PREMIER

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)

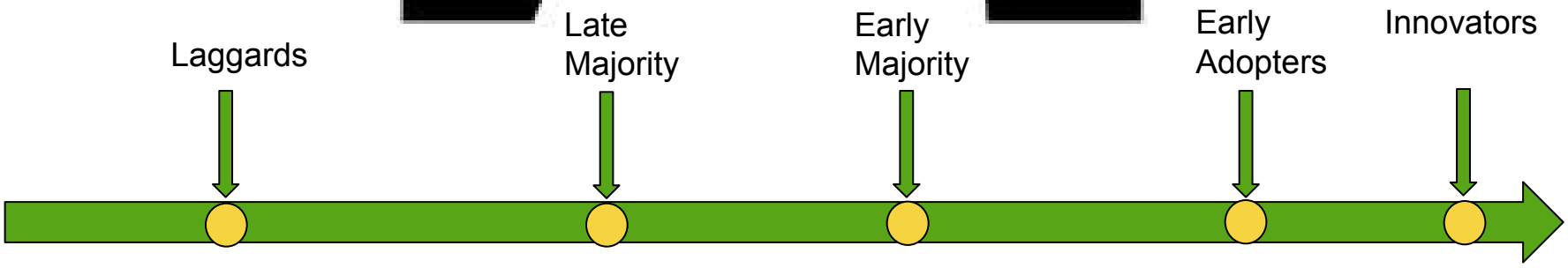
Transitioning to value based payment: A foot in two worlds

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

TOTAL COVERED LIVES:

Lives

Full Risk (Clinical & Actuarial Risk):

Bundled Payment:

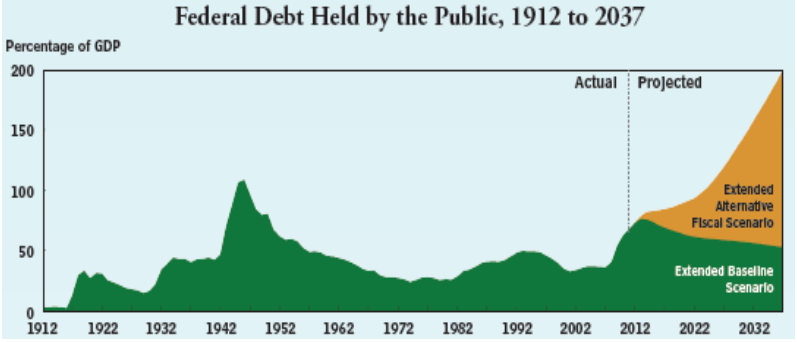
Shared Savings: (Medicare/Commercial)

Direct contracts

Pay for Performance/Bonus (Medicare VBP):

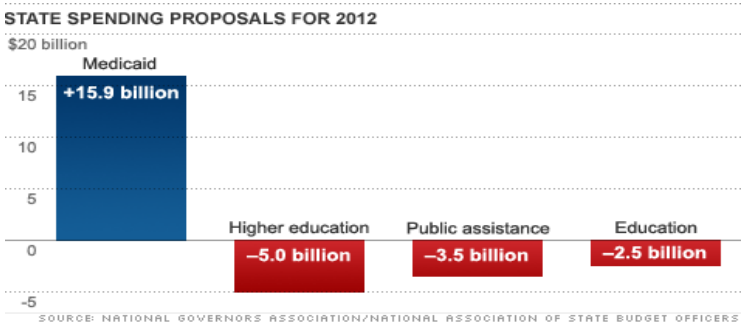
Market pressure

Federal

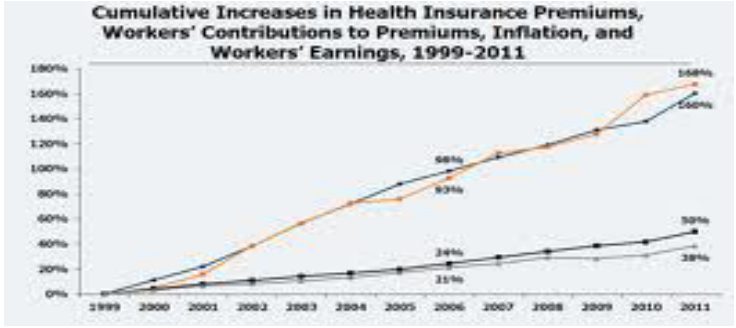


- Current Medicare enrollment is projected to increase from approximately 55M today, to 85M by 2035
- Dramatic projected growth of all major chronic diseases
- FFS payment reductions
- Value-based payment risk

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

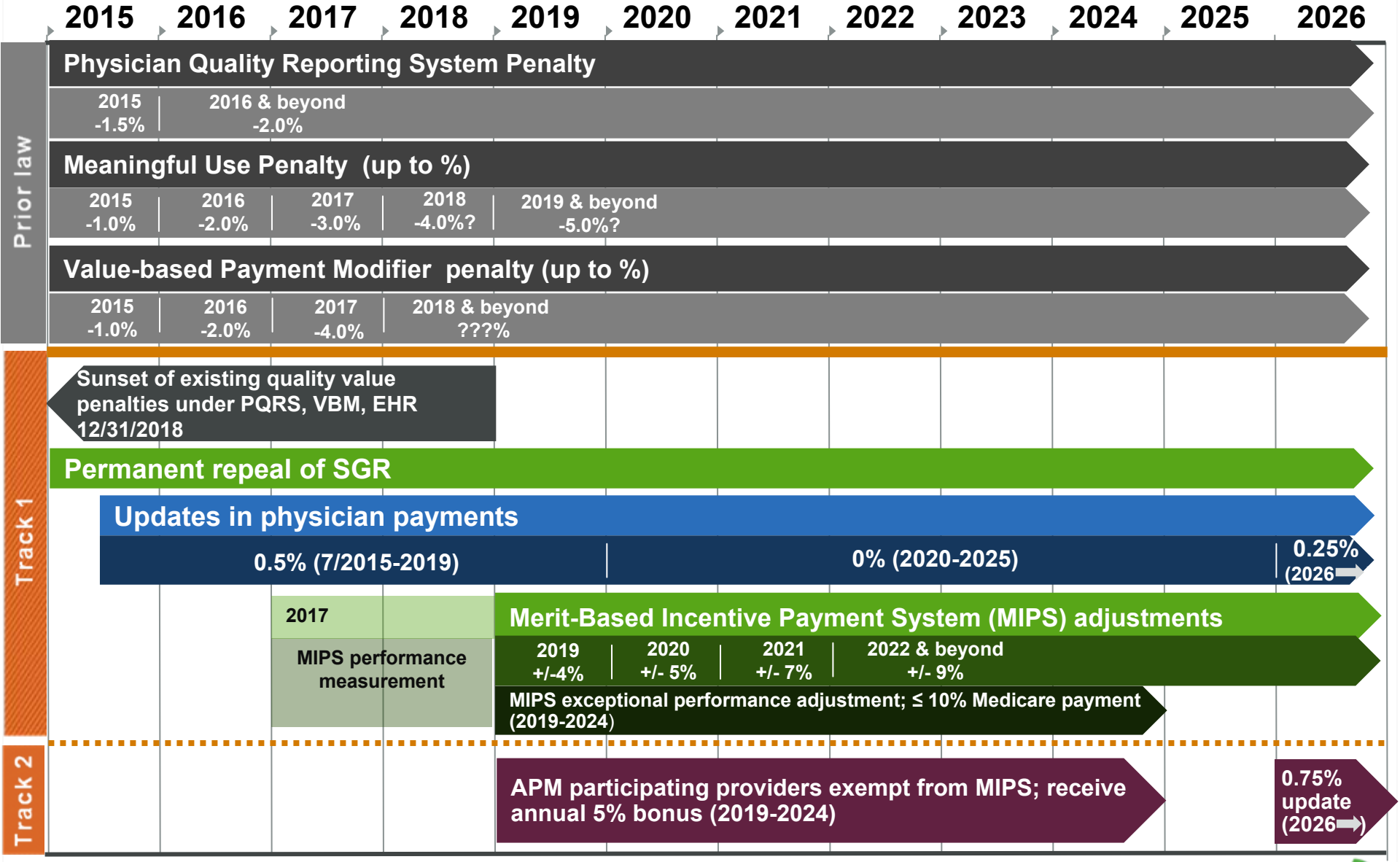
- Overwhelming bipartisan support.
- Provides new tools in implementing the payment reforms.
- Applies to MD, DO, PA, NP, Clinical nurse specialist, nurse anesthetist.
- 2021 includes therapists, psychologists, social workers, audiologists, and dieticians.
- Creates clear timetable and benchmarks.
- 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.

Prior law and MACRA reform timeline

(Medicare Access and CHIP Reauthorization Act of 2015)



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

Advanced Case Studies in Successful Hospital Value-Based Payment Initiatives

Greg Wojtal, VP/CFO BHN

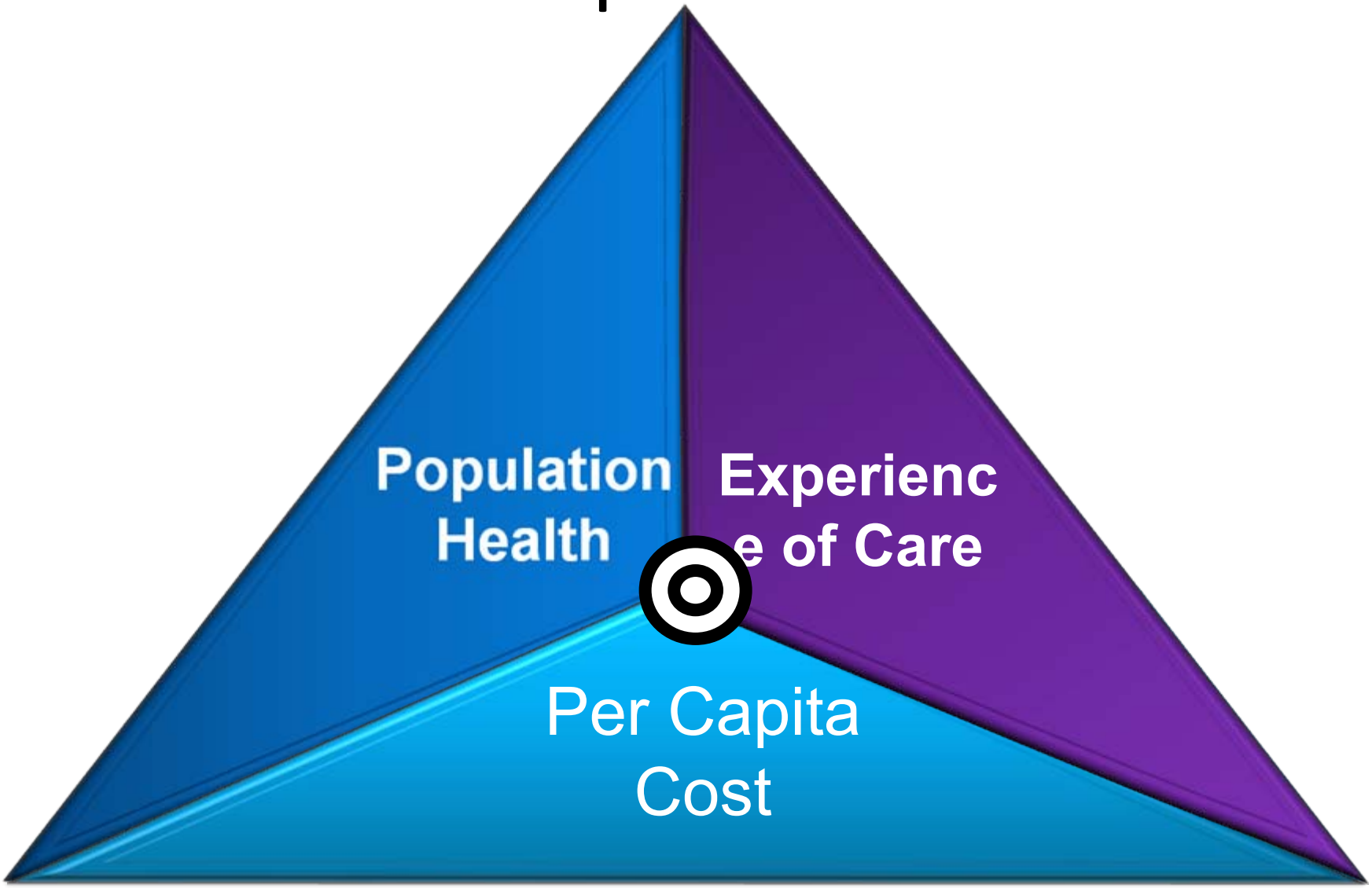
February 18, 2016

Banner Health

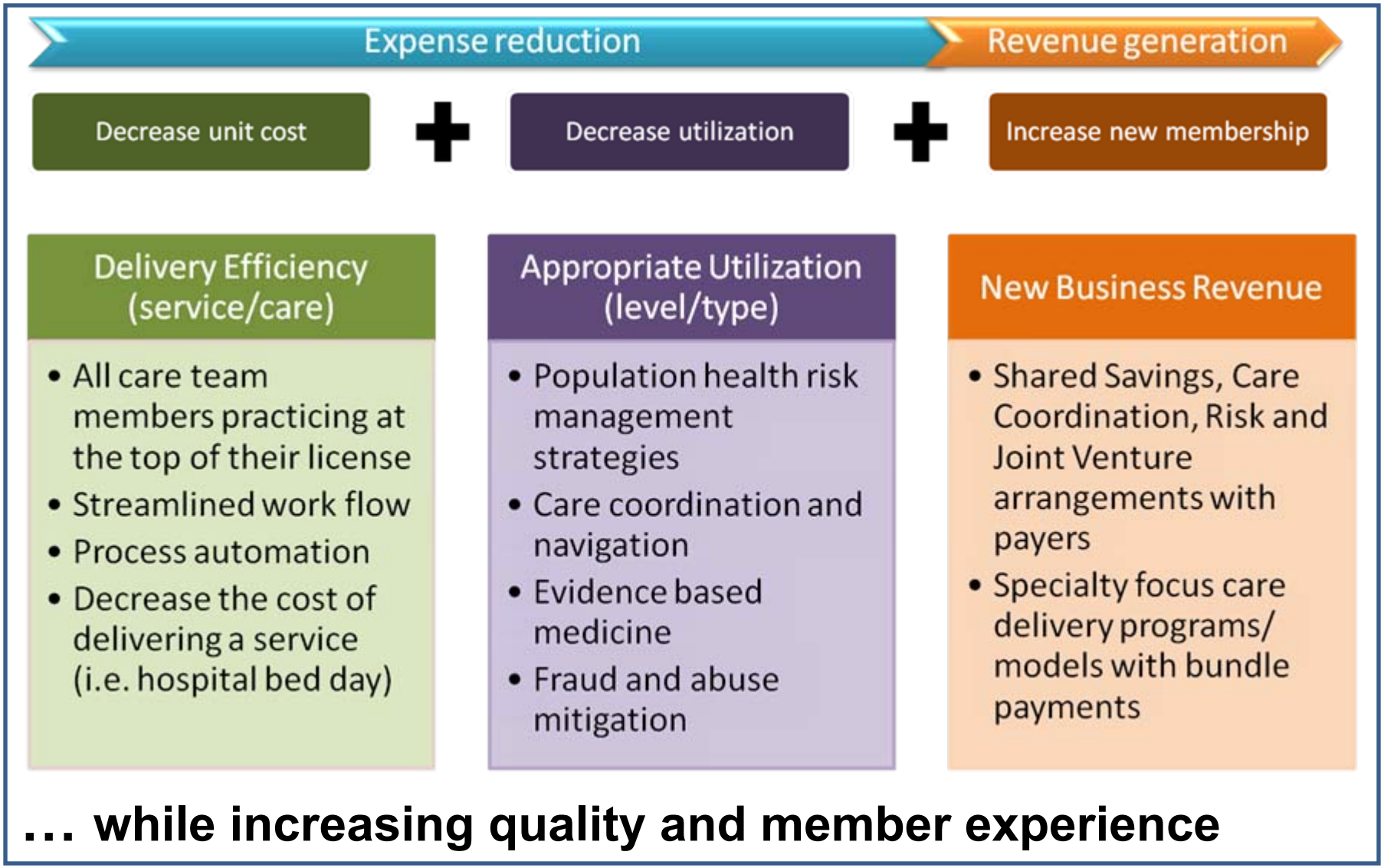
- 29 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group With More Than 1,500 Physicians and Advanced Practitioners and More Than 200 Banner Health Centers and Clinics
- Outpatient 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

Banner Health®

Triple Aim



Value Proposition in an ACO Type Model



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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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

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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 a 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.

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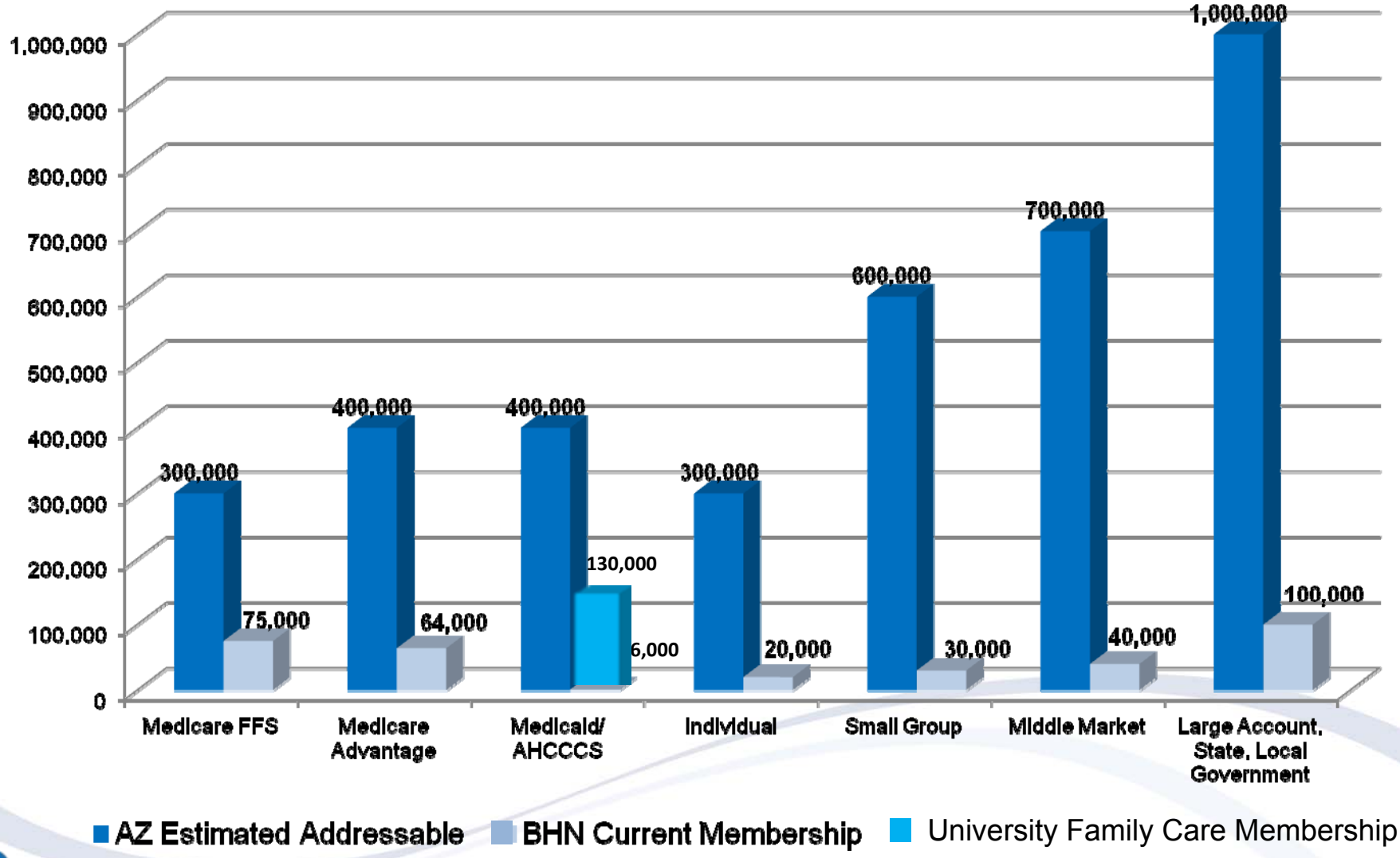
The What:
Key Market Segments



Banner Health®

Focused on New Value-Based Models of Care

Health Net®

Cigna®

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Humana®

aetna℠

UnitedHealthcare

Banner Health®

Health Care System

Financing
- Employers
- Government
- Individual

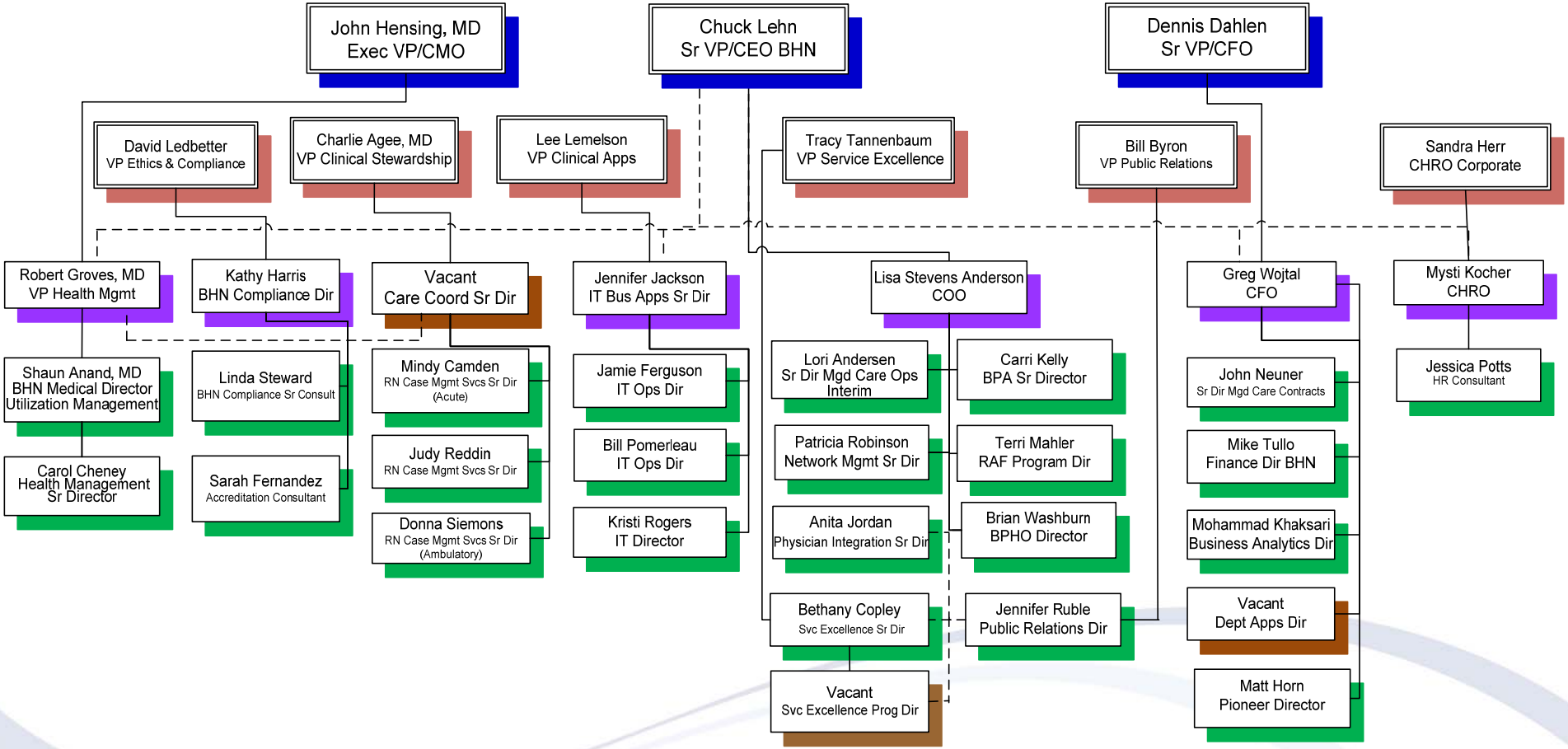
Insurance
- Risk Contracts
- Joint Ventures
- U of A Health Plan

Payment
- Banner Plan Administration
- PHSO

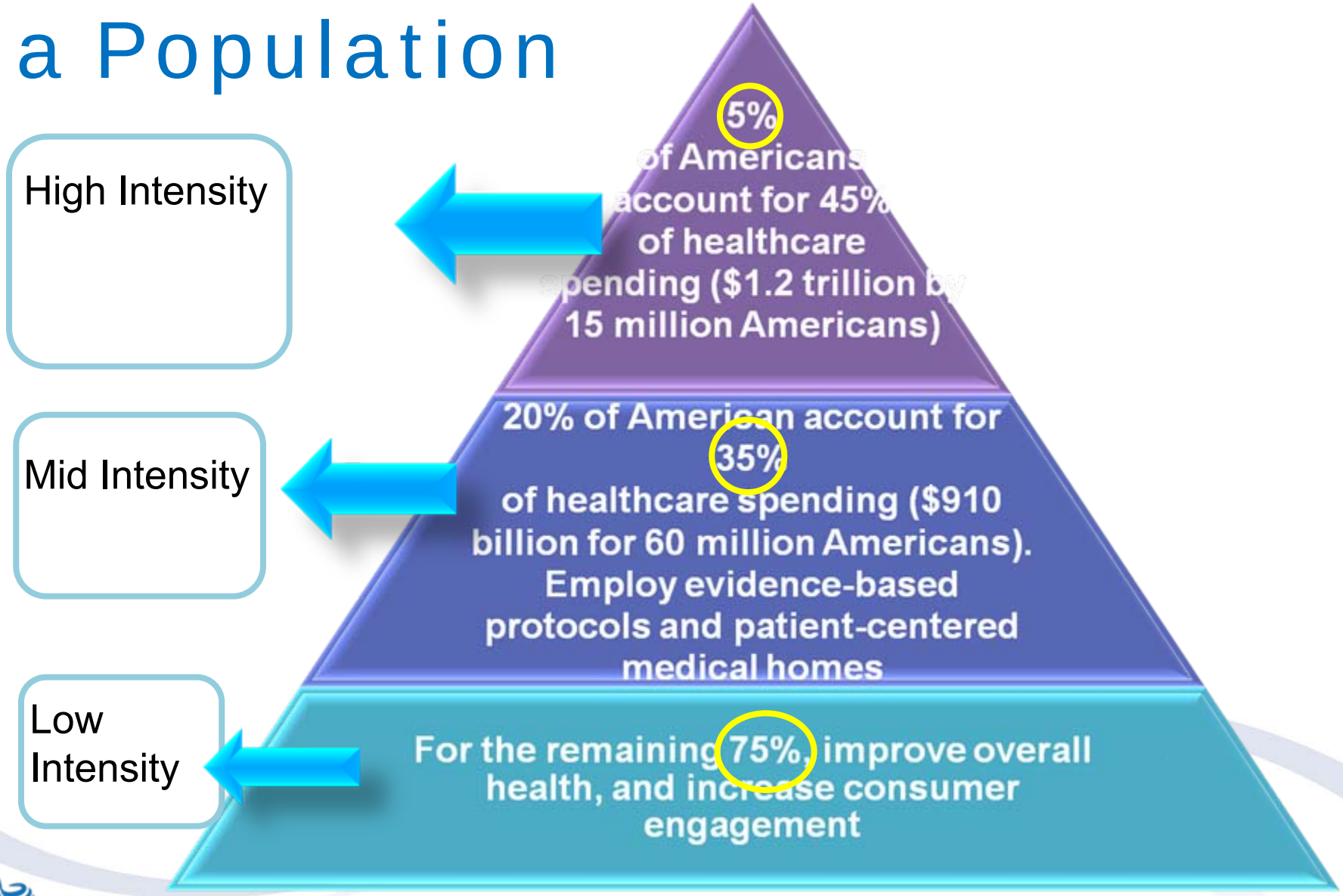
Delivery
- Provider Integration
- Health System Integration
- Future Healthcare

Infrastructure
- Population Health Platform
- Enterprise Data Warehouse

Banner Health Network Senior Leadership Team



Managing Risk for a Population



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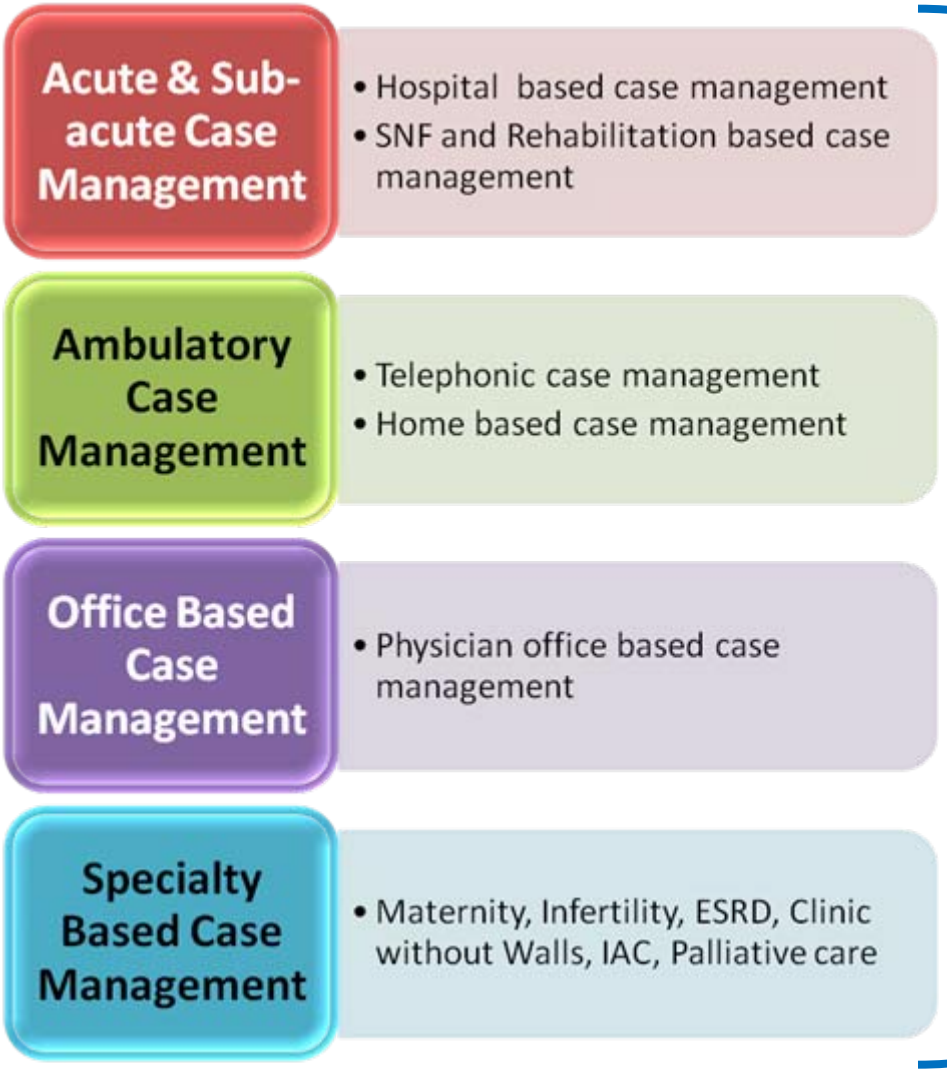
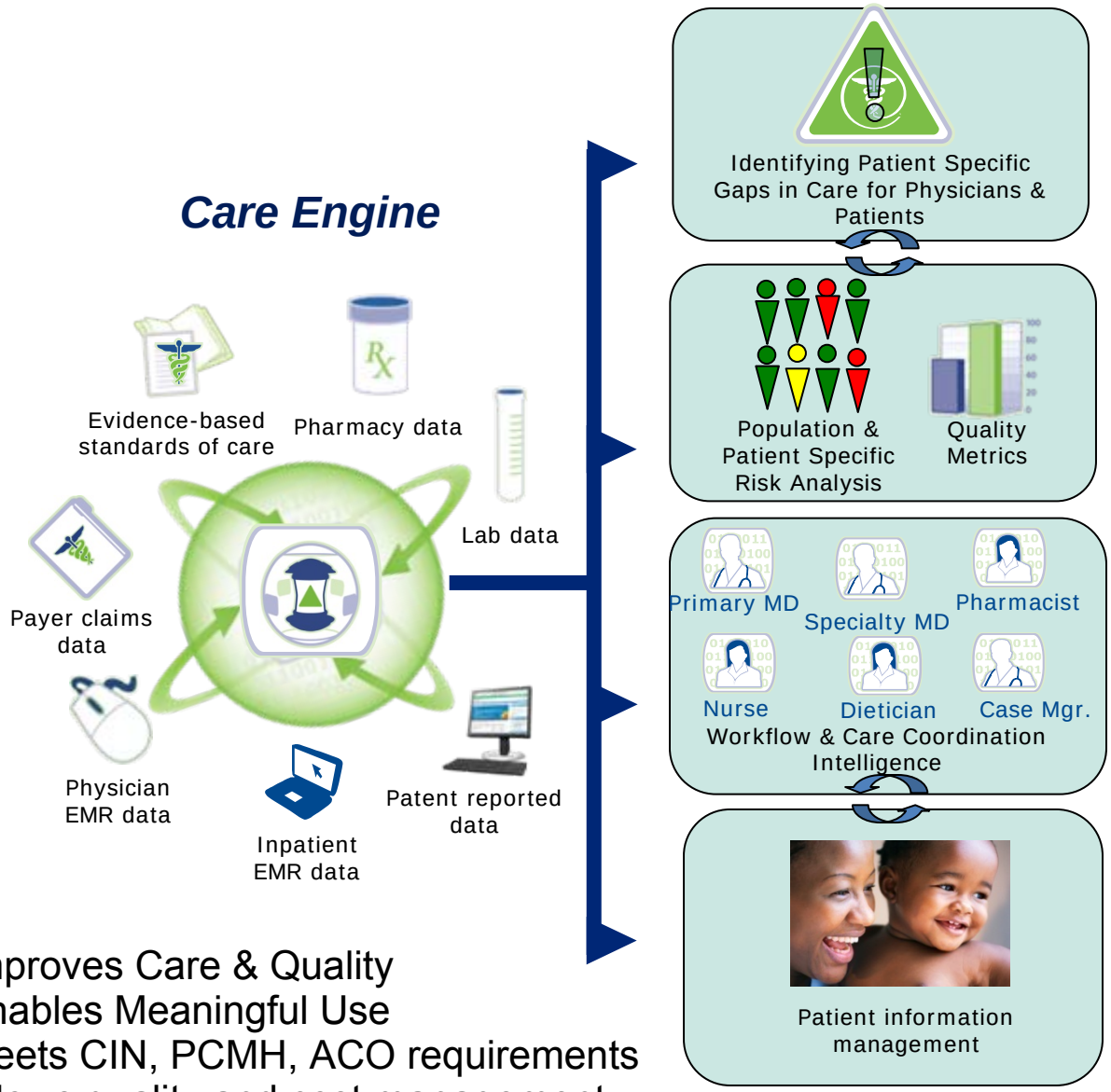
Case Management Practice Settings



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

Clinical Decision Support at the Point of Care



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

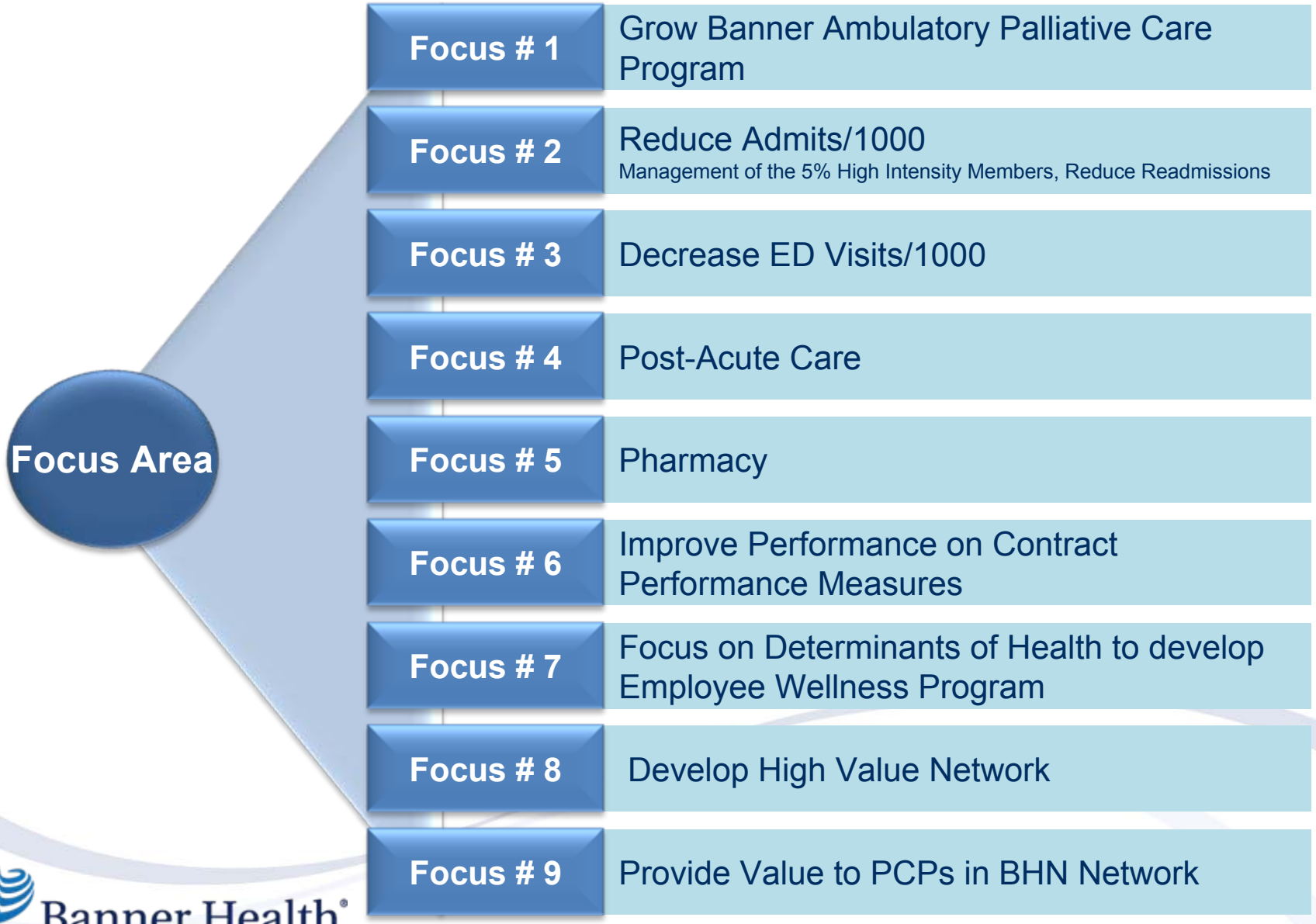
Data Analytics and Reporting:
The right information to the right clinician…right away

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



Banner Health

Member Assessment Center Dashboard

Select Patient Type: ED, IP Select Facility: BBH, BBMC, BBWMC, BDMC, BD

Select Member Source: BHP, BPA, CMS, HLN, MEDI, UHC

1 of 1 100% Find | Next

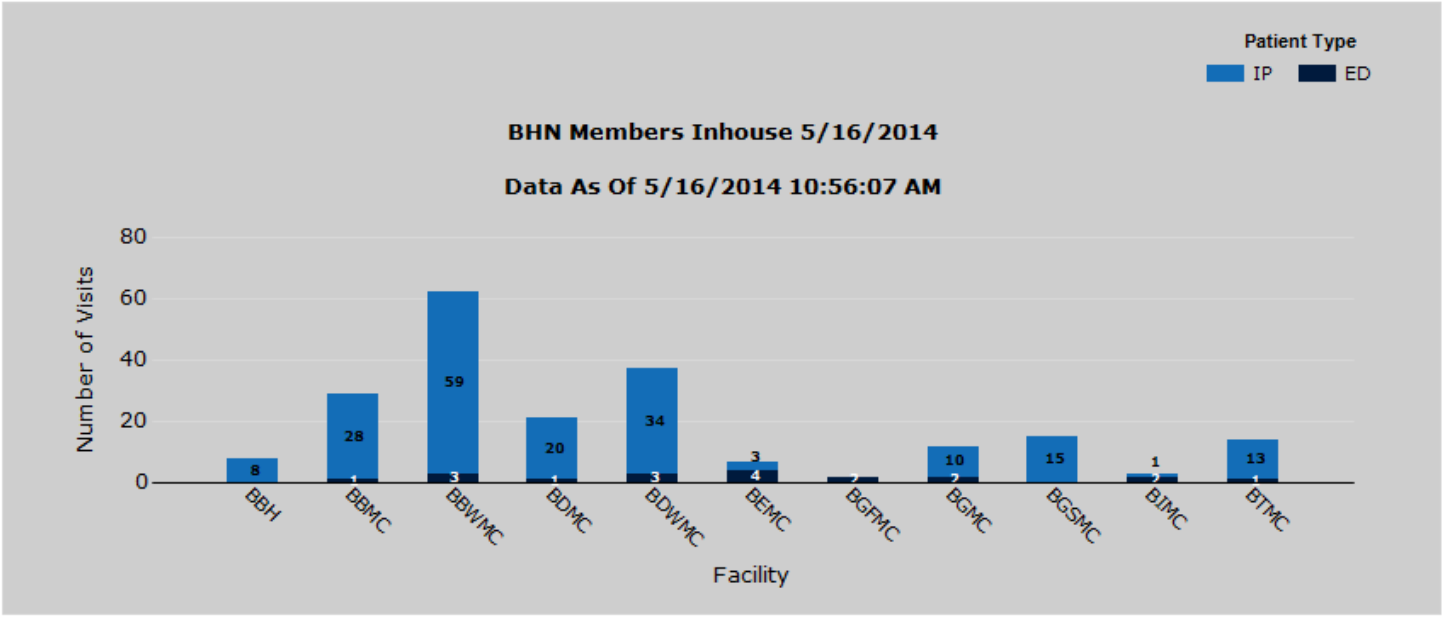
Banner Health Network

Discharges Trends

# of Members

207

Open Data Definitions Document



Patient Tracker

Fac	Mbr Src	Risk Category	Patient Name	Pat Type	Sex	Age (In Years)	Member ID	Account Number	Admit Date	Discharge Date	Member ALTID	Primary Care Physician	High Risk Flag	Case Manager	Admitting Diagnosis
BBH	CMS	SR	Patient Name	IP	F	70	11111111	11111111	2014-05-14		11111111 A	Primary Care Physician	N	Case Manager	SICK SINUS SYNDROME
BBH	UHC	FR	Patient Name	IP	M	83	22222222	22222222	2014-05-14		22222222	Primary Care Physician	N	Case Manager	CAD
BBH	UNK		Patient Name	IP	F	81	333333333	333333333	2014-05-11		333333333	Primary Care Physician	N		MEDIASTINAL MASS

Physician Scorecard

MEASURE	% of Incentive
ENGAGEMENT A. PCP Engagement Meeting Attendance • Minimum 6 meetings B. Office Manager Meetings • Minimum 6 meetings C. BHN Quality Team meeting • Required 2 Meetings	20% Weighted by total BHN Membership
RISK ADJUSTMENT PARTICIPATION A. Monthly Education/Training Attendance • Minimum 5 meetings p/year B. Patient Assessment Forms (PAF) completed • Minimum 70% submission of provider PAF forms	40% B. MA Membership 90% A 80% B 70% C
IN NETWORK UTILIZATION 1. +5% reduction in OON spend over 2013 (Pioneer)	10% Weighted by Membership 5%
QUALITY A. Members Without an Office Visit 1. Medicare Advantage: • Minimum 10% MWOV 2. Pioneer: 5% MWOV B. High risk (HR) care plans 1. 80% MA HR pts. w/care plan 2. 80% Pioneer HR pts. w/ care plan	30% 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

Solutions
Healthe Care, Wellness, MyBanner, ecW portal, MEC, JTN Referrals Management, Doc on Demand

Care Delivery
- Care Management
- Care Coordination
- Medical Management
- Member Engagement
- Clinical Decision Support
- Care Transitions
- Virtual Care

Future State
Integrated Consumer web and mobile tools, Eviti, Consumer Engagement Management

Solutions
Impact, Avidity, Emdeon, Buck Solutions, Lexis Nexis, P2P, BHN.com, Morrissey, IVR, RAF, Mckesson

Administrative Functions
- Enrollment
- Eligibility
- Claims Processing Services
- Billing
- Provider Portal
- Member & Provider

Future State
Bundle Payments, Single Bill,

Solutions
Healthe Registries, Clinical Performance Tracker, Scorecards & Dashboards, Crimson

Analytics
- Risk Stratification
- Identify Gaps in Care
- Utilization Management
- Network, Practice & Provider Comparisons
- Business Development Opp.
- Member Engagement Opp.
- Behavioral Analysis

Future State
Standard Reporting and Analytical tools , Predictive Analytics , Cerner Analytics, HCC Intelligence

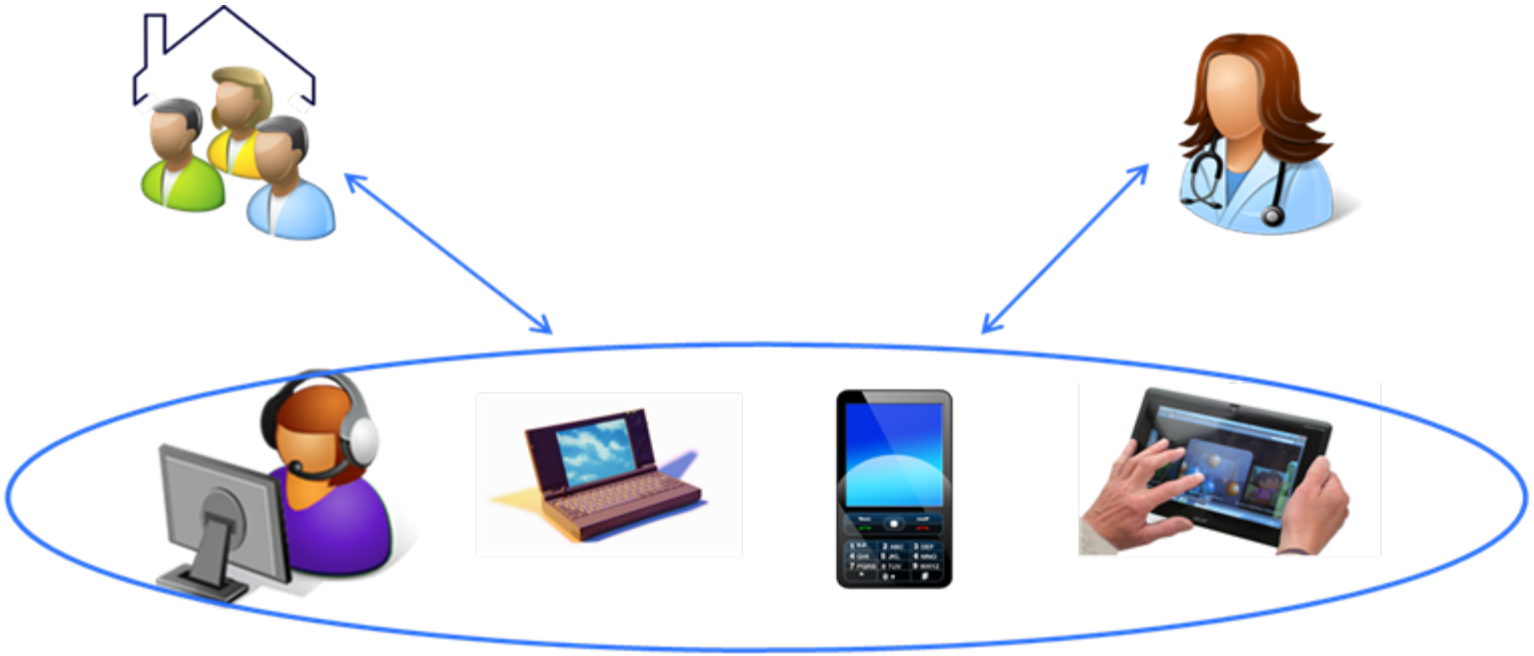
Solutions
Cerner, eCW, other EHRs, Healthe Intent, Teradata, State HIE

Data Capture & Integration
- Population Health Platform
- Enterprise Data Warehouse
- Master Data Management
- Identity Management
- Healthcare Data Models

Future State
Social Media, Real-time clinical data, External benchmarks

Banner Health

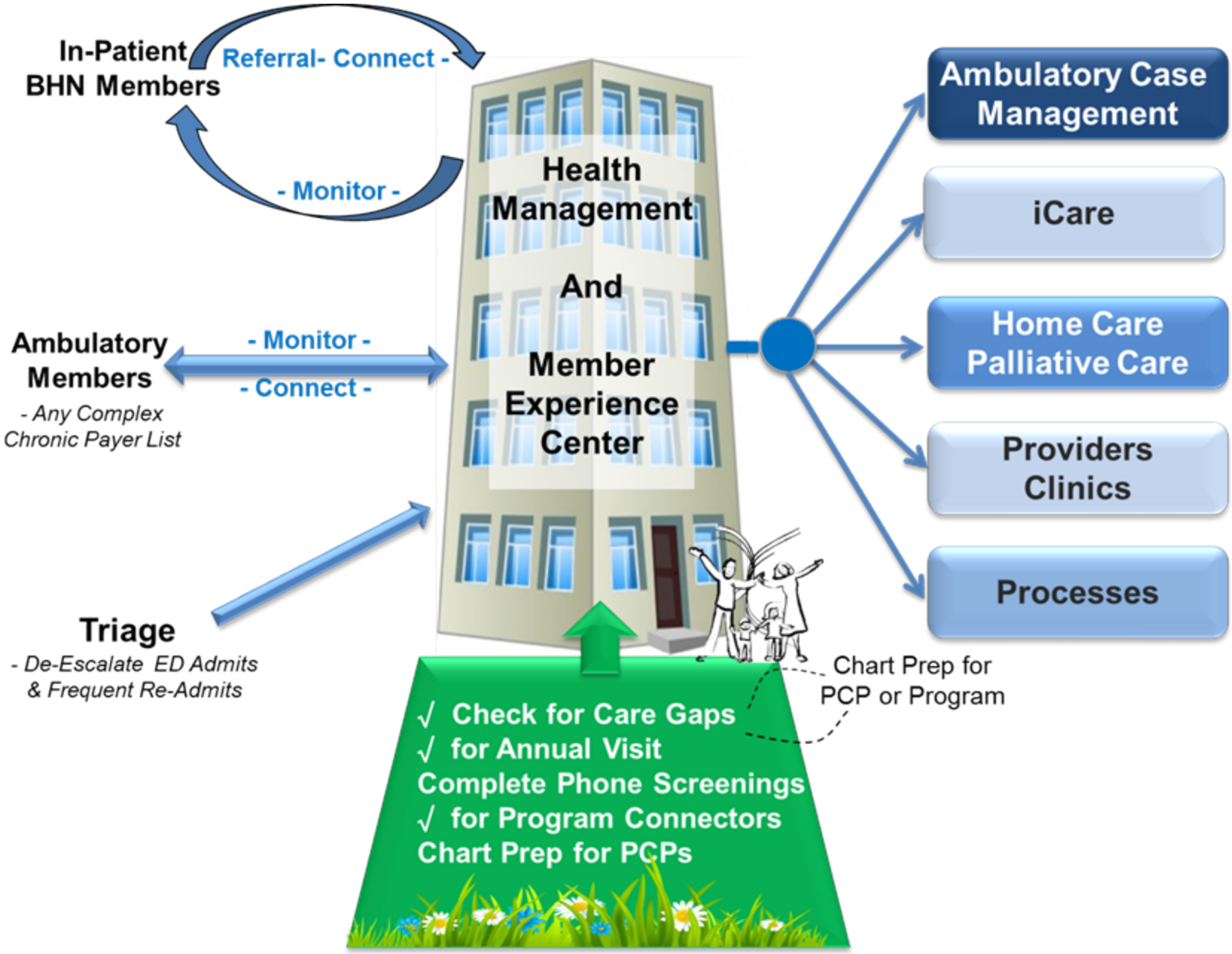
Customer Engagement



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:

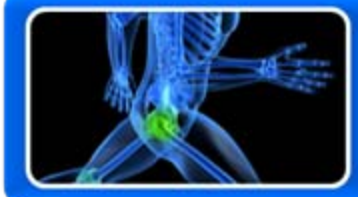


High Value Network Priorities

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

INOVA™
Join the future of health.

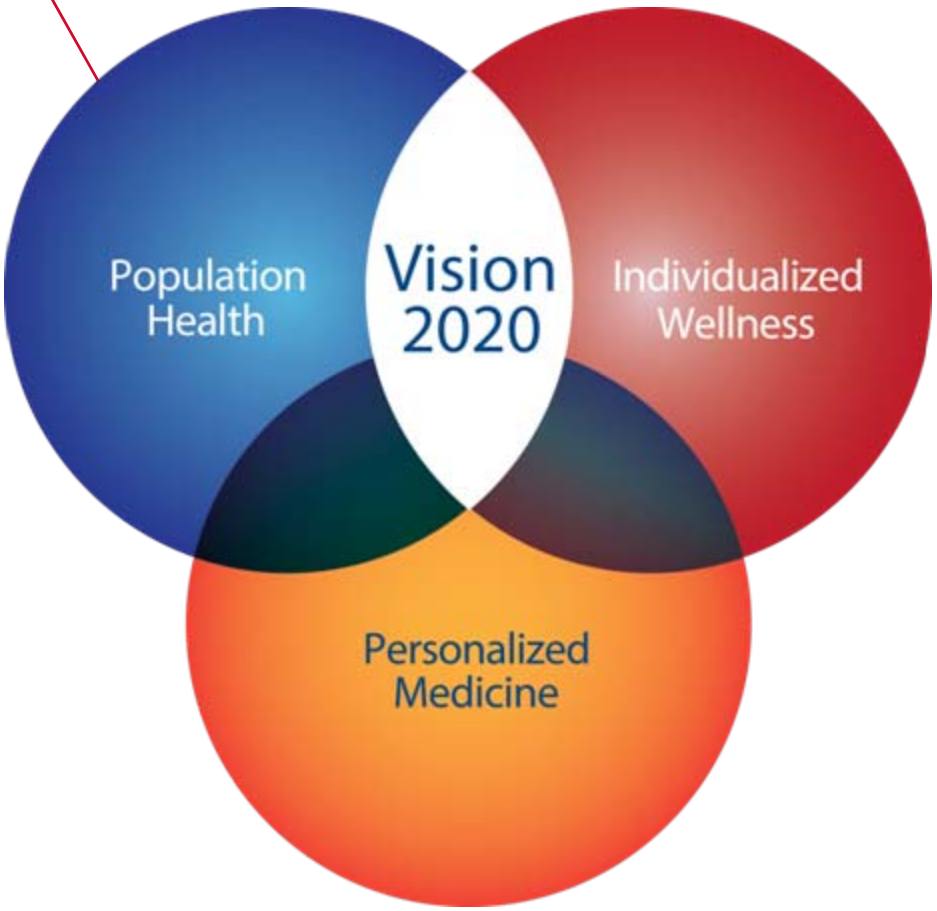
Goal

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

INOVA™ Join the future of health.

Assessing Strategic Options

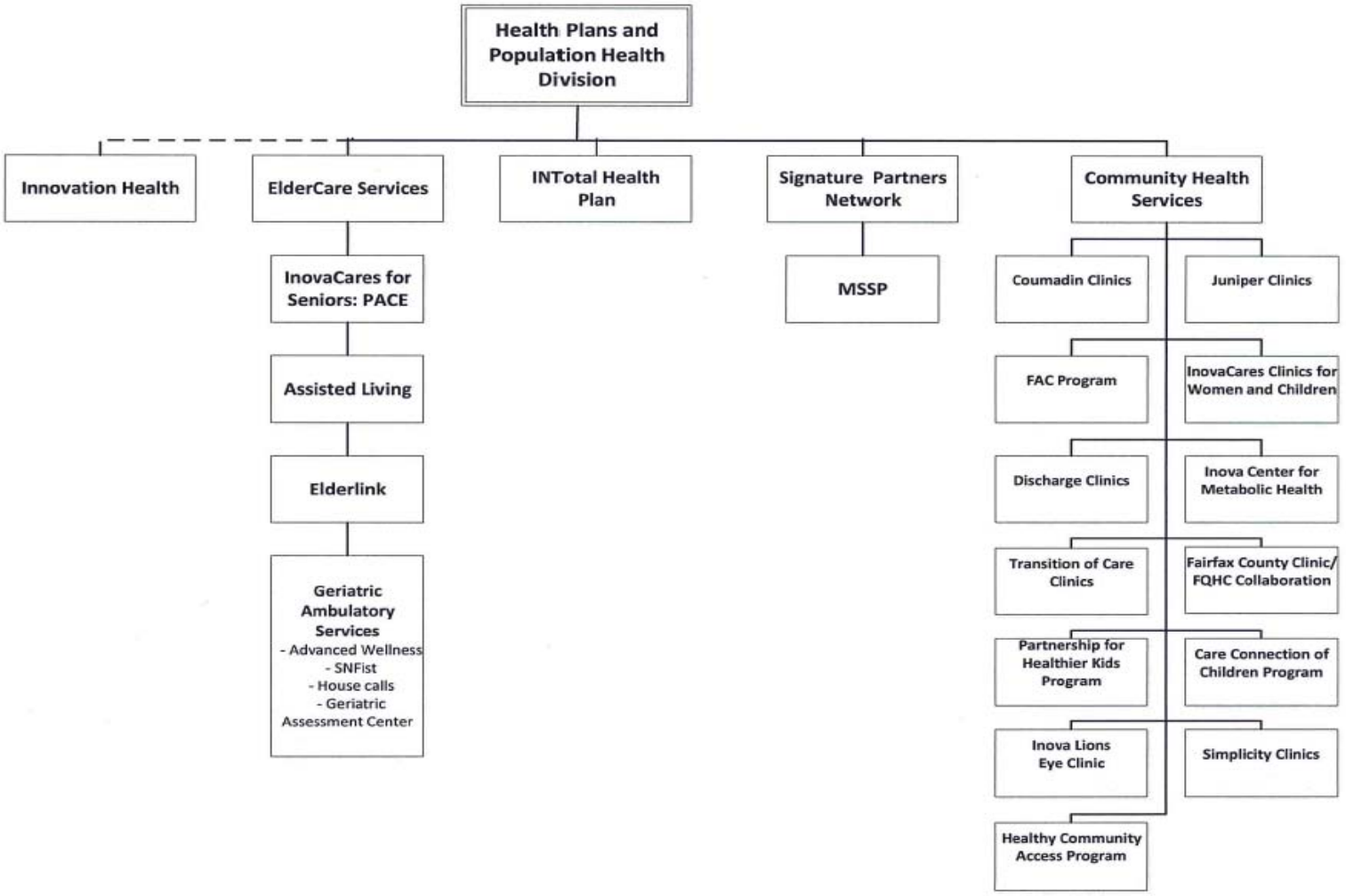
- ✗ **Do Nothing / Status Quo**
- ✗ **Contract Directly with Employers/Payers**
- ✗ **Build and Market Own Health Plan**
- ✓ **Partner & Joint Venture New Health Plan**

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*

Divisional Org. Chart

INOVA™
Join the future of health.



Why Aetna?

INOVA™
Join the future of health.

- 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.

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

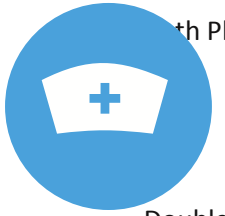
Middle Market- 101-3,000

National Accounts -3,000+

Public Sector

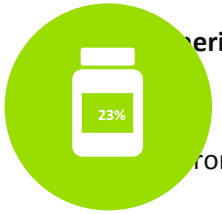
Federal Employee Plan

Early Results Indicators



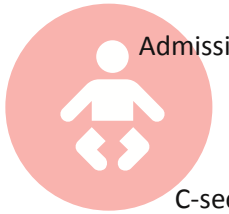
th Pharmacy Rider and Medical Pharmacy **per member per month (PMPM) trends less than 3%**

Double digit trends are not uncommon in most health plans



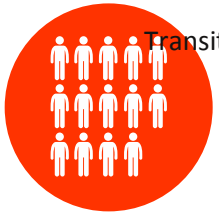
eric prescribing rate increased 23 percent or 5 basis points

rom 78 percent to 83 percent for all drugs**



Admissions for C-sections have **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.

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

INTotal

INOVA™
Join the future of health.

- 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

Inova ElderCare Services

- 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

Signature Partners

High-Value Physician Clinically Integrated Network

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 SNF we 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

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

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

Aetna Premier Care Network – Innovation Offering

INOVA™
Join the future of health.

- 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

INOVA™
Join the future of health.

- ✓ 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, 2015

MPact Health

VBP Innovation Case Study 1

Creating a CIN

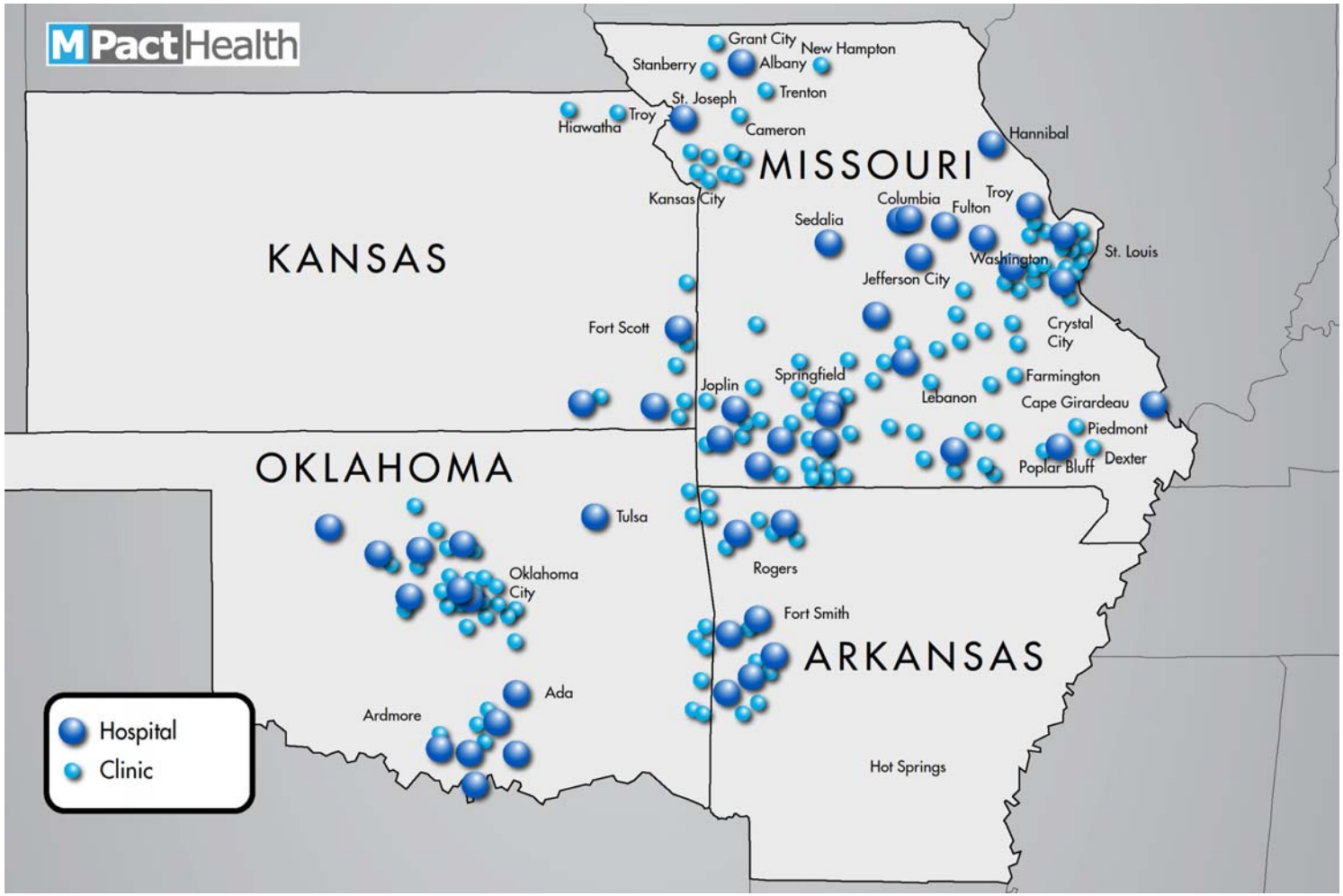
Mosaic Standard VBP Agreements

- 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

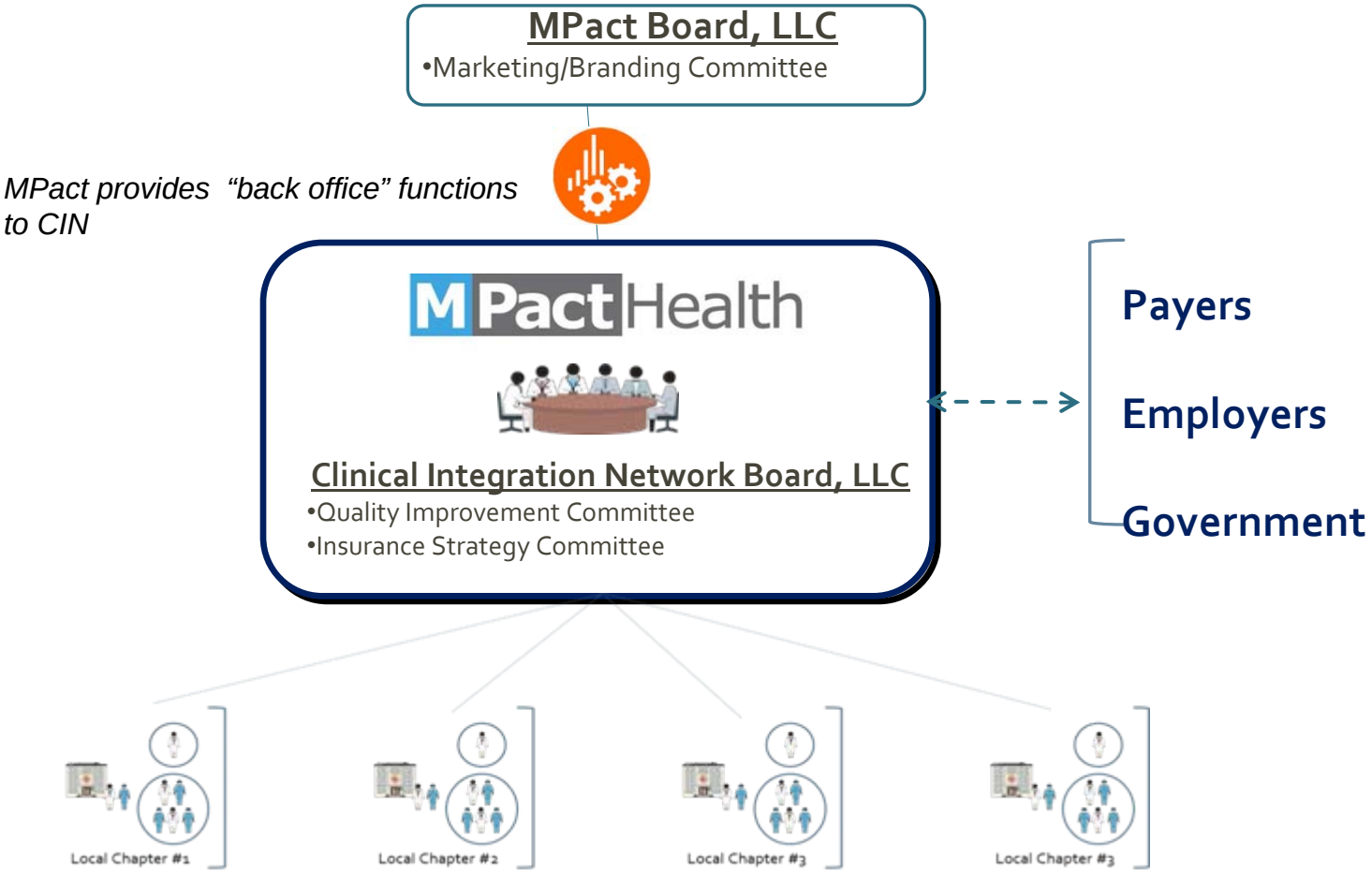
Now adding MPact Health CIN

- 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

MPact Health


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

Organizational Structure



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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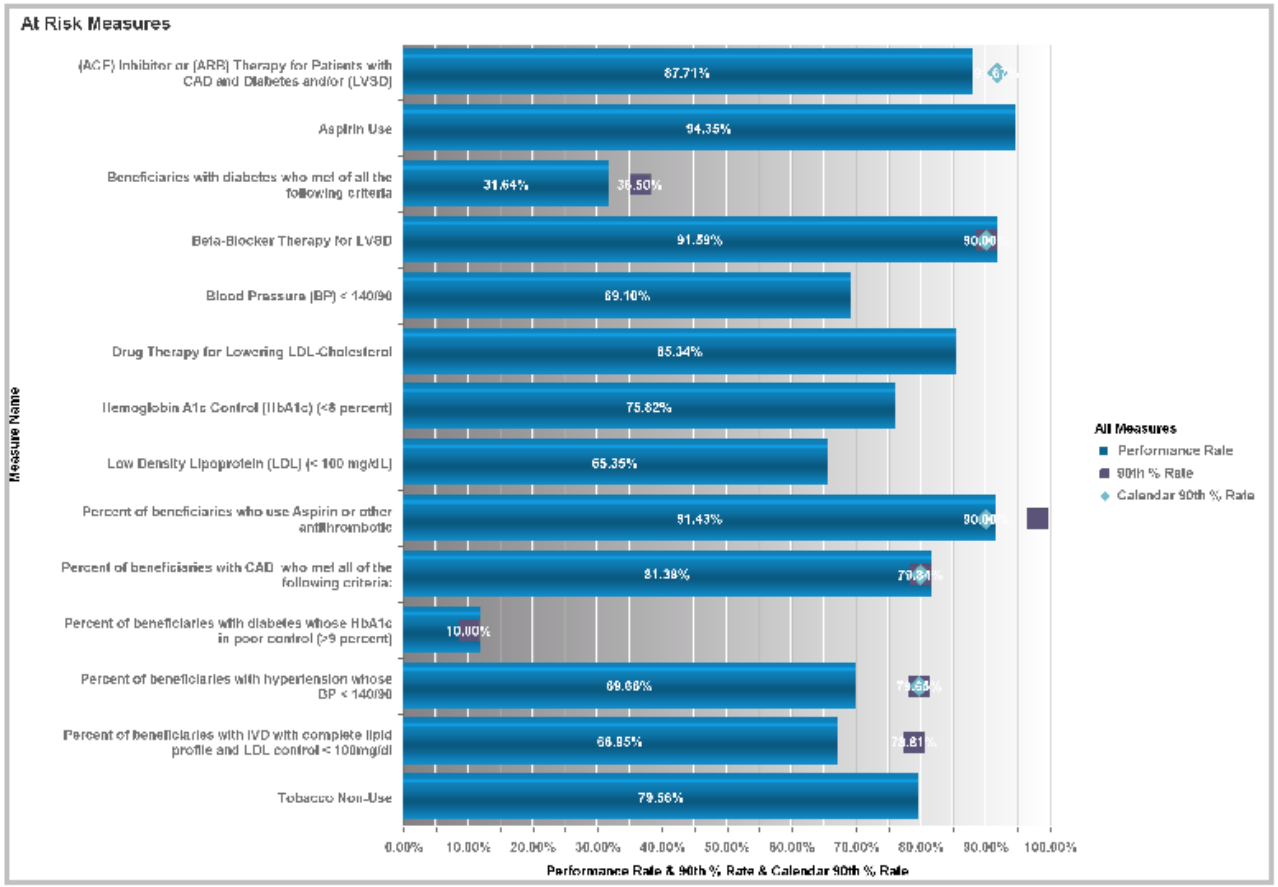

Page 1 of 1

Quality Improvement
Where We Started

MPactHealth At Risk Population by Org

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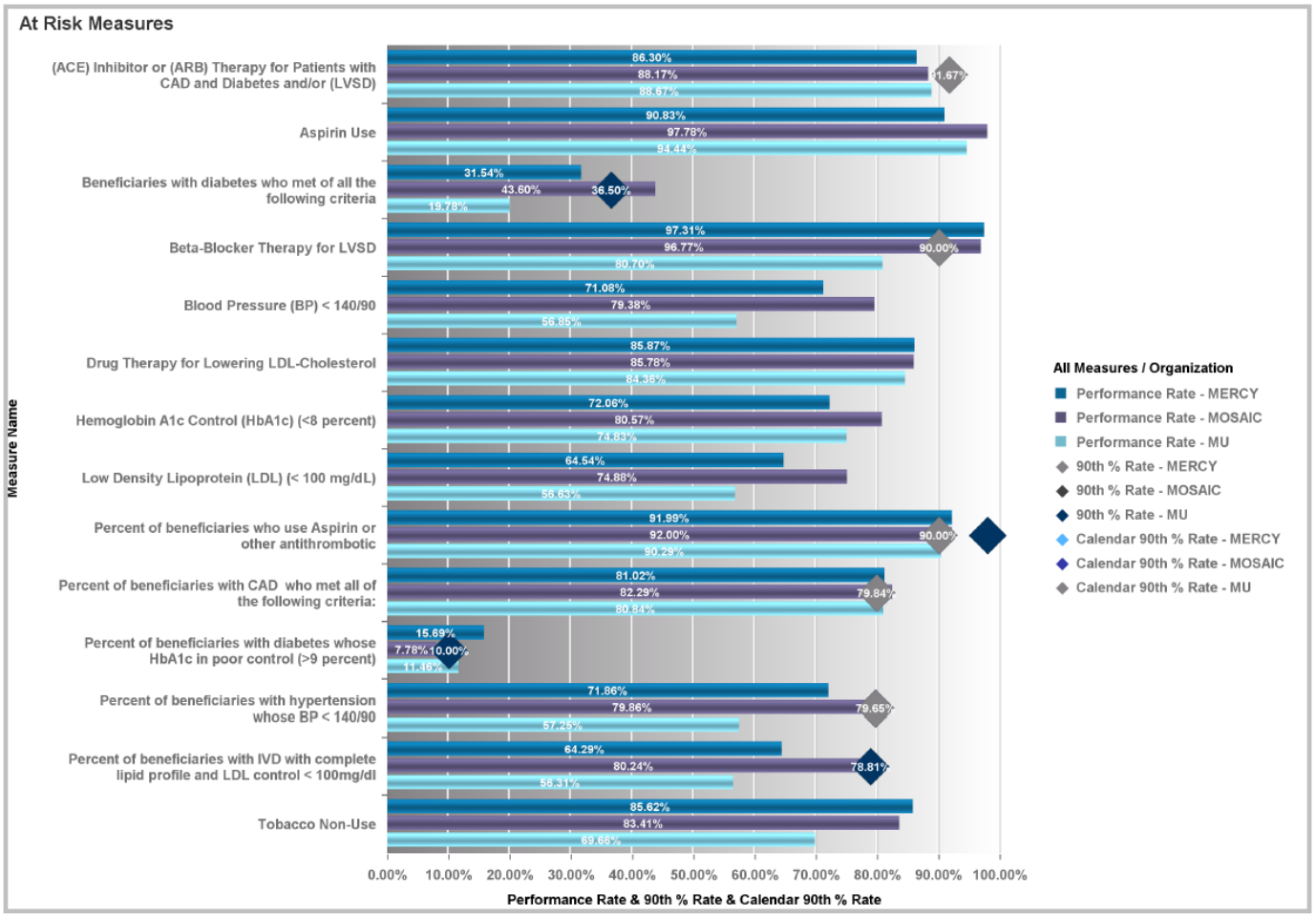

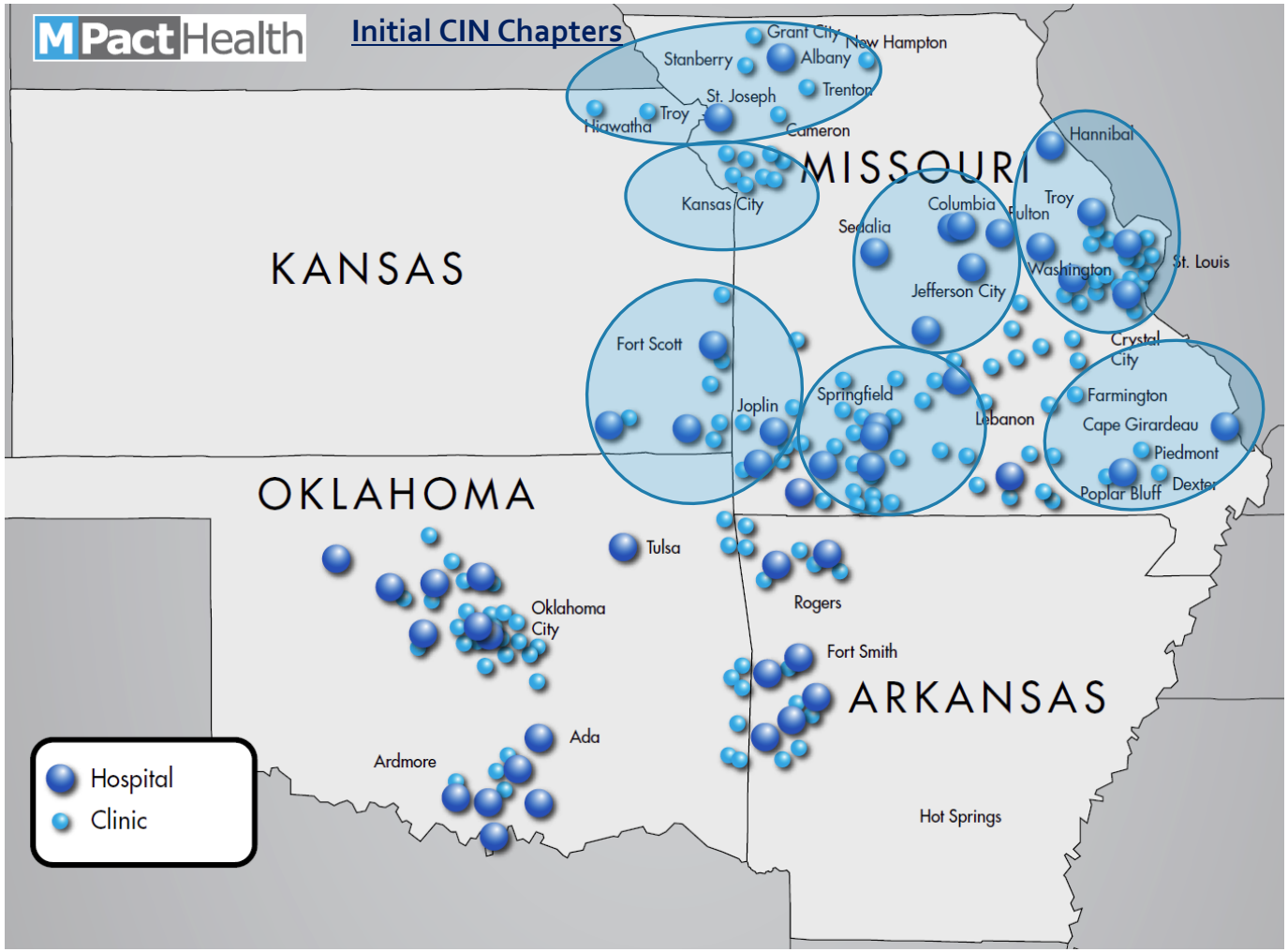
MPactHealth
Initial CIN Chapters
Grant City
New Hampton
Stanberry
Albany
Trenton
St. Joseph
Troy
Hiawatha
Cameron
Hannibal
MISSOURI
Kansas City
Columbia
Fulton
Troy
Sedalia
Washington
St. Louis
KANSAS
Jefferson City
Fort Scott
Crystal City
Springfield
Farmington
Joplin
Lebanon
Cape Girardeau
Piedmont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

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 Walmart, Lowes, PBGH
- MU narrow network option for University of Missouri employees

MPactHealth

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