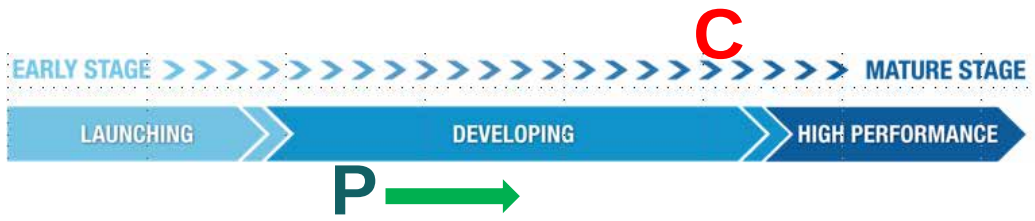
Providence HealthEngage



Creating Value for Employers

- **Optimize Healthcare $:**
  Reduction in unit cost and utilization;
  Coordinated Network with Aligned Incentives;
  Network rewarded for efficient and effective care

- **Employee Engagement in Health:**
  Proactive engagement; improved experience via easier access (ExpressCare) and coordinated care across the health continuum;
  Provider-based Care Management support

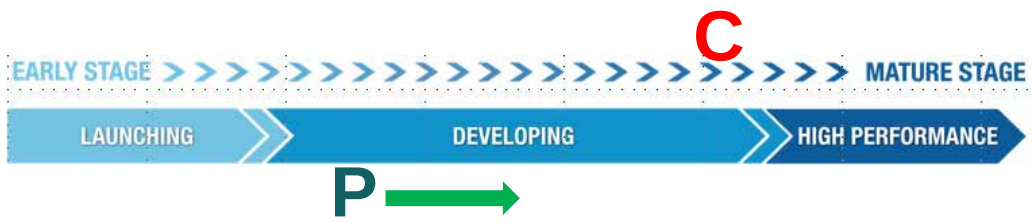
Capturing Value for PH&S

- **Capture New Membership / Increase Share of healthcare spending:**
  Narrow, Coordinated Network; Care Managers engaged in referral process; Data enables action

- **Reward for PopHealth success:**
  Opportunity to benefit financially from PopHealth initiatives that reduce unnecessary utilization and improve health outcomes

- **Competitive positioning:**
  Market leadership in innovative, accountable solutions;
  Synchronize with business model transformation

Providence HealthEngage



Financial comparison: Traditional PPO vs. HealthEngage ACO

Traditional PPO

MAX PMPM -- $400

Expected PMPM -- $320

HealthEngage ACO

MAX PMPM -- $375

Expected PMPM -- $300

Net MAX PMPM -- $345

50-50% share in 80-120 corridor → +/- $30 PMPM

ACO Journey Map

Competency Expectations

- ○ Not Started
- ◑ In Process
- ● Complete

	LAUNCHING	DEVELOPING	HIGH PERFORMANCE
	1 – 3 years	2 – 7 years	4 – 10 years
Clinical Governance			
Provider Responsibility	◑ Providers approve clinical and operational goals and plans	○ PCPs and specialists oversee quality and patient experience	○ Accountable for achieving sustained high performance
Network			
Primary Care (PCP)	● Established	◑ Add high value PCPs	○ Optimized and refine network
Hospitals & Specialists	● Identified and recruit	○ Add high value hospitals and specialists	○ Optimized and refine network
Care Model			
Medical Home	◑ Implementing	○ Established, integrating behavioral health	○ Optimized and complete
Risk Stratification	● High-risk patients targeted	○ Expanded to include moderate risk consumers	○ All consumers targeted
Clinical Guidelines	● Established for high-risk patients	○ EMR-based, expanded use across conditions	○ Complete guidelines across ACO
Quality	● Siloed quality efforts	○ Coordinated quality efforts	○ Continuous quality improvement
Care Coordination	◑ Through health plan or ACO	○ Shifting to ACO	○
Site of Care	○ Adding low costs sites of care	○ Refer to efficient sites of care	○ Integrated into care model
Medication	● Polypharmacy and reconciliations	○ Evidence-based use, adherence and efficiency	○ Value-based, efficient across sites
Consumer Experience			
Access	○ 24/7 access	○ Expanded 24/7 and same day urgent access	○ Consistent 24/7 and urgent access
Pro-active Outreach	● Limited to high-risk patients	○ Expanded for moderate risk consumers	○ Consistent outreach to all consumers
Satisfaction	○ Measured for high-risk patients	◑ Improves for high/moderate risk consumers	◑ Concierge model for all consumers
Portal	● Basic, includes records, messaging	◑ Addition of care plans and content	◑ Comprehensive and mobile-enabled
Technology & Analytics			
Electronic Hlth Record	● Multiple separate systems	◑ Limited data exchange	○ Complete interoperability
Predictive Analytics/Reg.	○ Primary care registries only	◑ Primary and specialty care registries	○ Integrated registries
Data Analytics	○ Limited to EHR data	● Multiple data sources to identify opportunities	○ Use comprehensive clinical/claims data
Finance Model			
ACO Risk	○ Gain-sharing tied to quality/cost	◑ Gain-/Loss-sharing tied to quality/cost	◑ At risk for total cost of care
Physician Incentives	◑ Small incentive, limited ACO panel	○ Increased incentive, expanded ACO panel, introduce downside risk	○ Compensation with incentives tied to performance

VillageMD | Who We Are

PAUL MARTINO, Co-founder and Chief Strategy Officer

Management services organization that empowers primary care providers for success in value-based care through:

- Clinical care models
- Multi-payer value-based reimbursement contracts, including CMS/Medicare
- Technology solutions, including data analytics
- Clinical and administrative resources
- Development and deployment of cognitive and physical ancillary services

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The VillageMD Solution

Financial alignment,

supported by a **clinical model**,

which drives **superior cost and quality outcomes**

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Providers Say Commercial Payers are Unwilling to Share Risk

"**28.8% of providers** said they participate in shared savings contracts with commercial payers, despite the fact that providers are accountable for shifting to a value-based system in order to maximize Medicare through pay-for-performance plans" (Premier Survey, July 2016)

"Folks are eager to move into commercial risk-bearing contracts for the purposes of MACRA, and it is **slow going in many, many markets**…"
(Bryan Smith, principal at Premier)

Source: Livingston, Shelby. "Providers Say Commercial Payers Are Unwilling to Share Risk." Modern Healthcare. N.p., 12 Oct. 2016.

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Houston, TX

Population: 5,920,416

- 4th largest MSA in the country

Income per capita:

- Houston: $31,668
- Texas: $28,210

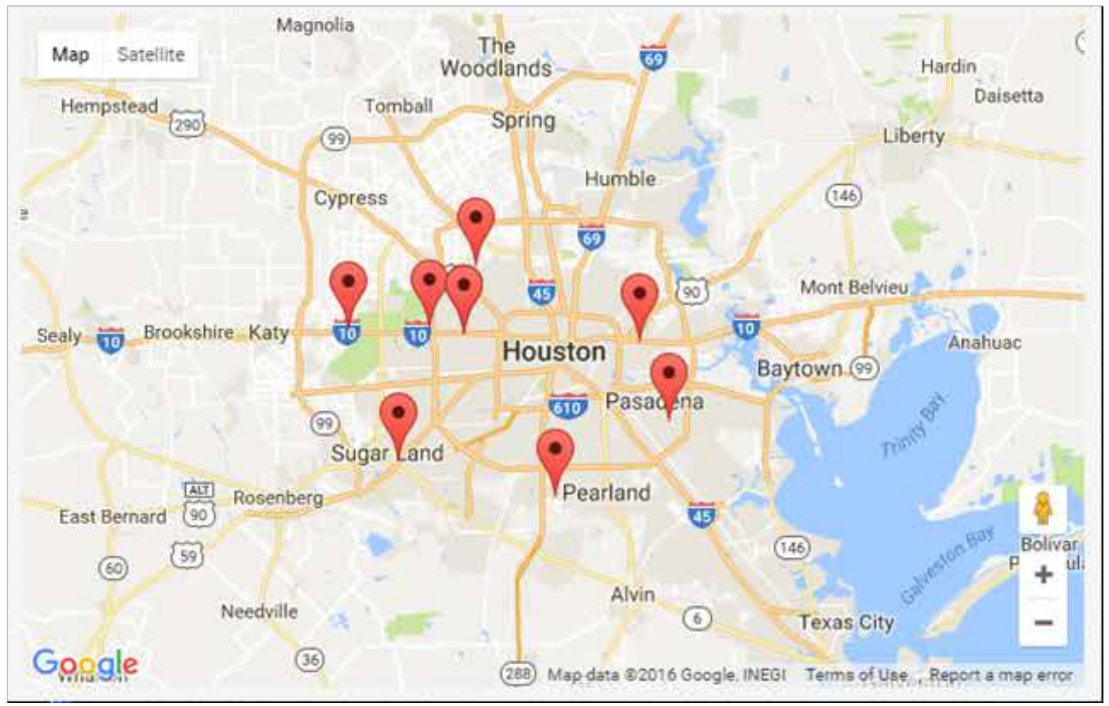
Medicare Advantage: 294,470

- 20% of all MA beneficiaries in the state of Texas

Houston, TX

Village Family Practice

Independent Medical Group

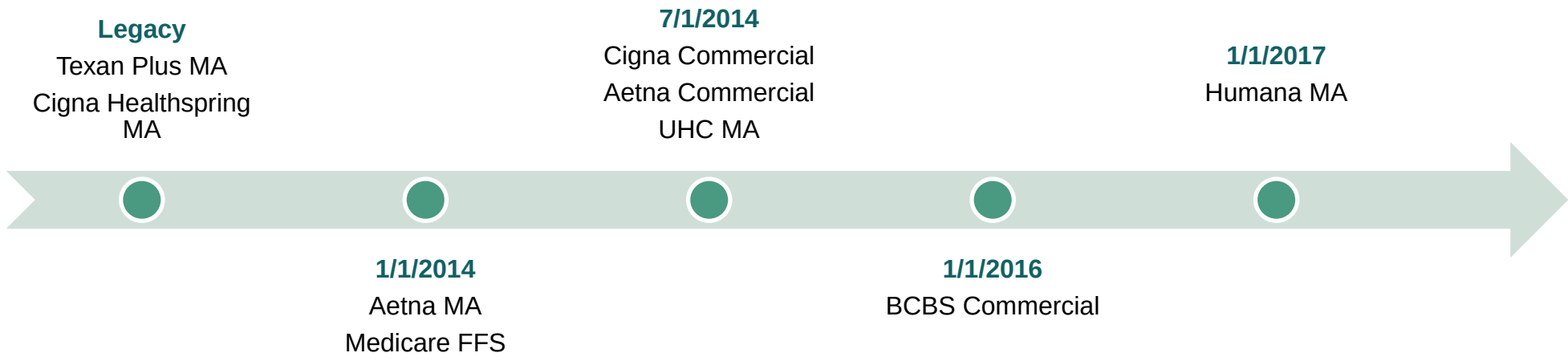


Village Family Practice

- Established in 1975
- Grew from 2-3 physicians in 1978 to 50 providers across 9 locations today
- Focus on adult primary care medicine
- Integrated in-house physical therapists, endocrinologists, and podiatrists

Houston | Financial Alignment

- Adopted first risk-based contracts in late 1990s. Today, 90% of all patients are covered by contracts that are value-based models.



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Houston | Clinical Model

Village Family Practice and VillageMD have developed programs, processes, and practices that address care delivery, access, patient engagement, and chronic disease management.

These programs drive improved clinical outcomes and total cost of care savings.

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Houston | Clinical Model

- **Cognitive Ancillaries**
  - AWV, CCM, TCM
  - Patient Education
- **Predictive Modeling**
  - High Risk Care Management
  - Chronic Care Management
- **Physical Ancillaries**
  - POC Pharmacy
  - Lab
  - Imaging
- **Nursing Quality**
  - Rooming Guidelines
- **Admissions/Readmissions Management**
- **Access Programs**
  - Avoidable ED visits
  - Urgent Care Hours
  - Call Culture
  - Village @ Home
- **High quality, low cost referral network**

VILLAGE
FAMILY PRACTICE

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Houston | Clinical Model

Attribution

Knowing who your patients are

Acuity

Knowing which patients are sick

Utilization

Knowing where your patients have been

Physician Education & Engagement

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Houston | Clinical Model

AWVs get patients in the office for a full and complete assessment of their health

Nurse Practitioner

Patient

- Nurse Practitioner conducts a Health Risk Assessment, updates all relevant health information, & documents health status
- Focus on prevention & closing gaps in care, & referrals to Care Management Program
- Utilizes the AWV benefit for Medicare and the HRA benefit through commercial payers

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Houston | Clinical Model

Rooming Guidelines for Diabetic Patient Office Visits

Registered Nurse
Rooming Patient

- Draws blood
- Orders labs for HgbA1c, lipids, and blood chemistry
- Orders Urine Microalbumin test
- Makes necessary referrals for retinopathy and peripheral vascular exams
- Removes patient's shoes
- Asks specific health questions for diabetic patients in advance of the physician exam

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Houston | Clinical Model

- Physician driven, patient centered
- Face-to-face visits in PCP office, in the building, and in the community
- Live, real-time access to EMR, augmented with claims data
- Coordinated care among multiple disciplines
- Localized to connect patients to available community resources
- Personalized to break through barriers

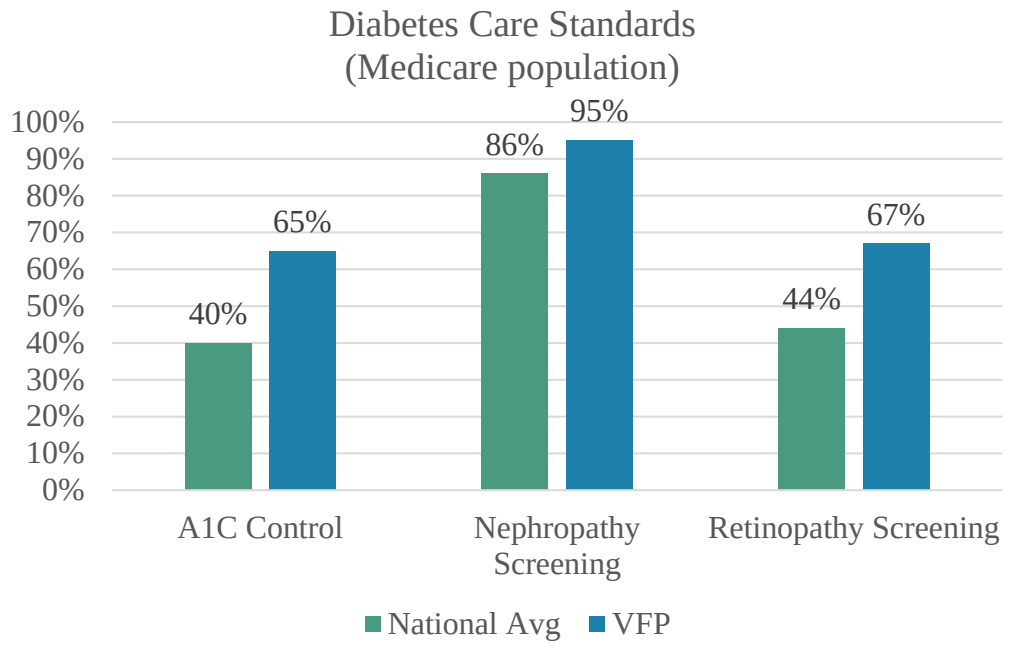
Houston | Clinical Model

Healthy Interactions Diabetes Education Program

- Partner with ADA-certified leader in diabetes education content development
- Over 500 patient participants annually
- Significant improvements in A1C
- Sessions led by Certified Diabetes Educator (CDE)
- Focus on disease education, tools to manage blood glucose, management of diet, exercise, and medication management

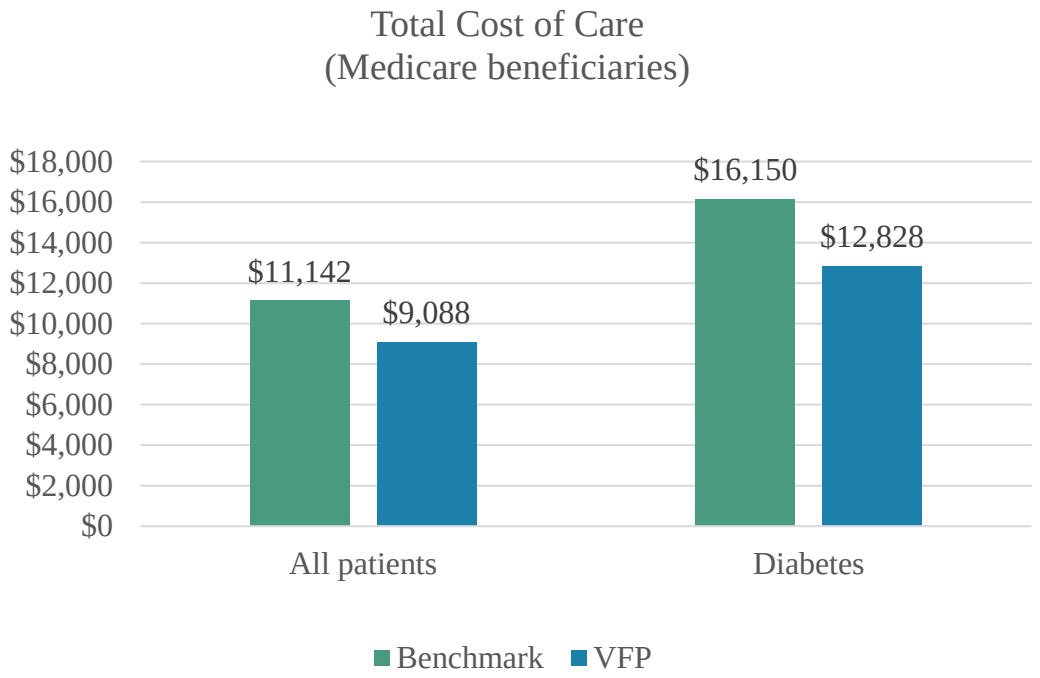
Houston | Quality Outcomes

Integration of specialists provides patients with needed exams and improves quality of care



Source: Village Family Practice Patient Data and CMS

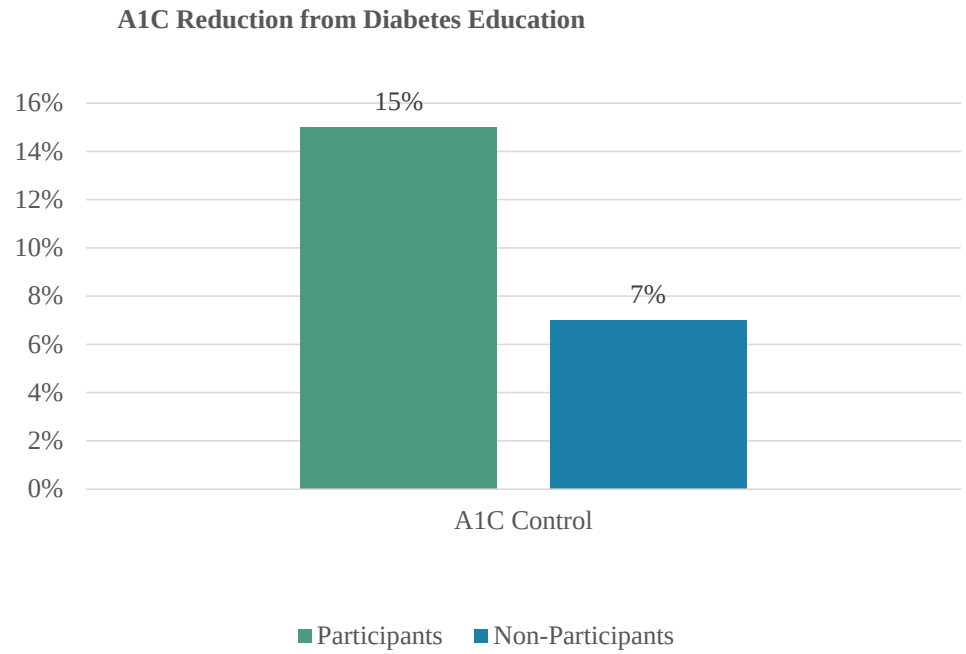
Total cost of care results for Diabetic Population



Source: Village Family Practice Patient Data and CMS

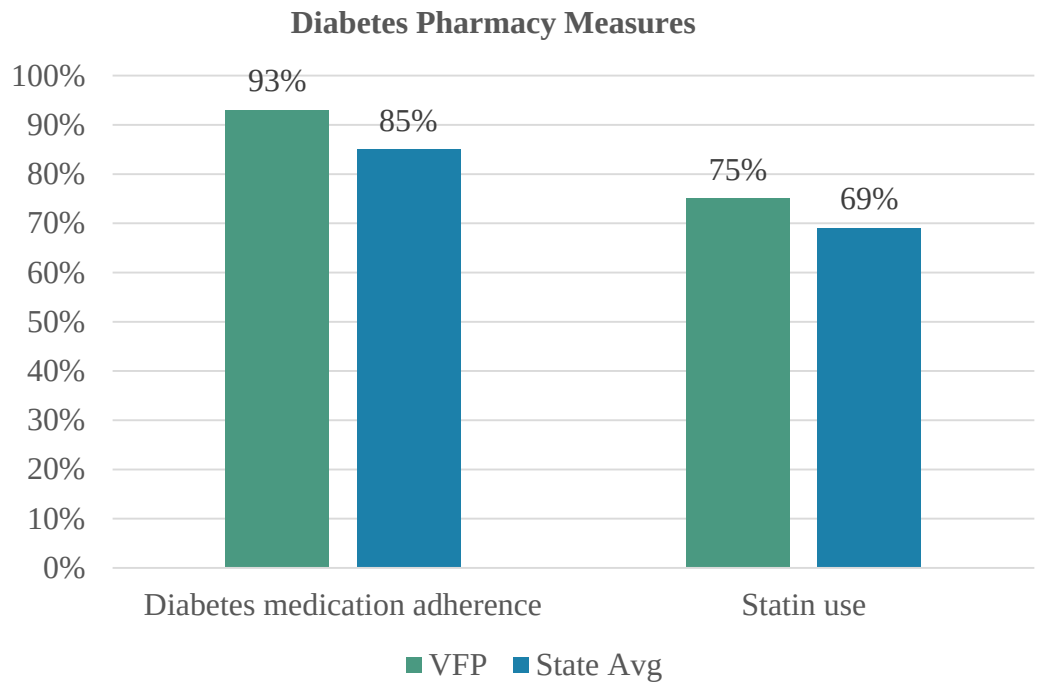
Houston | Quality Outcomes

Diabetes Education has resulted in significant improvements in A1C



Source: Village Family Practice Patient Data (Healthy Interactions)

Village Pharmacy has helped Diabetic patients better manage their medications



Source: Village Family Practice Patient Data

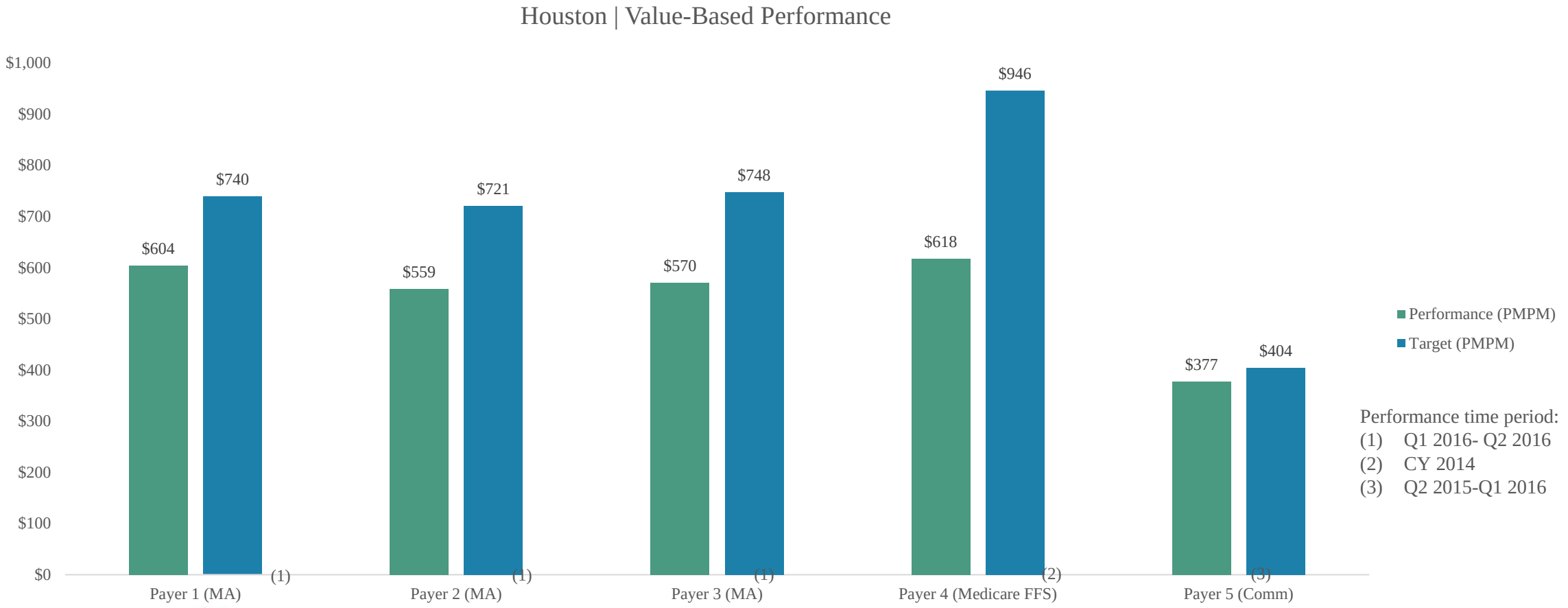
Houston | Financial Outcomes

- Accountable Care Coalition (ACC) of Texas is a Universal American ACO. Village is the largest contributor to the ACO's results.

MSSP Performance Data (2013-2014)				
	Performance Year	**Gross Savings ($)**	**# of Members**	**Savings per Member**
ACC of Texas	2013	$19,096,710	33,739	$ 566
Village Family Practice	**2013**	**$8,640,098 (45% of total)**	**2,353 (7% of total)**	**$3,671**
ACC of Texas	2014	$16,041,318	21,296	$ 753
Village Family Practice	**2014**	**$ 5,498,714 (34% of total)**	**2,409 (11% of total)**	**$2,282**

Source: CMS

Houston | Financial Outcomes



Indianapolis, IN

Indianapolis, IN

Population: 1,887,877

- 14th largest MSA in the country

Income per-capita:

- Indianapolis: $29,745
- Indiana: $26,396

Medicare Advantage: 84,570

- 29% of all MA beneficiaries in the state of Indiana

Community Health Network

Integrated Health System

- $2B not for profit health system
- 200 total sites of care in central Indiana
- 10 acute care and specialty hospitals
- 9 ambulatory surgery and endoscopy centers
- 13 ambulatory pavilions and 200+ ambulatory locations
- 600+ employed providers (300 PCPs)

- Community Health Network partners with VillageMD
- Launched joint venture, Primaria Health, on September 2015
- Anthem is first payer to support joint venture, September 2015
- Multiple payers now supporting this JV

Indianapolis | Financial Alignment

10/1/2015
Anthem Commercial

1/1/2016
Anthem MA
Humana MA
ProHealth (CHN Employees)

10/1/2016
UHC Commercial
Aetna Commercial

1/1/2017
Medicare FFS (MSSP)

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Indianapolis | Clinical Model

- **Cognitive Ancillaries**
  - AWV, CCM, TCM
  - Patient Education
- **Predictive Modeling**
  - High Risk Care Management
- **Nursing Quality**
  - Rooming Guidelines
  - Pre-visit Planning

Leveraging existing network of CHN services

- **Physical Ancillaries**
  - POC Pharmacy
  - Lab
  - Imaging

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Indianapolis | Clinical Model

The building blocks for transforming to a new model of care

Year Three Goal

Attribution

Knowing who your patients are

Acuity

Knowing which patients are sick

Utilization

Knowing where your patients have been

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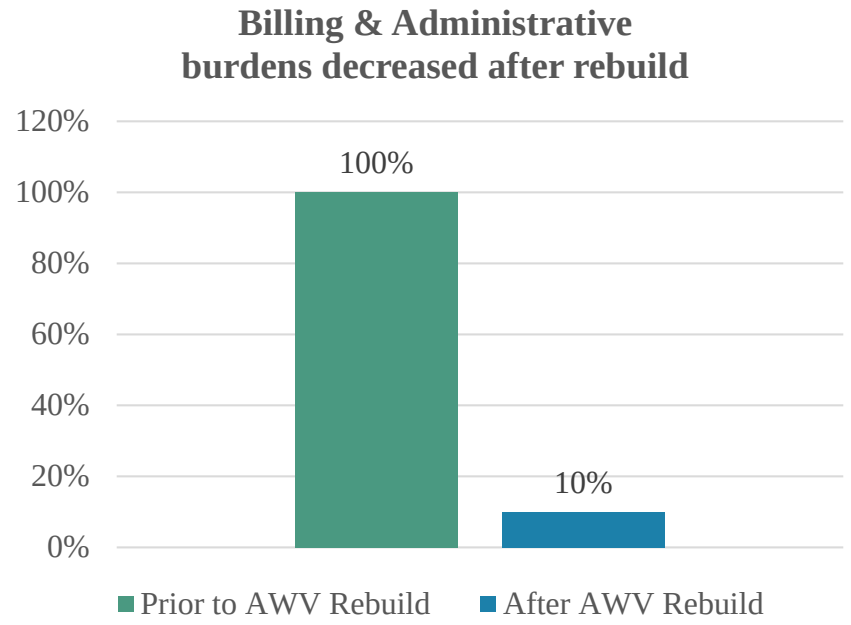
Indianapolis | Clinical Model

Automated AWV leaves more time for patient care and less time on EMR

MD, NP or Pharmacist spends time with patients:

- Identifying high risk behaviors, social determinants of health, potential gaps in care
- Assessing and documenting health status for accurate attribution & acuity
- Determining best method of care, referral into Care Management programs or other needed services



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