr>
<td>Beta-Blocker Therapy for LVSD</td>
<td>77.75%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
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<td>80.00%</td>
</tr>
<tr>
<td>Blood Pressure (BP) &lt; 140/90</td>
<td>71.03%</td>
<td>70.00%</td>
<td>70.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
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<td>80.00%</td>
</tr>
<tr>
<td>Drug Therapy for Lowering LDL-Cholesterol</td>
<td>72.00%</td>
<td>70.00%</td>
<td>70.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
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<td>80.00%</td>
</tr>
<tr>
<td>Hemoglobin A1c Control (HbA1c) &gt;/= 8 percent</td>
<td>86.52%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
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<td>90.00%</td>
</tr>
<tr>
<td>Low Density Lipoprotein (LDL) &gt;/= 100 mg/dL</td>
<td>84.44%</td>
<td>83.00%</td>
<td>83.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
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<td>90.00%</td>
</tr>
<tr>
<td>Percent of beneficiaries who use Aspirin or other antithrombotic</td>
<td>74.46%</td>
<td>73.00%</td>
<td>73.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
</tr>
<tr>
<td>Percent of beneficiaries with CAD who met all of the following criteria</td>
<td>87.52%</td>
<td>86.00%</td>
<td>86.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
<td>90.00%</td>
</tr>
<tr>
<td>Percent of beneficiaries with diabetes whose HbA1c in poor control &gt;/= 8 percent</td>
<td>71.06%</td>
<td>70.00%</td>
<td>70.00%</td>
<td>80.00%</td>
<td>80.00%</td>
<td>80.00%</td>
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<td>80.00%</td>
</tr>
<tr>
<td>Percent of beneficiaries with hypertension whose BP &lt; 140/90</td>
<td>75.68%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
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<td>85.00%</td>
</tr>
<tr>
<td>Percent of beneficiaries with IVD with complete lipid profile and LDL control &lt; 100 mg/dL</td>
<td>74.81%</td>
<td>74.00%</td>
<td>74.00%</td>
<td>85.00%</td>
<td>85.00%</td>
<td>85.00%</td>
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<td>85.00%</td>
</tr>
<tr>
<td>Tobacco Non-Use</td>
<td>63.82%</td>
<td>63.00%</td>
<td>63.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>
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?
As the CIN is Finalized, CI Work Continues

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

Narrow Network Example
Case Example MU Columbia Campus

- 13,000 employees in central Missouri
- A third plan option was added for 2015 centered on the University physicians and hospitals
- 15% less than the standard options
- 47% took the narrow option
VBP Innovation Case Study 3

Expansion in an ACO model
Case Example Mosaic Kansas City

• Expansion market
• Seven facilities in 12 months (primary care, 2 ASCs, 2 imaging facilities)
• 24 PCPs initially
• ACO model – no inpatient beds, quality, wellness, convenience.
Discussion
Summary/Questions
THANK YOU