Welcome everyone to the Health Leaders network webcast on Value-based Care 101. Today, we have our guest speaker, David Hochheiser, who's the Vice president of Payor Relations and contracting for St. Francis Missionaries of Our Lady Health System, who also has oversight over the payer relations component of Health Leaders Network. Welcome, David.

Thank you, Kaki (Katherine Strange). I really appreciate it and am really excited today to be talking about value-based care and setting some of the basic understanding around value-based care for learning in order to understand what's in the contracts that we have with many of the payers.

Why Value Based Care

1. The Triple Aim *(or Quadruple)*
   - Patient Experience *(Better Care)*
   - Health of Population *(Better Health)*
   - Reducing per capita Costs *(Better Value)*
   - Clinical Experience *(Better Physician Health)*
2. Provider-payor alignment
3. To slow down the growth of healthcare spending
4. Because why not?

LAN Goals
Healthcare payments tied to quality and value

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

It's worthwhile to start the conversation a little bit on the why are we doing value-based care? Why is this becoming important? There are several reasons that are really driving this?

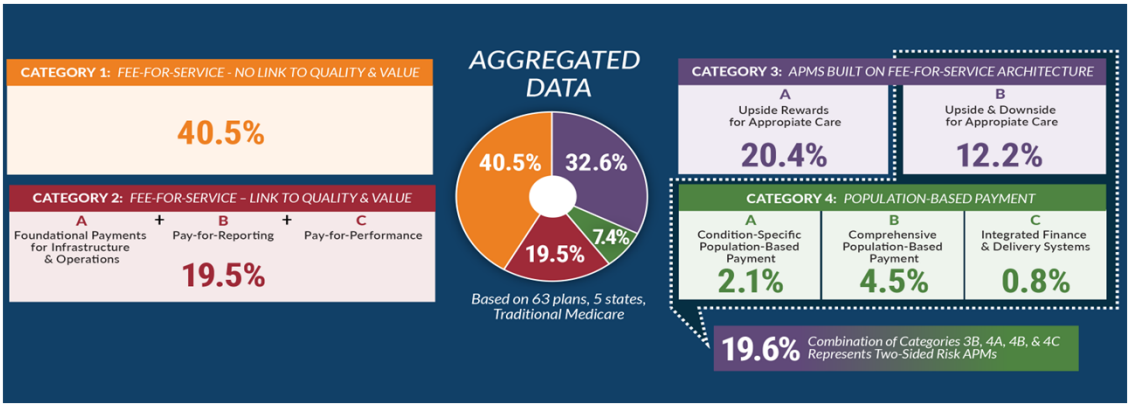
1. One, there's been a lot of talk about what you will hear called the Triple or sometimes the Quadruple Aim. This includes better patient experience or care for our patients, better population health or healthier outcomes for people rather than just the idea of taking care of a disease, reducing per capita costs or better value, and then, the 4th is better clinical experience and better health for physicians. The goal was to really start thinking about things in that way versus a very transactional health system which is what people feel like we've historically had.
2. The second thing that's driving it is a lot of provider and payer alignment. Payers are wanting to be more like providers and providers are wanting to be more like payers. Because of that, value-based care is a mechanism, a financial mechanism, that can help align the providers and payers so that they're both striving towards the same ultimate goals.
3. And then the third and, probably, one of the most important is the growth of healthcare spending. Over the years, it continues to grow at a very, very high crate and this is becoming concerning because it's becoming a bigger and

bigger part of US spending. Is there something we can do to slow down the growth of the curve because it continues to grow faster and faster and outpacing growth of many of the cost-of-living indexes that we have?

4. And then, you know, people have tried a number of things so why not try something called value-based care? You'll also hear value-based care described as an alternative payment system or alternative payment methodology.

There is an organization called the Learning Action Network with the acronym of LAN. They sent out a series of goals. Their national network consists of both providers and payers that are really trying to drive the quality and value or value-based care alignment. They set out a series of goals in 2020. What is important is that the goals that they have around Medicare Advantage and traditional Medicare are that by 2025, 100% of the payments in healthcare will be tied to some form of value-based care. They expect that the commercial and the Medicaid will move slower for many reasons, but still 50% of the payments will be tied to value-based care in those two arenas. That's a lot of money tied and that is why it's such an important topic for us.

In 2021, 40.0% of U.S. health care payments, flowed through Categories 3&4 models. In each market, Categories 3 & 4 payments accounted for:



Without going into too much detail, this slide details the different categories and types of various payments.

1. In orange is category on which is Fee for Service in which there is no link to quality performance metrics or value.
2. The category two payment systems is still fee for service, but there's some type of linked quality value such as Pay for Performance if you hit certain measures, or Pay for Reporting, if you report certain data. You can get additional dollars or have penalties if you're not doing that. That's category two and you can see based on the data that's here. This is based on 2018 that about 64% of payments are still tied in those two categories. It's not until you get to category 3 and category 4 where you really start seeing the bigger impact of value-based care
3. Category three is where it's an APM or an alternative payment methodology and is built on fee for service architecture. They are broken down into the two subcategories. Those that have upside rewards with no downside risk for the provider, and those where there is upside and downside for appropriate care.
4. Ultimately category 4 is where you have a population-based payment. You can see the kind of boxed out area representing 14.5% of the data back in 2018, which is the 3B's. All of the category 4 is, ultimately, what they are considering

as a healthcare payment tied to quality and value. So, it was 14.5% back in 2018, and remember, the goal is to get to 100% for Medicare Advantage in traditional Medicare.

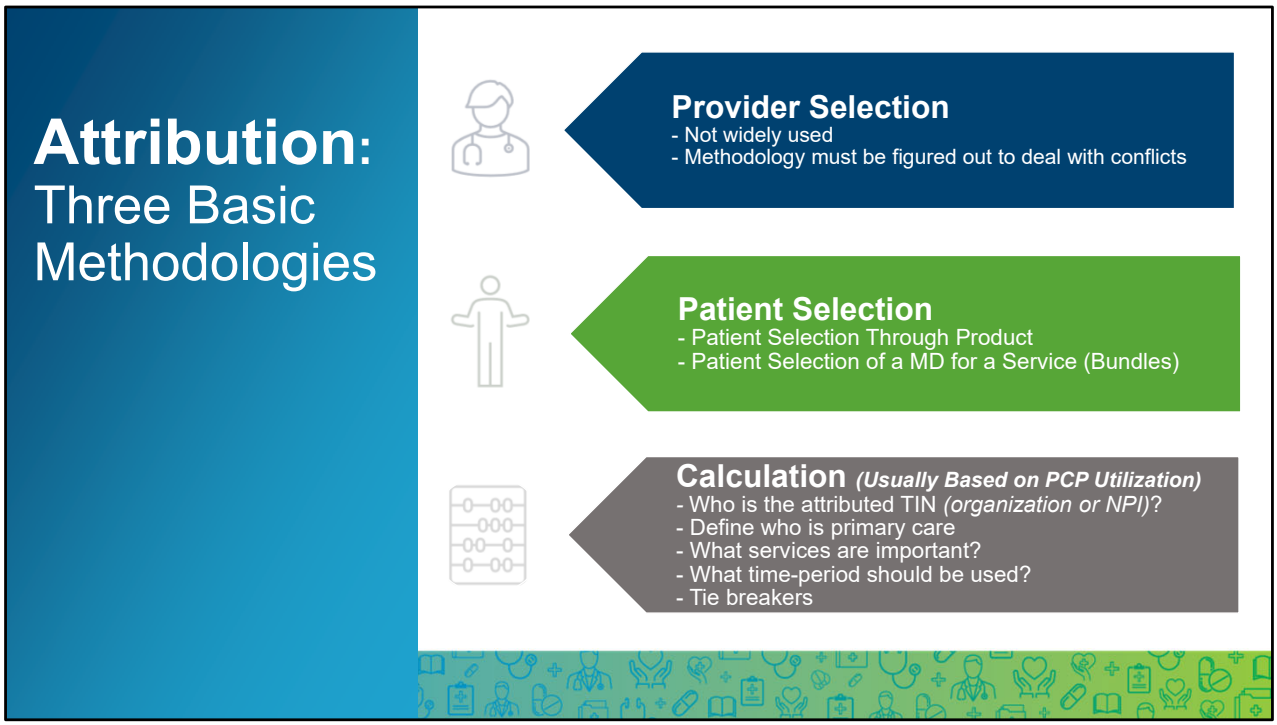
Basic Building Blocks of VBC

Who	Attribution
What	Quality Measures Financial Measures
How	Bonus Payments CMFs/PMPMs/Capitation Total Cost of Care

As we start thinking about value-based care, I think it's important to understand what some of the basic building blocks are as it relates to value-based care.

1. The first is Who are we talking about? The value-based care lingo is attribution. Who's attributed to the provider that they have responsibility for.
2. The What is “What are we measuring?”. Are we measuring quality and what are the specific measures around it? Are we measuring financial performance and again, what are the specific measures that we're measuring around it?
3. And then the How is, for the attributed population, are we performing well on whatever the measures are? If so, how do we ultimately get some form of payment? Is it a bonus payment of a one-time payment structure? Is it a CMF or care management fee which is fee for doing something, or a PMPM which is something that is done monthly which can ultimately lead into some form of capitation. Or is it a total cost of care? The idea is that there's a premium that's coming in from somebody who's paying for the service, and, therefore, we're trying to keep the total cost of care under that premium dollar.

This is really what the insurance companies are doing, and now you have a sense of more of that alignment between the payers and the providers and why this is going in that direction.



The first, we're going to talk about is attribution. There are really three basic methodologies that are used for attribution:

1. The first is Provider Selection and this is the idea of a provider saying that this member is mine. This not really a widely used methodology because there's a particular set of problems that come with it. The problem is that if you have multiple providers saying this member is mine, then which provider ends up with the attribution? How does this conflict then get resolved? Providers do and should have some form of say in terms of what's going on. In reality, what the providers need to do is be work with and educate their patients on what they can do to make sure that they are the accountable party for the people that they think they are accountable for.
2. The second methodology which is widely used in the Medicare Advantage market is Patient Selection.
    - This is the idea that when somebody signs up for a product, they select a physician as their primary care physician. So, now the Member has a choice. Since there's only one member, he/she can

only make one choice, and, therefore, there is a unique situation as it relates to the attribution.
    - This can also happen in the form of a bundle. For an example, having a service such as an orthopedic surgery, choosing an orthopedic surgeon. This type of methodology is widely used in Medicare Advantage, Medicare Advantage products, and many of the traditional Medicare products where the member or patient is expected to choose a primary care physician. This methodology tends to have a lot of negative connotation on the commercial side because people remember the old HMO days and they really don't want to have that choice. They feel like even though most products don't use the primary care physician as a gatekeeper. There's still this perception that if I choose a physician, they're going to act as a gatekeeper.
3. For those products where there is no member selection, a calculation-based algorithm is used. That's where we ultimately fall to these calculation-based algorithms. It's usually based on some form of who is the PCP or primary care physician who is most utilized. You get into a whole series of questions around the algorithms which are the variations that happen.
    - So, who is the attributed entity? Are you attributing to a TIN, an organization, or to an individual physician? Because in the idea of group care, what you really want is everybody to stay within the TIN organization. They may be seeing multiple individual physicians, or NPIs, or caregivers, but the TIN level is, obviously, the preferred over an individual physician or NPI.
    - Who can get attribution in the case of primary care? For example, does it include Geriatricians or other support services such as endocrinologists or OBGYNs? Those are the type of questions that we must ask in terms of who is considered to be a primary care physician.
    - What services are going to be used to decide who got the most visits? Is it going to be a count of visit or dollars? Are there certain visits or only office visits versus all types of visits? Are people going to use things like prescription utilization or whoever has prescribed the most prescriptions? Those are the types of service questions that become important.
    - What time period are going to be looked at? One or two years?
    - What tie-breakers are going to be used?

These are all questions that we must ask. They're good methodologies. One

of my favorites is the Blue Cross methodology where they, actually, attribute to a TIN first. Then once they've assigned it to the organization, allowing for more community-based care, they assign it to an individual NPI, and they're using office visits as the calculation. A different methodology that I do not like is one that uses who is the last provider that the patient last seen. This methodology is wrought with issues especially for those providers working in the urgent care setting. A patient may end up being attributed to an urgent care provider instead of their regular PCP just because he/she recently went to the urgent care. Therefore, as a provider, managing and understanding how they can influence attribution is very important.

Quality Measures

- What are the measures?
- What do we need to do to define success?
  - ✓Outcomes *(performance measures)*
  - ✓Process *(did I do something or not)*
- What are the benchmarks?
  - ✓ Target based *(you must get 80% of people to have controlled high blood pressure)*
  - ✓ Trend based *(you must improve off your historical 70% controlled)*
- Mostly based on what the federal/state governments think is important
- Patient Satisfaction is becoming a bigger and bigger part of Quality

- Quality measures are a big part of all of these value-based care systems and methodologies. They want to make sure that we're not measuring just financial outcomes, but that we have tied quality into it. That's why it becomes very important. So the questions we have to ask here is what are the measures that we're being subject to?
- And ultimately, what do we need to do to define success? Around those measures. Is it an outcomes-based measure or a performance measure?
  - ✓ Something like how many people who have high blood pressure do I have under control under some measured amount, usually measured as a percentage? I've got 50 or 60 or 70% of those people under control. So, am I having a positive outcome?
  - ✓ The other type of measure we often see is called a process measure. Did I do a specific thing, or did I get the patient to do a specific thing? These are typically around testing. For example: did I have my colonoscopy screening? Did I have a mammogram screening? These are the typical types of measures. Did I do a well child visit? These are the types of things that you see. Did I do a specific item?

- Then we have to ask what are the specific benchmarks or targets that were set for each of those outcome measures.
    - ✓ The idea on a target base you must get 80% of the people to have a controlled high blood pressure is one type of measure. Often those measures are set on national levels which for us here in Louisiana is a challenge because we typically perform worse as a state on many of these health outcomes measures compared to many other states in the US.
    - ✓ And then the second piece is what would consider more of a trend-based metric where rather than trying to reach some national metric. What we're really trying to do is to improve our historical performance. Often times, we get a blend of these two things. We can get partial credit if we get some improvement, but we don't get to the target are the types of ways these are blended together.
- Much of the targets are based on what the federal and state governments think is important. The reason for that is pretty obvious. If a big federal institution is mandating certain measures, we would like to not chase 30 different measures for 30 different providers or 30 different payers. We'd rather have some level of consistency. Therefore, there are a number of the measures that are mandated by both federal and state governments that we ultimately take across many of our quality or value-based care arrangements.
- And then the last thing I want to say is that patient satisfaction is becoming a bigger and bigger piece of quality. To be successful around that is much more of a team-based effort outside of the traditional care parameters. The important thing is not just the experience that the patient has with the physician, but all the surrounding services as well. Was I able to schedule an appointment in a timely manner? How long did I have to wait in the waiting room? How long did I have to wait in the back? Was I greeted in a nice manner. All of those things become very important in terms of patient satisfaction. As that becomes a bigger and bigger portion, we have to think about how we are engaging with that member not just when they're in the office or in the care room, but even when they're outside thinking about or trying to schedule an appointment. So it's a much bigger thing that they're asking us to change.

Financial Measures

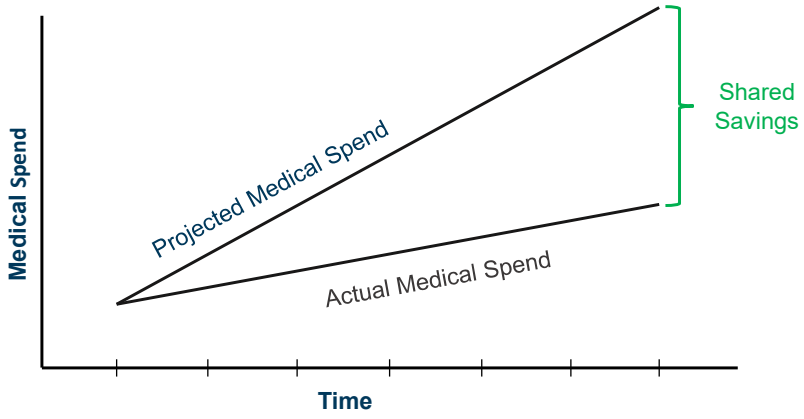
- Total Cost of Care
  - ✓Often measured in PMPM (Or Risk Adjusted PMPM)
    - What risk adjustment methodology is in place if any?
    - How does risk figure in (individual/small group vs. Medicare and others)?
- Cost of a service or episode of care
  - ✓Cardiology, Orthopedic Bundles
- What are the benchmarks?
  - ✓Trend based
    - ➢ Fixed trend (costs increase by a specific percentage)
    - ➢ Retrospective trend (beat your peers)
  - ✓Premium (payment from the insured) based
    - ➢ Fixed % of the premium dollar
  - ✓Fixed Cost

- This slide is about the financial measures. Still kind of in what are we measuring? We talked about quality. The other piece is financial. We must have some financial measures. Ultimately, if we're going to have an impact on the total cost of care. The total cost of care is one of the key measures that's often used here.
  - ✓ It's typically measured in a per member per month. What was the spend per member per month? We think the total cost divided by the number of members divided by the number of months that come up with that PMPM number and that's one of the ways that we get typically measured.
    - One of the questions becomes is does risk adjustment play into that because, obviously, if somebody's sicker, we would expect that there was a higher cost figured into that.
    - How does that risk figure in? Does it take on different mechanisms? Often times you will find groups, pool, certain sets of individuals, or populations together. The commercial or individual and small group population may have a very different cost structure than, say, Medicare, where people are older. Even within Medicare, you might see different pools where we have one pool that's focused on people who are just traditional Medicare Advantage people, and those who are end stage have end stage renal disease. Obviously, they have a very different cost structure.

Therefore, often times they will try to manage the risk by putting people into different pools.

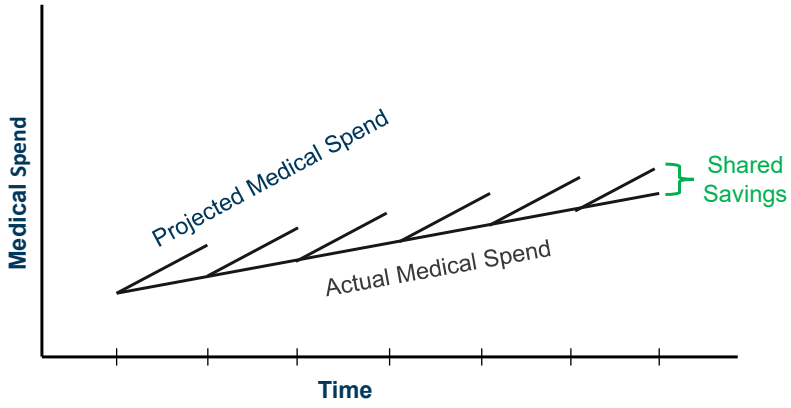
- One of the other measures that comes around is the cost of a specific service or episode of care. This is most often used in the bundle type situation where you're looking at what's the total cost for an orthopedic bundle. So when I have a knee replacement, what's the total cost of care? And there's a target that's set. If you can come below that, there can be some success savings between the payer and the provider.
- Third piece here is what are the benchmarks that are being set? Which is really starting to get into the targeting.
    - ✓ Are those benchmarks set on a trend base?
        - ➢ And when I say trend based, meaning we should start with a basic what did it look like in a previous year, and we trended it forward based on some agreed upon percentage, which is typically what we would think of as a fixed trend.
        - ➢ Oftentimes it can be a retrospective trend. We will look back over a larger population and say what happened in the year that you just did and did you perform better than everybody else did. That is the idea of a retrospective trend. Those are two types of trend-based targets.
    - ✓ Also, there's the idea of our premiums. How much money is coming in and how much of that payment goes to the medical care? Usually, it's a fixed percent of the premium dollar and that can be used as the target.
    - ✓ Sometimes ultimately there can be a fixed cost. But ultimately, that fixed cost is usually based on one of the two other methodologies.

Shared Savings

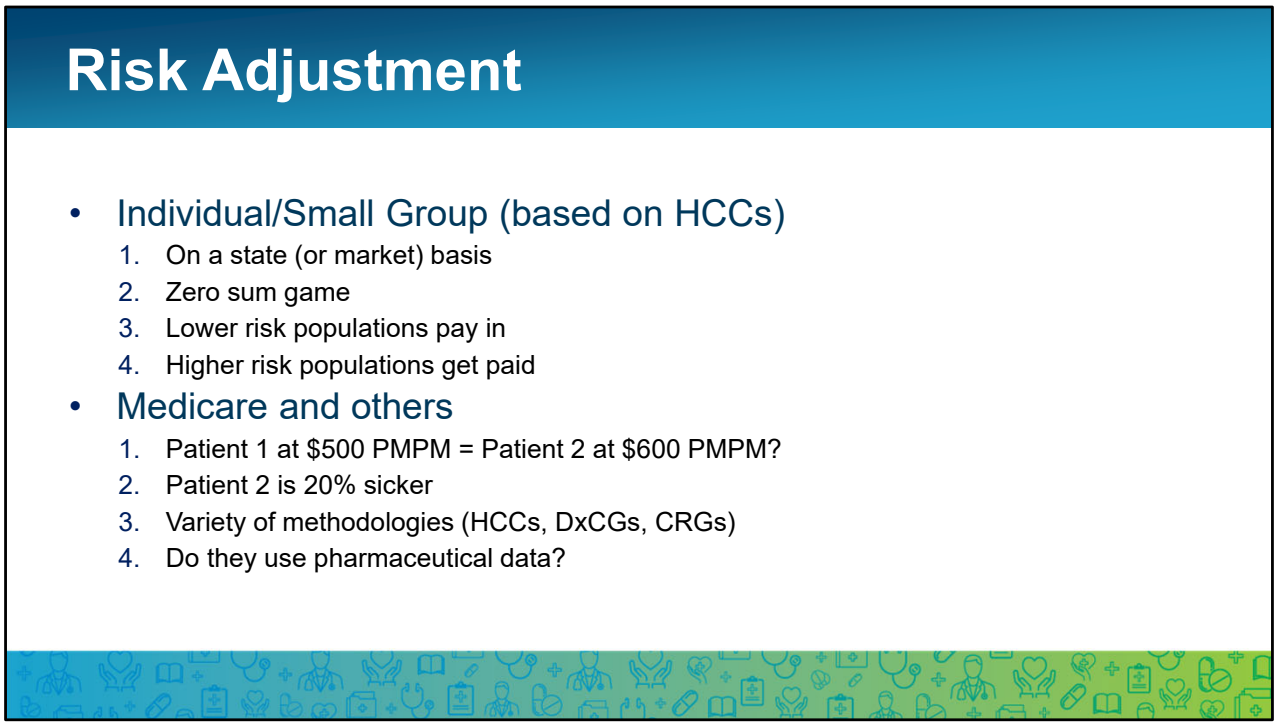


When we talk about shared savings in any of these methodologies. This is the ultimate concept here. What you're seeing on the bottom axis here is some period of time represented by each of the tick marks, and on the up and down and Y axis is the medical spend. You can see at the very beginning both the projected and the actual are, actually, the same number. So that's kind of our starting point. If we're successful, in time, as you move from left to right here, the projected medical spend is going up, but the actual medical spend is going up at a slower rate than the projected medical spending. The difference between the two, as you see on the right is represented by that Curly bracket is the shared savings. That's the amount that we are saving over where we projected to spend. In this type of algorithm, you can see when we went from the first mark to the second mark, The projected starts at where the previous projected end. That's why you get that kind of smooth straight line. This is a good thing for us as a provider community as compared to the scenario.

Shared Savings Restarting Point



In this scenario, what you can see is after the first tip is that projected medical spend that slant upwards resets to where the actual medical spend was. Therefore, any credit we would have gotten during the first time period for success, we lose and we're kind of start over at Ground Zero. This is one of the things that we have to watch for in any of the scenarios. Ultimately, what this leads to is once we get all the shared savings out, there's nothing left. You can see, ultimately in the end, the shared savings is smaller. The amount that we're looking at is smaller, and it becomes harder and harder each year to be successful in these types of scenarios.

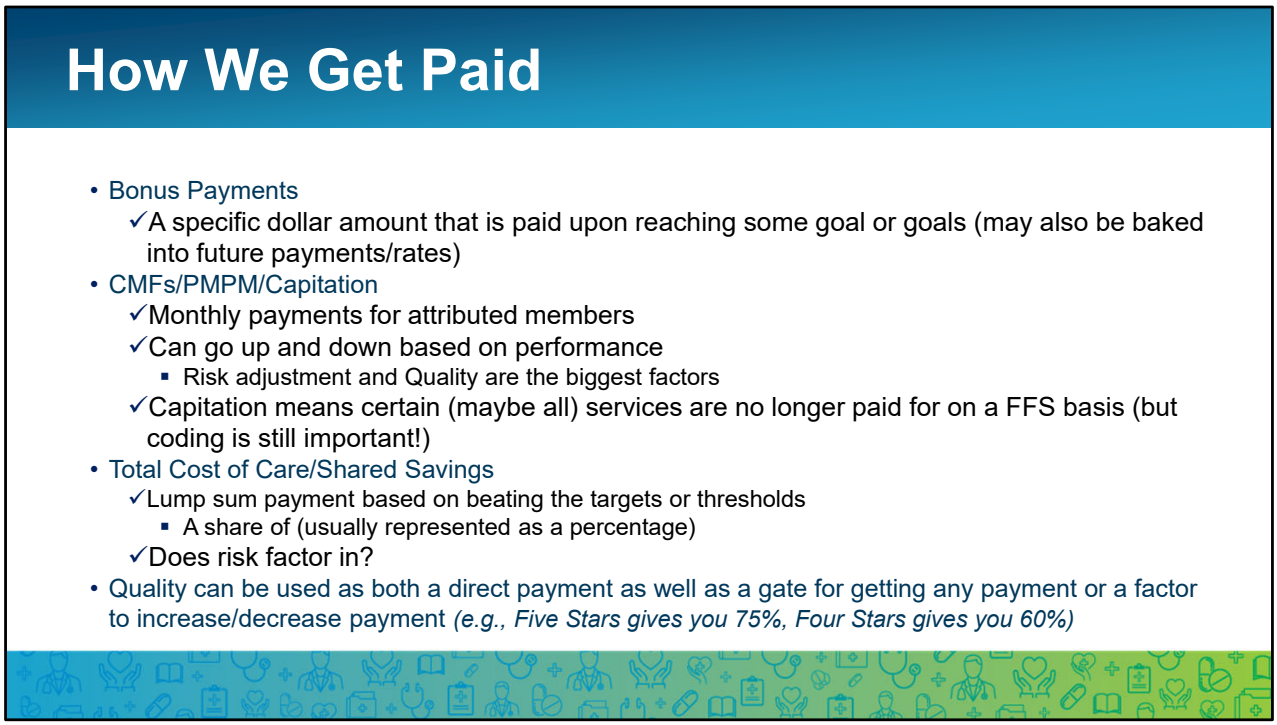


- That leads me into how do we deal with risk adjustment? Risk adjustment takes on a whole series of different methodologies and forms.
    1. For example, the Exchange or ACA, or what's called the individual and small group market, there's a type of risk adjustment that basically says on a statewide basis for that population it's a 0-sum game. What that means is that when they form the ACA, in multiple plans were participating in a given state, one plan might get much sicker patients than another plan.
    2. Therefore, what they effectively did was they said the plans with lower risk are likely to make more money than the plans with higher risk. So what we will do is we'll require the plans with lower risk to pay money into a pool,
    3. Those plans with a higher risk will draw money out from the pool. Ultimately, the way they measured that kind of 0 sum game was using the HCCs or hierarchical condition codes that are similar for the Medicare population. That's one type of risk adjustment that we typically only see that and then exchange type market or product.
- More common for us, like Medicare and others, is that there's an actual risk adjustment factor that's used to adjust any of the financial targets.
    1. It, basically, gets that how can Patient 1 at $500 PMPM be equal to

Patient 2, who's spending is at $600.00 PMPM.

2. This is because Patient 2 has diagnosis or services that represent them as 20% sicker than Patient 1.
3. There's a whole variety of methodologies that are used around HCCs, which I mentioned on the Marketplace product is also what Medicare uses. Once you get outside of Medicare, the states and the commercial plans, they all use their own methodology. Typically based around collecting diagnosis codes and services that are done, the DxCGs and CRGs are two of the more common of these methodologies.
4. Also, we have to ask questions such as do they use pharmaceutical data? Because if everything is based on diagnosis coding, then it's important that I get at a doctor’s visit. However, if I don't get a visit and somebody's taking a drug that's specific to a given disease, we should get credit for the risk that's associated with that disease because the person's taking the drug even if I never came in for a visit? And what happens over a longer period of time because some of these diseases as we know you don't get healthier around it and so should we be looking back at longer and longer periods of time.

These are all things that go into that risk adjustment. It's a complicated science. Ultimately, the message that I would want to bring to us as a system is to try to do our best at representing what is the full set of disease states that, as a physician, I'm managing. Also, looking back and understanding some of the patient’s medical history is very important because that's one of the things that will help us better capture the risk, and be successful in terms of representing how sick our patient truly is.



How do we get paid? I hit it on a little bit of this on an earlier slide. There are different types of financial structures that are out there.

- Bonus payment is one of them. The idea is that it's specific dollar amount that we get paid upon reaching some goal or goals. There also may not be a specific payment, but a rate increase of 5% higher if you do a certain thing or reach a certain goal. That's something that we see Medicare does. If you participate in Medicare risk-based programs, you can get a higher fee for service rate. Many of the hospital quality programs where if we get successful in terms of managing some hospital quality measures, we may get a bonus payment either in cash or in increased rate in the future.
- The second most common used methodology are some forms of a monthly payment. Either care management fees, fees for doing specific services, or a PMPM, or capitation type methodology. These are, typically, monthly payments for attributed members. They can and often do, go up and down based on performance. The idea that if I have higher performance, I get a higher number. If I have lower performance, I will get a lower number, and obviously risk adjustment and quality are the biggest factors that impact those types of performance. Ultimately, what capitation means is that certain, potentially all, but at least certain services are no longer paid on a fee for service basis. They are paid through a regular monthly fee. But even in those situations, coding is still

important because that capitation payment may be very directly tied to risk adjustment. We may get a higher monthly fee for somebody who's sicker. Therefore, coding is still very important on the capitation basis.

- And then the third thing that we see in a lot of are what we call total cost of care, or shared savings agreements is, effectively, a lump sum payment based on beating the financial target or threshold. Usually, they represent a share of that savings. So if you think back to that graph and that curly bracketed amount. If that was the total savings, we would usually get a percentage of that savings, and we have to ask a series of questions. Does risks figure into that savings?
- And the other piece is that quality can play a very important part here in the payment or total cost of care. So, we may get a direct payment for quality, but we also may get an increased share of the savings if we do better. If we get to a five star, we may get 75%, four stars, we get 60%, and a three star, we get 50% of the shared savings. So often there's a tie-in of quality back to the total cost of care, and we're required a lot of time by many of these organizations to ensure that one of the reasons why we have a lot of this quality measures that were not just limiting care to do that. But ultimately to be successful, but ultimately, we're providing the best in high-quality care. We as an organization believe very strongly that value-based care is here to stay, and that we will see more of it as time goes on. Hopefully, you gain an understanding from this presentation as to why you are doing some of things that you are doing as a health system and why are they important to us because they do have financial implications for us. Ultimately, we want o be successful whether triple or quadruple aim in terms of driving value, driving quality, and satisfaction for the care that we deliver.

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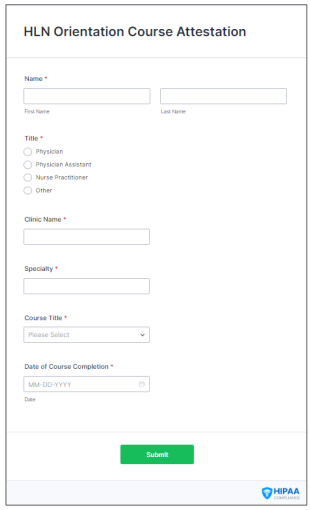

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