Valence Health

Valence Health Solutions To Support

Prepared for First Illinois HFMA

November 2015

Discussion Topics

- Valence Health overview
- Specific areas of opportunity
  - Optimize risk contracts
  - Analyze and improve in-network utilization
  - Improve quality
  - Bundled payments
- Other area's of opportunity
- Next steps

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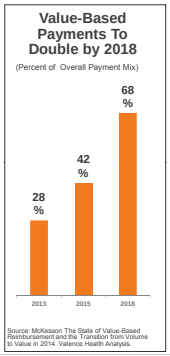
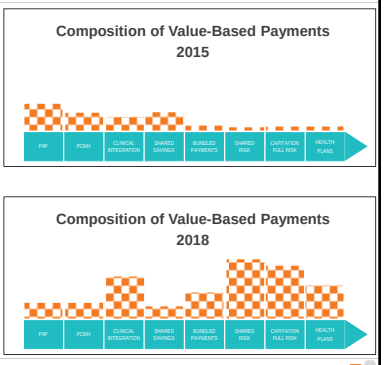
The $300 Billion Value-Based Payment Shift is a Story of Magnitude and Composition





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Dedicated To Helping Providers Successfully Enter Value-Based Arrangements

Vision

Providers should be in full control of the care they provide–clinically as well as financially

Mission

To be indispensible in helping healthcare providers manage their patient populations by accepting financial responsibility and rewards for the quality of care they provide

Mantra

Total solutions for value-based care

4

20 years of Serving ~100 Hospital & Health System Clients Nationally

- Total solutions for value-based care since 1996
- Long-term successful clients – clinically and financially
- National presence with 900+ employees
- Serve Hospitals, IDNs, IPAs, PHOs, ACOs
- Serve 90,000 physicians, 135+ hospitals
- Support ~1,500,000 lives in health plans and risk arrangements
- Will launch or assume 12 risk arrangements and health plans in 14 months*

*Dec '14 – Jan '16

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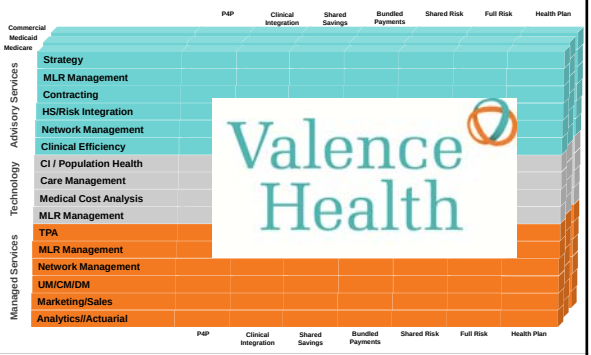
Comprehensive Yet Flexible Set Of Solutions To Empower Value-Based Success



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We Continually Help Clients Pursue Their Value-Based Goals

"Pathfinder"
Developed a playbook to drive consistent results across inconsistent markets. Accelerating implementation of VBC models by 2x

Incentive Plan Administration
Developed comprehensive 3 year plan, tracked performance and administered payments

Care Gap Closure
Identified and closed gaps in care increasing quality and generating a 5X ROI in PCP visits

Care Model Redesign
Supported creation of new clinical pathways with clinical and financial benefits

Network Optimization
Analyzed referral patterns to identify ways to increase domestic utilization

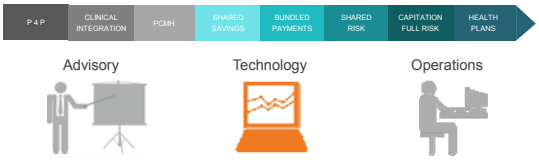
CIN Design & Build
De novo start of CIN, inclusive of P&Ps, Recruitment, Technology and Management

Optimize Employee Health Plan
Revamped benefit design and administration with goal of 8% expense reduction

Develop PSHP
Grew plan to 160,000 lives PSHP and provided incremental services to performance

Driving Client Value Across the Risk Spectrum, Evolving as Markets and Capabilities Evolve

A Few Client Examples Tell the Story



Advisory | Technology | Operations

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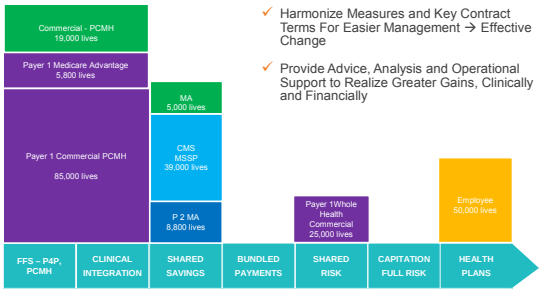
Optimize & Rationalize Value-Based Contracts In 3 Major Ways

- ✓ Provide a Common Management Structure And Reporting Platform
- ✓ Harmonize Measures and Key Contract Terms For Easier Management → Effective Change
- ✓ Provide Advice, Analysis and Operational Support to Realize Greater Gains, Clinically and Financially



We Use Our Expertise and Technology To Produce Results

Key Valence Health Actions	Benefits
• Review all existing risk contracts	• Identify key metrics to track, common terms and areas of focus, and items to change/harmonize
• Import all payer data into vQuest and perform analyses	• Gain immediate insight into performance and opportunities by contract, specialty, diagnoses, geography, provider, etc. → target areas for investigation and improvement
• Leverage analysis into operational and clinical recommendations, inclusive of expected impact	• Allows you to prioritize and choose actions
• As needed, provide clinical, operational support to implement selected recommendations	• Increases chances of successful changes

Comprehensive Integrated Suite of Technology and Analytics Solutions That Support Risk

Clinical Quality *(Vision)*
- Clinical integration
  - Aggregate data
  - Physician attribution
- Patient care
  - Risk stratify populations
  - Identify care gaps
  - Build registries
- Provider performance
  - Benchmark performance measures
  - Stratify by location, specialty, practice, etc.
  - Report on multiple programs

Care Management *(vCare)*
- Workflow solution for medical management
  - Utilization Management
  - Case Management
  - Disease management
- Designed to support URAC and NCQA standards
- Drives patient engagement
- Analytics align with Vision and vQuest
- Embedded care guidelines

Medical Cost Analysis *(vQuest)*
- Analyze medical costs and trends
- Risk stratify and prioritize patients
- Predictive modeling
- Tracks medical expense across major categories
- Measure provider performance on cost and utilization
- Supports delegated Risk and health plans



Proactively Design Risk Arrangements To Establish With Payers

Client Example

- High profile Regional system
- > $2 Billion in Net Patient Revenue
- Wanted to pursue risk

Valence analysis suggested Sub-capitated Medicaid risk as most impactful path forward

1

Valence data analysis and contracting expertise helped define standard risk agreement for all MCOs

2

Valence helped develop contracting approach and negotiations with 3 of 5 MCOs

MCOs Contracted	3 of 5, 4 and 5 under pursuit
Lives Covered	30,214
Revenues	$ 62,533,836
Med Expense	$ 45,876,079
Admin Expense	$ 4,814,837
Net Income	$ 11,842,920
Net Income %	18.9%
MLR	73.4%
Admin Ratio	7.7%

Example - vQuest Produces Specific Clinical and Financial Benefits

- At-risk population >100,000
- Open to collaboration for improvements

vQuest indicates that OB-GYN & Delivery costs are above national averages

1

Additional analysis by VH actuarial & advisory team shows costs are driven by an abnormal number of premature deliveries

2

VH's clinical advisory team supports development & delivery of innovative education program for pregnant mothers, especially first-time mothers

3

- Clinical impact → 8% reduction in Premature Birth, 17% reduction in births resulting in NICU stay
- Financial Impact → Cost savings in excess of $5 million

Perform Regular Medical Economics Reviews To Identify Areas of Opportunity

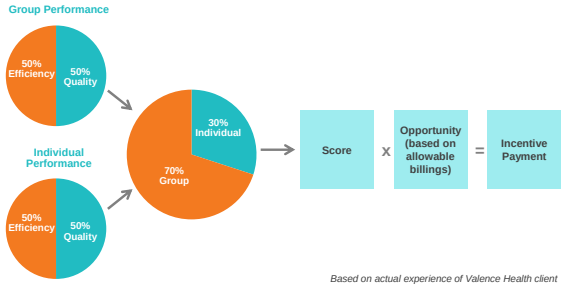
- Trend Analysis
- Practice Variation – Cost & Utilization
- Practice Variations – Quality
- Population Stratification and Mgmt
- Regional Performance Analysis
- Product Performance Analysis

Turning Insights Into Action

Situation	Action	Impact
ACO has millions of dollars at risk for achieving high well child visit compliance	Replicated the quality metric in a prospective way to identify, outreach, and schedule appointments	ACO achieved the highest scores in the state and earned maximum available, > $2 million
ACO struggles with repeat visitors in the ED	Implemented an ED Diversion program to outreach and educate	• Modest improvements in ED visits • Significant improvements in office visits for members in the program
Health Plan has poor MLR performance in certain geographies	Main driver is poor hospital contracts in those geographies. Renegotiated or termed contracts as needed.	MLRs returned to manageable levels
Health Plan pharmacy trends exceeding industry norms	Searched, selected, and implemented new PBM.	• Immediate savings of $5 PMPM • >$5 million in 3 years

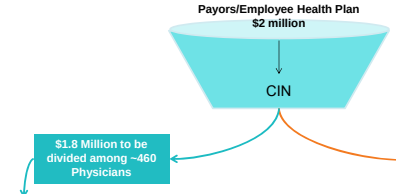
Incentive Payments to Individual Physicians Should be Based on Group &Individual Performance

Example of Physician Incentive Payment Model



Based on actual experience of Valence Health client

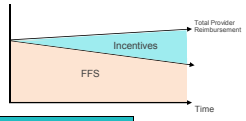
Example - a P4P arrangement including annual performance-based bonuses



Metric	Measurement	Amount	Additional Comments
EMR data provided to CIN by end of 2012	Yes/No	$1,250 with a 25K practice cap	Physicians who received a 2011 payment will not receive payout for 2012
QA Portal Web Training	Yes/No	$250	All physicians must be trained individually to qualify for incentive
Compliance to Protocols	Compliance Performance Quartile	$0 for first quartile $500 for second quartile $1,000 for third quartile $1,500 for fourth quartile	Volume threshold at the guideline level for eligibility
	>90% performance on SCIP Measures	$3,000	Applicable only to Surgical Specialties that do not have an approved protocol

Illustrative incentive structure for CIN physicians

Over time physician compensation shifts more towards incentives and away from FFS payments



Illustrative Example of Funds Flow Distribution

Assumptions	
# lives	100,000
# physicians	200
Current Professional PMPM	$28.00
Current Total Reimbursement	$33,600,000

Incentive and Reimbursement Calculation	Year 1	Year 2	Year 3
Reimbursement bump	4%	4%	4%
Portion incentive based	50%	75%	100%
Reimbursement:			
Base: Same as current	$33,600,000	$33,600,000	$33,600,000
Fee-based incremental amount	$672,000	$685,440	$0
Incentive amount	$672,000	$2,056,320	$4,195,460
Total	$34,944,000	$36,341,760	$37,795,430
Reimbursement per Physician:			
Base: Same as current	$168,000	$168,000	$168,000
Fee-based incremental amount	$3,360	$3,427	$0
Incentive amount	$3,360	$10,282	$20,977
Total	$174,720	$181,709	$188,977

Based on actual Valence client experience

Examples - Drive Meaningful Results Through Managing Risk

Actual Client Economics – Annual Results

	Client 1	Client 2	Client 3	Client 4
	Delegated Global Risk	Delegated Global Risk	Delegated Partial Risk	Health Plan
Lives Covered	315,338	30,214	39,053	108,167
Revenues	$ 677,419,226	$ 62,533,836	$ 75,389,612	$ 315,600,605
Med Expense	$ 533,516,684	$ 45,876,079	$ 64,201,745	$ 279,549,873
Admin Expense	$ 2,989,404	$ 4,814,837	$ 3,612,000	$ 34,507,666
Net Income	$ 140,913,138	$ 11,842,920	$ 7,575,867	$ 1,543,066
Net Income %	**20.8%**	**18.9%**	**10.0%**	**0.5%**
MLR	78.8%	73.4%	85.2%	88.6%
Admin Ratio	0.4%	7.7%	4.8%	10.9%

Source: NAIC Website, Valence Health Client Financials

Managed Services for Flexibility To Meet Evolving Needs

	Hamilton	NorthShore	Driscoll	[illegible]	Maine Community
	• Commercial Plan • 35,000 lives	• Delegated Risk, Commercial • 45,000 lives	• Medicaid Plan • 145,000 lives	• Delegated Risk, Commercial • 15,000 lives	• Commercial Plan • 80,000 lives
Claims Management	X	X	X	X	X
Broker Management	X				X
Customer Support	X	X	X	X	X
Member Fulfillment	X		X		X
Finance & Actuarial Support – MLR Management	X	X	X	X	X
Network Management	X				X
Reporting, GPRO, MSSP	X	X	X	X	X
Eligibility & Capitation	X	X		X	X
Medical Management	X	X		X	X

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Example - Software, In-House Actuaries And Experts Turn Data Into Actionable Insights

Analysis
What Leakage Is Occurring?

Investigation
Why Is Leakage Occurring?

Action
How Do You Affect Change?
What Do You Need To Do?

Specialty	In-Network PMPM	Out-of-Network PMPM	Total PMPM
Neonatology	$1.87	$1.34	$3.11
Neurology	$0.31	$0.06	$0.37
Nurse Practitioner	$0.51	$0.03	$0.54
OBGYN	$1.72	$0.27	$1.99
Ophthalmology	$0.31	$0.14	$0.45

Top Out-of-Network Neonatologists

Provider	Patients	Paid / Patient	Total PMPM
Dr. Smith	12	$843	$2.51
Dr. Jones	4	$563	$0.38
Dr. Kamp	1	$700	$0.12
Dr. Rodgers	1	$624	$0.10

Count of Specialists

Specialty	Before	After
Neonatology	7	8
Neurology	5	6
Nurse Practitioner	24	24
OBGYN	18	18
Ophthalmology	4	4

PCP Incentive Program

Metric	Value x Quartile
TCOC Quartile	$0.25
In-Network Referral Quartile	$0.20
Quality Quartile	$0.20

Analysis: Questions To Answer with Data

- What leakage is occurring?
  - Who is leaving the network?
  - Why are they leaving the network?
- Which providers are referring outside the network?
- Which providers are they seeing outside the network?
- What is the economic impact of changes in referral patterns?

Provider Attributes
- Provider Name
- Provider Specialty
- NPI
- Business Name
- TIN
- Referring Provider (optional)

Encounter Attributes
- Procedure Code(s)
- Diagnosis Code(s)
- Financial fields
- Date of service

Member Attributes
- Patient Identifier
- Patient Demographics
- PCP
- Risk Score

Payer data is member-centric across the entire care continuum

Example Analysis: How Much is Leaving the Network?

Specialty Cost and Utilization Profile
Claims Incurred July 2013 through June 2014, Paid through September 2014

Export to Excel

Provider Specialty	# of Patients	Paid	# of Services	Visits/ 1,000	Paid/ Patient	Paid/ Service	Paid/ RVU	Paid PMPM
Pediatric Medicine	20,614	$6,007,142	213,416	2,352	$291	$28	$22	$20.96
Obstetrics and Gynecology	3,724	$3,375,678	88,652	770	$906	$38	$22	$11.78
Neonatology	1,543	$1,002,023	10,034	39	$649	$100	$30	$3.50
Family Medicine	4,000	$907,733	30,862	362	$227	$29	$20	$3.17
Multispecialty Clinic or Group Practice	2,179	$875,148	9,417	8	$402	$93	$53	$3.05
Emergency Medicine	7,423	$728,299	15,519	67	$98	$47	$23	$2.54
Anesthesiology	2,750	$677,861	433,110	1	$246	$2	$6	$2.37
Psychology	926	$316,282	5,941	0	$342	$53	$75	$1.10
Cardiology	917	$259,564	4,802	45	$283	$54	$28	$0.91
Diagnostic Radiology	5,485	$230,271	10,080	0	$42	$23	$25	$0.80
Otolaryngology	937	$207,204	4,625	58	$221	$45	$22	$0.72

Example Analysis: To Which Providers Are They Referring to Outside the Network?

To Whom Are They Referring To

Summary

Applied filters: Incurred Month between 201307 and 201406 **AND** Product equal to (all possible values) **AND** Claim Type equal t possible values) **AND** Provider ID equal to (all possible values) **AND** Provider Specialty equal to Neonatology **AND** PCP ID equal t (all possible values) **AND** Employer Group equal to (all possible values) **AND** Group Size equal to (all possible values)

Provider Name	Provider Specialty	Unique Members	Units	Allowed	Paid	RVUs	Paid/Unit	Paid/RVU
EVERETT, HUNTER	Neonatology	286	1,732	$250,960.68	$247,148.59	7,646.7	$142.70	$32.32
COOK, SEAN	Neonatology	237	1,512	$226,281.14	$221,618.82	6,929.7	$146.57	$31.98
FISHER, ANDON	Neonatology	287	3,676	$117,485.60	$116,662.88	5,132.1	$31.74	$22.73
SEXTON, NICHOLAS	Neonatology	145	426	$64,642.39	$64,146.43	2,029.1	$150.58	$31.61
EASLEY, BRYAN	Neonatology	153	476	$62,331.35	$61,863.51	1,956.4	$129.97	$31.62
FAIROW, TARON	Neonatology	140	379	$51,640.39	$44,209.18	1,608.6	$116.65	$27.52
GARRISON, JUSTIN	Neonatology	91	348	$46,538.93	$44,763.47	1,428.7	$128.63	$31.33
FINSLEY, KRISTIPHER	Neonatology	105	359	$44,123.78	$43,923.36	1,402.8	$122.35	$31.31
HANLIN, JESUS	Neonatology	63	304	$32,167.03	$32,143.06	1,016.6	$105.73	$31.62
MUNOZIZUCAR, DESTINY	Neonatology	119	201	$27,243.10	$27,121.34	866.7	$134.93	$31.29
HERRERA, TRAVIS	Neonatology	27	117	$15,241.22	$15,241.22	475.8	$130.27	$32.03
AWEYS, GABRIEL	Neonatology	16	78	$14,486.81	$14,486.81	435.3	$185.73	$33.28
ALLISON, LAYRONDA	Neonatology	16	55	$13,105.27	$13,105.27	410.1	$238.28	$31.95
CERVANTES, CHRISTIAN	Neonatology	49	126	$9,666.23	$9,088.06	304.9	$72.13	$29.81

Analysis: Referral Package Summary

Investigation and Action: There Are Various Potential Causes for Referral Leakage and Ways to Remediate It

Design and Administration
- Poor health plan benefit design
- Unclear policies and procedures
- Lack of adherence to policies
- Ineffective authorization and referral policies
- Lack of an adequate provider network
- Lack of access (office hours, appointment availability, and/or geographical access)
- Lack of data

Behavioral
- Lack of education
- Ineffective incentive design
- Pre-existing relationships (i.e. historical referral relationships, "golf buddy")
- Lack of physician engagement
- Lack of referring patients back to PCPs
- Conflicting messages from numerous payors
- Poor physician satisfaction
- Patient self-referral overruling physician preferences

Potential Actions
- Network adequacy analysis with geoaccess mapping
- Data aggregation solution, analysis and action plan development
- Improve/simplify policies to be more provider-friendly
- Evaluate value propositions for physicians and align programs to them
- Education sessions
- Modify incentive plan
- Recommend alterations to health plan benefit design to payors

Action: Operational Insights To Address Network Utilization

Client Example: Policy Changes

Situation: Hospital revenues decreasing due to falling NICU volumes driven by better prenatal care

Action: Hospital owned Health Plan applied its leverage to create a policy to transfer all infants <1000 grams or <28 weeks to their facility

Impact:
- Health Plan saved over $22 million in 5 years
- Hospital NICU revenues up 50% due to increased volume

Client Example: Incentive Changes

Situation: Clinically Integrated network did not have an incentive program to help drive quality improvements and results.

Action: Valence helped develop incentive program, and subsequently administered program, calculating payouts and processing payouts to physicians.

Impact:
- Managed $1.4 million in incentives
- Quality scores improved
- Multi-million dollar risk-based payments received by client

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Recent Study For Publication Indicates Significant Clinical & Market Results For CIN Clients

Market Share

27% Improvement

Specialist Utilization

16-30% increase

Quality metrics

35% Improvement

ER Visits

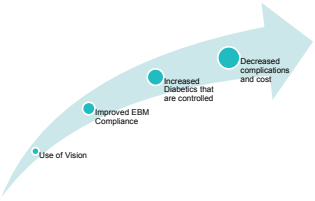
8 % Decrease

PCP Visits

24% increase

Addional Findings

- Studied Diabetics within one large CIN
- Found that controlled diabetics consumed 77% fewer ED visits and 60% fewer inpatient admissions
- Patients that are compliant with the EBM guideline for Diabetes are on average better controlled than those not compliant
- Physicians who actively used Vision had a 4% gain in Diabetes Management compliance
- Resulted in savings of about 10% for the diabetic population



Why – Consider Bundle Payments for a Variety of Reasons

External Pressures	Internal Pressures	Diversify Payer Mix
2016 Medicaid joint replacement bundle mandate	Bundle programs can increase market share and revenue	Payer consolidation
State bundle programs	Improving quality and efficiency	Alternative contracting sources

Extensive Data Analysis Ensures Preservation of Margins and Creates the Optimal Physician Panel

1 2 3

Example Data Needed

- Volume
- Cost per case
- Variation analysis of cost and quality
- Revenue per case
- Margin per case
- Readmissions
- Complication rate
- Other quality metrics (blood utilization, antibiotic administration)

Select physicians based on cost and quality data

↓

Likely a mix of employed and independent

↓

Panel is presented as the highest quality in the market

↓

Should create competition and drive more cases outside the bundle

Go to Market Strategies Include the Creation of New Marketing Materials and Campaigns

1 2 3

Direct to Employer

- In person meetings
- Sales collateral (one-pagers, videos, etc.)
- Ongoing management and reporting
- Health Fairs / Employer events

Broker

- In person meetings with potential clients
- Provides competitive advantage for brokers

Payers

- Ability to get in front of clients during sales process –per polices and guidelines when government run
- Provide ongoing reporting

Operations of Bundled Payments Could Require New Capabilities, Processes and Skills

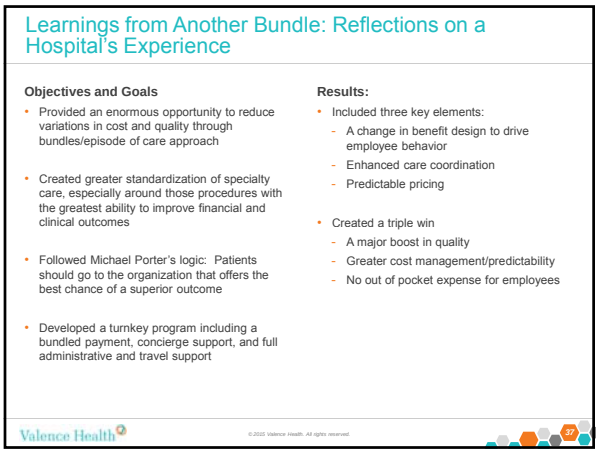
1 2 3

Internal Processes

- Patient navigator roles
- Patient identification in charts and electronic medical records
- Billing processes
- Communication with patients
- Interaction with Employers and Payers

External Processes

- Claims administration
- Payments to physicians
- Contract administration
- Reporting


Learnings from Another Bundle: Reflections on a Hospital's Experience
Objectives and Goals
Provided an enormous opportunity to reduce variations in cost and quality through bundles/episode of care approach
Created greater standardization of specialty care, especially around those procedures with the greatest ability to improve financial and clinical outcomes
Followed Michael Porter's logic: Patients should go to the organization that offers the best chance of a superior outcome
Developed a turnkey program including a bundled payment, concierge support, and full administrative and travel support
Results:
Included three key elements:
A change in benefit design to drive employee behavior
Enhanced care coordination
Predictable pricing
Created a triple win
A major boost in quality
Greater cost management/predictability
No out of pocket expense for employees
Valence Health
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