CareMount Medical's Transition to Population Health

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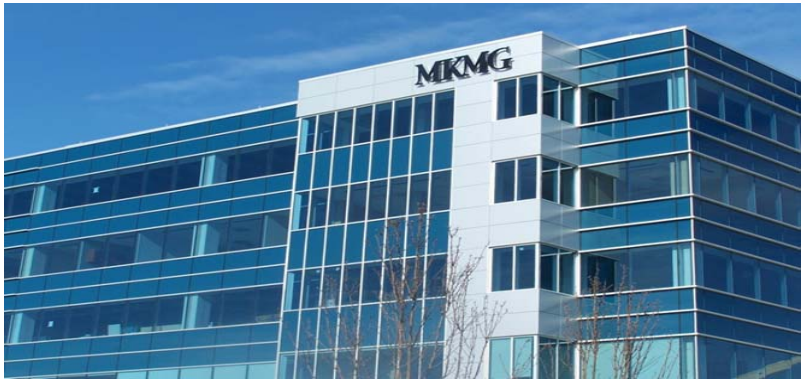

- Multi-specialty medical group practice founded in 1946 by eight physicians
- The largest independent, physician-owned and physician-led medical group in NYS

Practice Overview

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- The Group serves Columbia, Dutchess, Putnam, Ulster and Westchester Counties in New York's Hudson Valley
- 450 primary care and specialty physicians
- Forty specialties represented
- Forty office locations throughout the five counties
- 525,000 active patients

Managing and Improving Health

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- Market continues to evolve:
  - Medicare and Commercial ACOs
  - Medicare Advantage Contracts
  - Bundled Payments
  - Direct Employer Contracts and Self-insured Models
- Shift from FFS to Value:
  - Focus on Cohorts as well as the Individual Patient
  - The Model of Care Evolves
    - Identify Health Risks and Intervene
    - Keep Healthy Patients Healthy

Alternative Payment Model Framework

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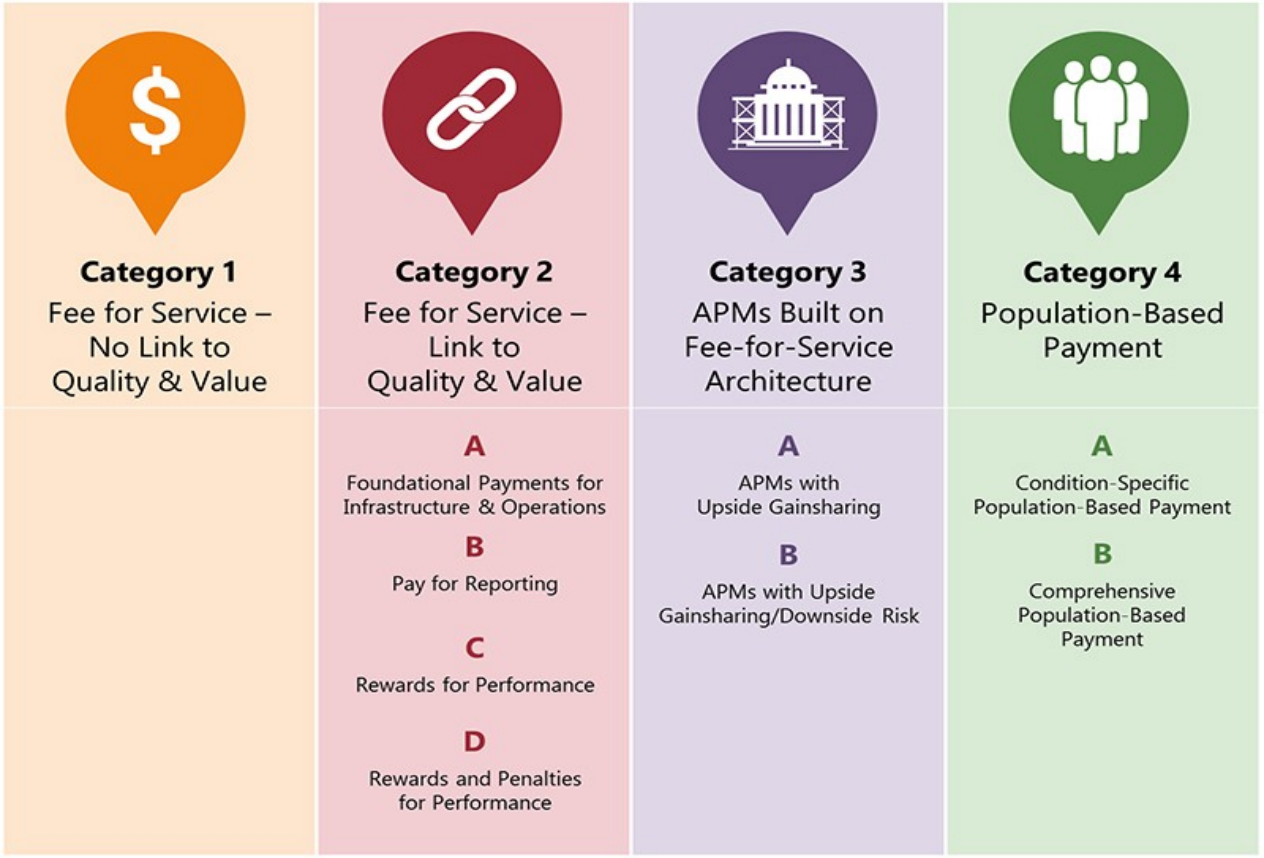

Health Affairs Blog: Paying Providers For Value: The Path Forward

Samuel Nussbaum, Mark McClellan, Mark D. Smith, and Patrick H. Conway

January 14, 2016

Data Required on Multiple Fronts

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Clinical	Provider / Network Management	Financial / Actuarial
1. Patient satisfaction	1. Provider efficiency	1. Trends & Predictive modeling
2. Disease & pop management	2. Quality reporting	2. Risk adjustment
3. Population analytics	3. Incentive models	3. Contract performance
4. Care management	4. Provider scorecards	4. IBNR
5. Gaps in care		5. Pro-forma modeling
6. Episode and other groupers		
7. Patient engagement		

The CareMount Story – Thus Far

- CareMount has:
  - Excellent and Highly Trained Physicians
  - Integrated Single EHR Platform
- CareMount Future Focus:
  - Expanded Care Coordination
  - Increase in Consumer Focus and Patient Access
  - Increased Facility with Risk and Pop Health Analytics
  - Invest in Network Development/Integration, and Gain Ability to take Risk and Manage the Total Cost of Care

CareMount Example: Road to Risk

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ACO

1. Low historical benchmark (BM) limits shared savings upside
2. Use claims data to build high-value network
3. "Feeder" for MA, CCM, bundle migration
4. Satisfies Medicare GPRO quality reporting
5. New regulation extends low BM to 2019*

ACO CCM

1. Chronic Care Management code pays $42 PMPM
2. 70% of Medicare ACO (i.e., 16,000 lives) qualifies for CCM billing

   16k x $42 x 12 mo = $8M
3. Utilize ACO nurses and infrastructure to bill CCM

Bundled Payment

1. Specialist- focused risk contracts
2. Episodic payment encompasses acute DRG + 90 days
3. 58 episode types
4. Medicare bundled pilot should re-open in 2017

Profit-Sharing MA

1. Top Medicare pop. health strategy
2. Grow MA membership
3. Tighten Leakage
4. Launch HMO 2018

* CMS proposed new MSSP ACO benchmarking rule on 1/28/16. Rule introduces regionally-blended benchmarks for ACO contract renewals starting in 2017. However, early start ACOs like MKMG (i.e., 2012/2013 start) need to wait until their 2019 contract renewal to receive new benchmarks.

Managing and Improving Health

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From Bundles to Global Capitation, Aligning Care Models to Payment Models

Roy Smythe, MD
Chief Medical Officer
Valance Health Chicago, IL

Provider Based Population Health: No Need to Reinvent the Wheel

Frederic S. Goldstein
Founder and President
Accountable Health, LLC Jacksonville, FL

How Data Helped Jack Up the Hill

Christopher Coloian, MHA
Senior Vice President
CaféWell Insights/Welltok® Burlington, MA