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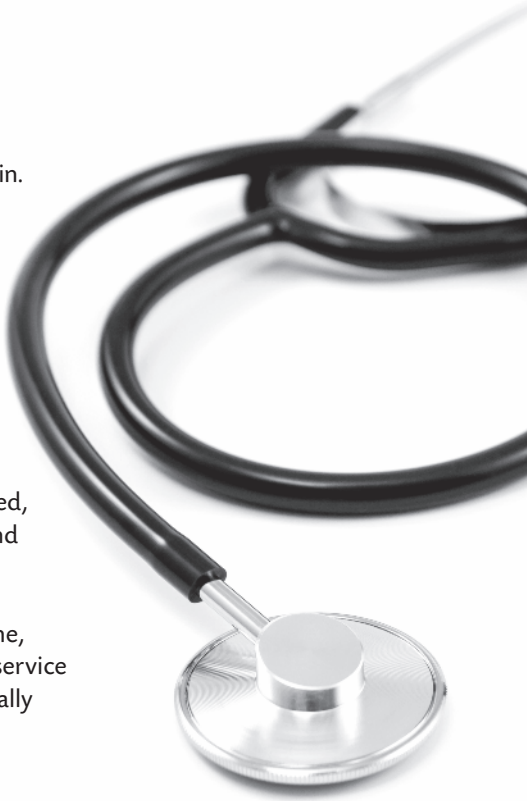
A SPECIAL REPORT FROM INDEPENDENT HEALTH

A Catalyst for Change in Moving to a Value-based Model of Health Care Delivery

INTRODUCTION



For health care consumers and all stakeholders in the U.S. health care system, it's a familiar refrain.

The cost of health care continues to climb at an alarming and unsustainable rate, while the quality of care and our population's overall health remains low compared to other developed nations.

The current fee-for-service payment system, along with a lack of meaningful data on cost and quality, is a major contributor to the challenges that continue to plague the U.S. health care system.

A new, alternative payment model that is value-based, in contrast to traditional volume-based, has the potential to dramatically transform and improve health care delivery in our region and throughout the nation.

Value-based payment rewards physicians for providing patients with evidence-based medicine, while advancing safe, appropriate and effective care as opposed to a volume-based, fee-for-service model that rewards more – and often unneeded, duplicative and, in some instances, potentially harmful – tests, treatments and/or procedures.

This overutilization drives up costs unnecessarily.

> "At the highest level, the shift to value-based payment models is a reflection of what does and doesn't occur under the current model of our health care system: not enough services of proven value are being performed and too many services are done that don't add value. Our community cannot afford this inefficiency."
>
> —— *Michael W. Cropp, M.D., President and CEO, Independent Health*

THE RISING COST OF HEALTH CARE IN THE U.S.

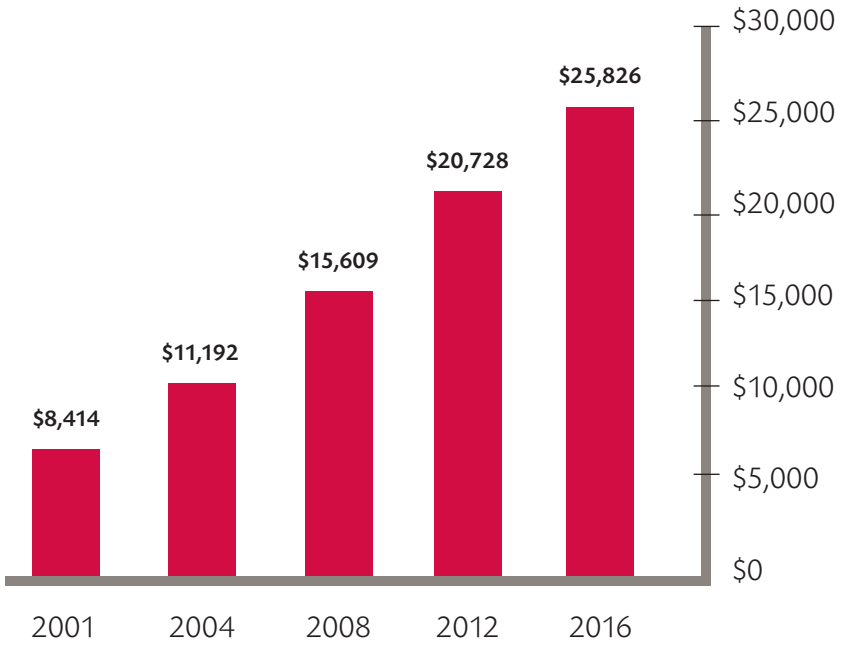
The U.S. health care system spent $3.2 trillion in 2015 or almost $10,000 for every person according to the Centers for Medicare and Medicaid Services (CMS). Health care now represents 17.8 percent of the gross domestic product (GDP) and will likely increase to more than 20 percent by 2025 as more people age into Medicare and need additional health care.

The cost of health care for a typical American family of four covered by an average employer-sponsored health plan in 2016 was $25,826, more than triple the cost in 2001, according to the annual Milliman Medical Index (MMI).

Even though the annual percentage increase of 4.7 percent in health care spending for a typical American family of four the past year was the lowest annual increase over the past 15 years as reported by MMI, the rate of increase is still well above the growth in the consumer price index (CPI) for medical services, and far surpasses the average 2 percent increase in median household income between 2004 and 2014.

More than ever before, health insurance is a critical component of a family's financial security, yet it continues to become less and less affordable.

Annual cost of health care for a typical American family of four covered by an average employer sponsored health plan, according to the Milliman Medical Index.



QUALITY OF HEALTH CARE IN THE U.S. IS LOWER THAN OTHER DEVELOPED NATIONS

It is widely recognized the U.S. spends far more on health care than other developed nations. According to statistics from the Organization for Economic Cooperation and Development (OECD), the U.S. spends almost twice as much as other countries on health care in terms of GDP, and more than 2.5 times the OECD average in per capita spending. Unfortunately, this extra spending is not resulting in improved quality and health outcomes.

In fact, the U.S. consistently performs worse compared to other developed countries in evaluations of international health care systems.

- Since 2004, The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, has issued five reports on how the U.S. compares to 10 other developed nations on five performance measures – quality, access, efficiency, equity, and health outcomes. Each time, the U.S. ranked last.
- Another report, commissioned by the National Research Council and the Institute of Medicine, which examined the U.S. relative to 16 developed countries, discovered consistently poorer health in the U.S. at all stages of life – from infancy to old age.
- Other reports by groups such as the World Health Organization paint a similar picture.

It appears U.S. health care consumers are not getting full value for their health care dollar. This high level of spending – which is resulting in a lower quality of care – is generating a sense of expediency for restructuring our system and looking at alternative models of care.

PAYMENT REFORM A KEY TO TRANSFORMING HEALTH CARE

Independent Health is committed to reducing the unsustainable trend of rising medical costs, improving access to quality care and achieving the "Triple Aim" of better health, better care and lower costs.

We believe efforts to transform health care, improve quality and achieve the Triple Aim should focus on five key actions:

- Promote prevention and wellness
- Revitalize and grow primary care
- Implement payment reform
- Achieve greater alignment of the health system
- Enhance health information

Action number three, implementing payment reform, involves efforts to continue moving away from the traditional volume-based, fee-for-service model of reimbursing physicians and providers to a value-based model.

"We are firm in our resolve to move to value-based care," said Michael W. Cropp, M.D., president and CEO, Independent Health.

"We are moving into an area of greater accountability for results from providers and health plans. Those providers who adopt and embrace it will be successful.

"At the highest level, the shift to value-based payment models is a reflection of what does and doesn't occur under the current model of our health care system: not enough services of proven value are being performed and too many services are done that don't add value. Our community cannot afford this inefficiency."

"A spirit of collaboration based on trust, transparency, data-sharing and insight between providers and health plans based on what is best for the patient is essential to achieve the most successful and sustainable models of care in this new system."

Transformation of the U.S. health care delivery system gained momentum in 2010 with the passage of the Affordable Care Act (ACA). The law established the Health Insurance Marketplace to extend consumer access to affordable care through private payers and provide strong incentives in publicly financed health care programs to connect provider payment to quality of care and efficiency.

VALUE-BASED CARE REWARDS PHYSICIANS AND BENEFITS PATIENTS

The rapid shift to value-based care is being driven in large part by the federal government. Building on the principles and foundation of the ACA, CMS has established a clear timeline to tie 50 percent of Medicare payments to quality or value through alternative payment models by the end of 2018. Although the future of the ACA is uncertain, the movement toward this new payment model remains strong.

Because CMS is the largest health care payer in the U.S. with more than 100 million consumers (including 57 million elderly and disabled beneficiaries) and at the forefront of the nation's health care delivery system, this will be the sea-change for new payment models that move away from volume-based, fee-for-service health care.

The passage of the bipartisan Medicare Access and Children's Health Insurance Reauthorization Act of 2015 (MACRA) supports the ongoing transformation of health care delivery by furthering the development of new Medicare payment and delivery models for physicians and other clinicians. MACRA aims to make three important changes to how Medicare pays those who provide care to Medicare beneficiaries:

1. End the sustainable growth rate (SGR) formula for determining Medicare payments for health care providers' services (see sidebar above).
2. Establish a new framework for rewarding health care providers for providing *better care*, not just *more* care, along with smarter spending.
3. Combine existing CMS quality reporting programs into one new system.

In May 2016, CMS issued its proposed Quality Measure Development Plan as part of MACRA to help CMS move more quickly toward its goal of paying for value-based care.

In September 2016, CMS announced it would give physicians and clinicians some flexibility on meeting MACRA requirements, outlining different options to comply with the new payment reform model.

A month later, CMS released the "Final Rule" on its Quality Payment Program for implementing MACRA. It impacts providers or clinicians billing Medicare, including physicians, nurse practitioners, physician assistants, and therapists.

Ending Medicare's Sustainable Growth Rate (SGR) Formula.

The sustainable growth rate (SGR) formula was a method used by CMS to control spending by Medicare on physician services. It was originally enacted by the Balanced Budget Act of 1997 and replaced the Medicare Volume Performance Standard (MVPS), which was the previous method CMS used in an attempt to control costs. In general, SGR was intended to ensure the yearly increase in the expense per Medicare beneficiary did not exceed the growth in GDP. Signed into law on April 16, 2015, MACRA ended use of the SGR formula.

The complex regulation – nearly 2,400 pages long – eases some timelines initially proposed and gives providers two reimbursement tracks for complying.

1) Advanced Alternative Payment Models (APMs) – Starting in 2019, providers can earn higher reimbursements if they adopt new ways of doing business, joining a leading-edge track that involves accepting financial risk and rewards for financial performance, reporting quality measures and using Electronic Health Records (EHRs). An estimated 70,000 to 120,000 eligible providers are expected to take this more challenging track in 2017, with up to 250,000 expected to do so the following year.

2) A Merit-Based Incentive Payment System (MIPS) – Beginning in 2019, physician pay will be based on success in four performance areas (based on 2017 performance), with an estimated 592,000 to 642,000 eligible providers expected to participate:
    a. Quality
    b. Resource use
    c. Clinical practice improvement
    d. Advancing care information (involves the meaningful use of certified EHR technology)

Approximately 380,000 providers are expected to be exempt from the new system as they don't see enough Medicare patients or their billings don't reach the required threshold.

Detailed information about the Quality Payment Program for implanting MACRA is available at: https://qpp.cms.gov/.

MOVE TOWARD VALUE-BASED REIMBURSEMENT GROWS

The National Committee for Quality Assurance (NCQA), American Academy of Family Physicians (AAFP), National Business Coalition on Health, Brookings Institute, and the Commonwealth Fund have all endorsed the move to value-based reimbursement.

Results from a national survey of 465 hospitals and payers released last summer by McKesson Corporation, a health care services and information technology company currently ranked 5th on the FORTUNE 500, found the adoption of value-based care has "graduated from the wave of the future to the tsunami of the present" and will dwarf volume-based, fee-for-service reimbursement by 2020. McKesson found payers are now 58 percent along the continuum toward full value-based reimbursement, a sharp 10 percent increase from 2014. Hospitals aren't far behind at 50 percent along the value continuum, up 4 percent over the past two years.

A December 2015 HealthEdge "State of the Payer" survey found 73 percent of health insurance executives are planning major, technology-driven transformation initiatives to help their organizations effectively participate in new health care business models and drive new levels of operational efficiency. The survey also found 80 percent of health insurers understand the significance of participating in a variety of new health care business models including value-based payments.

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>
> — *McKesson Corporation Survey*

Meanwhile, a December 2015 survey of 626 family physicians conducted in part by the AAFP found 33 percent are already pursuing value-based capabilities and 19 percent are in the development stage. Dr. Wanda Filer, president of the AAFP, said, "The time to adopt a patient-centered, value-based system and break free from the broken fee-for-service model is now." She asked the question, "Are physicians ready?" adding, "Are all health care stakeholders – including hospital systems, electronic health-record vendors, health plans and specialists – ready to support them?"

According to the AAFP physicians surveyed, the most important factors for determining the success of value-based payment models are:

1. Practice sustainability
2. Clinical outcomes
3. Physician and staff morale
4. Coordination of patient care
5. Costs savings for the practice
6. Patient satisfaction
7. Population health management

On January 28, 2016, some of the nation's largest health care systems and payers, joined by purchaser and patient stakeholders, announced the formation of the Health Care Transformation Task Force, a powerful new private-sector alliance dedicated to accelerating the adoption of value-based business models aligned with improving outcomes and lowering costs.

The Task Force challenged other providers and payers to join its commitment to put 75 percent of their business into value-based arrangements that focus on the Triple Aim by 2020.

Less than a month later, on February 16, 2016, CMS announced a new agreement with America's Health Insurance Plans (AHIP), medical societies, primary care and specialty groups, and consumer and employer groups to advance high-quality, value-based care. Known as the Core Quality Measures Collaborative, the initiative seeks to standardize seven sets of measures to be used by public and private payers to help accelerate the country's movement to improved quality. These core measures will be incorporated into the overall CMS quality measure development plan.

"In the U.S. health care system, where we are moving to measure and pay for quality, patients and care providers deserve a uniform approach to measure quality," said acting CMS Administrator Andy Slavitt, adding, "This agreement will reduce unnecessary burdens for physicians and accelerate the country's movement to better quality."

MOVE TOWARD VALUE-BASED REIMBURSEMENT

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McKesson Corporation is a health care services and information technology company currently ranked 5th on the Fortune 500.

REIMBURSEMENT MODELS - EXPLORING THE OPTIONS

Thomas J. Foels, M.D., executive vice president and chief medical officer at Independent Health, said value-based care can take different forms based on the approach being taken by the provider group and health plan involved.

Dr. Foels said there are several basic models being explored and adopted by most stakeholders in the U.S. health care system, including Independent Health:

1. Accountable care organizations
2. Patient-centered medical homes
3. Pay for performance
4. Episodic or bundled payments
5. Capitation
6. Shared savings

> The move to value-based care is essential to improving quality and reducing the unsustainable growth trend of national health care costs, but like anything new, it isn't an easy transition.
>
> —— *Thomas Foels, M.D., Executive Vice President and Chief Medical Officer, Independent Health*

Critical to achieving success in the transition is the ability and willingness of providers and payers to share claims, clinical data, insight on practice patterns and other metrics, including EHR information.

"Most doctors do not have a sense of how they are performing relative to their peers or – for that matter – how physicians within their own group are performing," said Dr. Foels. "Nor, do they realize what the total costs of care are. That's why it's important to supply them with that information."

THE PRIMARY CONNECTION IS LEADING THE WAY

Here in Western New York, Independent Health and some forward-thinking, high-performing physician practices and provider groups are on the leading edge of moving toward these alternative payment models. In fact, 65 percent of Independent Health's members are already aligned with a primary care physician (PCP) or provider who is currently in a value-based agreement with Independent Health.

Cancer Care of Western New York and Western New York Urology Associates (WNY Urology), Catholic Medical Partners, Chautauqua Integrated Delivery System, Buffalo Medical Group, Roswell Park Cancer Institute and Excelsior Orthopaedics, LLP, are among those who are partnering with Independent Health to implement a value-based or bundled payment model of reimbursement.

Our most advanced value-based reimbursement model is a physician collaborative called The Primary Connection, an innovative, physician-led initiative established with Independent Health in 2012. The Primary Connection consists of nearly 190 PCPs from 35 practice groups covering about 121,000 of our members. This collaborative is by invitation only and participation requires PCPs to meet and maintain key thresholds for efficiency and effectiveness over time.

The Primary Connection practices are paid through a unique hybrid reimbursement structure. At the core is a monthly global patient management payment (GPMP) that reimburses PCPs for evaluation and management services related to sick visits. The GPMP model also includes incentives based on measures related to practice and quality improvements and efficiency of care. The reimbursement is enhanced over what the physician would receive under fee-for-service to fund practice transformation. Select services, such as preventive care and immunizations, remain reimbursed under the fee-for-service model as to not discourage utilization.

Over the past couple of years, The Primary Connection practices have received intensive resource allocation from Independent Health from transformation experts who go into the practices to help them redesign workflows and focus on areas of opportunity for cost savings and quality improvement. These include pharmacists available to help with medication management, particularly with complex patients. In addition, the collaborative received a local grant to help subsidize the integration of behavioral health specialists into The Primary Connection practices.

The Primary Connection practices are now working on a specialty collaborative to help them develop strong relationships with high-impact specialties such as cardiology, gastrointestinal, neurology, radiology, allergy, and orthopedics. Through this effort, The Primary Connection PCPs and specialists work together to improve the management of patients. The number of potentially avoidable specialist referrals is decreasing because of the close collaboration, resulting in more care being brought back into the PCP practice, with more appropriate referrals being made to a more narrowly focused group of high-performing specialists.

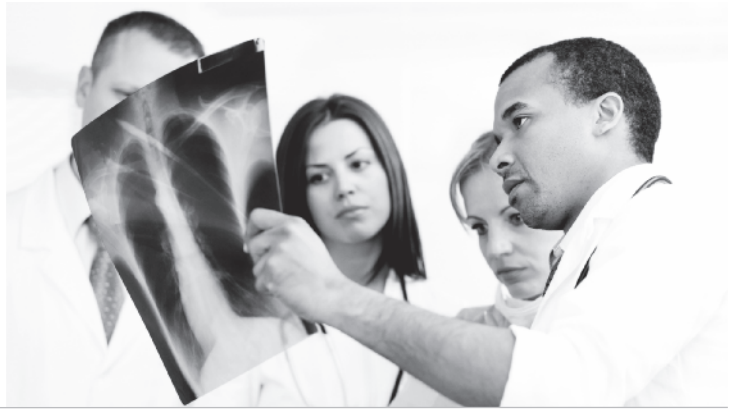
Independent Health has been supplying total cost of care performance data on specialists to The Primary Connection PCPs, who are also beginning to consider cost differences among the specialists they refer patients to. As a result, a "dream team" of high-performing specialists has been identified and more TPC referrals are being directed to these specific, highly efficient specialists. Collaborative physician work groups have also been established that address other ancillary services relationships.

PARTNERSHIP WITH WNY UROLOGY SEEING GREAT RESULTS

WNY Urology is a multi-specialty group practice with specialties in urology, urogynecology, radiation oncology and urologic pathology. It has approximately two-thirds of the urology medical care market in the region. WNY Urology and its affiliate company, Cancer Care of Western New York (Cancer Care), have offices in Erie, Niagara, Genesee, Chautauqua and Cattaraugus counties.

WNY Urology/Cancer Care began working with Independent Health on a series of value-based reimbursement programs about two years, working together for nearly six months to establish a partnership based on transparency, trust and shared responsibility.

The result of the collaboration is a value-based reimbursement program that rewards physicians for changing how they deliver care using their own utilization data, while leaving the practice of medicine to the physicians. It is a model for others to follow in order to achieve what patients want: better quality and an overall lower cost of care.



"Our model is different because it was built on a foundation of teamwork between our physicians and Independent Health.…Our relationship with Independent Health has unequivocally resulted in better care at lower costs."

—— *K. Kent Chevli, M.D.*

"Many times barriers are created by well-meaning insurance company administrators in their efforts to reduce the cost of care and keep premiums affordable for their members," said K. Kent Chevli, M.D., a physician at WNY Urology. "Our model is different because it was built on a foundation of teamwork between our physicians and Independent Health. When you combine the insight of physicians on patient care delivery with the insight the health plan data can provide, amazing things can happen which benefit everyone involved in the equation. Our relationship with Independent Health has unequivocally resulted in better care at lower costs."

These programs, which provide enhanced reimbursement to the provider group for meeting and exceeding national and local benchmarks of quality and efficiency, are working.

The five value-based reimbursement programs underway with WNY Urology/Cancer Care are:

1. Prostate cancer treatment
2. Benign prostatic hyperplasia or BPH (enlarged prostate)
3. Kidney stones
4. Testosterone therapy
5. Overactive bladder

Shared savings are based on:

- National and local benchmarks
- Cost per episode as compared to peers
- Quality metrics
- Other specific utilization metrics

Independent Health and WNY Urology hold quarterly meetings to review utilization reports and discuss data trends in order to identify improvement opportunities.

This new reimbursement method, along with ongoing collaboration and transparency, has been beneficial to Independent Health, WNY Urology and its physicians, but more importantly, the patients. The overarching goal is to improve quality while lowering the total cost of care, which drive premiums and members' out-of-pocket costs.

"Value-based reimbursement empowers doctors to improve quality and efficiency in order to make the system work better for patients," said Michael Duff, M.D., another physician with WNY Urology. "For example, Independent Health provides our doctors with data and insight on practice patterns, but importantly, leaves the decisions on care between the patient and their doctor, where they belong."

The reimbursement method for testosterone treatment has eliminated unnecessary costs while maintaining patient care and lowering patient cost share.

There are four different modalities of testosterone treatment: topical, oral, pellets, and injection, with each treatment essentially achieving the same result. To encourage more cost-effective utilization, the parties agreed on a case rate for this type of therapy in conjunction with a prior authorization program. The result was a double digit drop in cost per treatment.

Results of these collaborative value-based reimbursement efforts include:

- **Improved Quality**. WNY Urology's measures are better than its peers; achieving 5 percent higher quality
- **Improved Outcomes**. For example, cost per episode is 40 to 50 percent lower than peers for prostate cancer depending upon the line of business

According to Dr. Foels, after some initial hesitancy by providers, more and more physicians and practices are approaching Independent Health for assistance in working through an alternate payment model that creates a win-win strategy for both the provider and payer. "It's not top-down anymore, it's bottom-up as providers are approaching us as often as we are approaching them."

CATHOLIC MEDICAL PARTNERS

Independent Health and the Catholic Medical Partners (CMP), a group of more than 1,000 PCPs and specialists affiliated with the Catholic Health System, have been engaged in a total-cost-of-care risk model for more than a decade.

This is a two-sided risk model with both an upside arrangement (i.e., providers share in the savings if they achieve their goals) and a downside component (i.e., providers may be at financial risk if they do not meet their goals) that incentivizes the delivery of high-quality, efficient health care. The partnership, which has matured and evolved over the

years, has been mutually beneficial to both Independent Health and CMP, and more importantly, the community we collectively serve.

For example, the model has generated savings for both CMP and Independent Health, and through the collective efforts of both organizations, further savings are expected to continue.

CMP's commitment to population health strategies is aligned with Independent Health's strategic vision. Examples of population health strategies deployed by CMP include providing resources devoted to care management imbedded in their practices, as well as dedicated nutritionists, behavioral health specialists and pharmacists. Additionally, CMP has dedicated informatics resources that provide timely performance data to their physicians regarding their effectiveness in managing the total-cost-of-care of their respective patient populations.

Independent Health's alignment and engagement with CMP has allowed it to transition away from historical fee-for-service to reimbursement models that focus on and reward effective population management strategies (i.e., total-cost-of-care and pay-for-value).

CHAUTAUQUA INTEGRATED DELIVERY SYSTEM

Comparable to CMP, the Chautauqua Integrated Delivery System (IDS) is a group of 139 physicians. In May 2016, Independent Health and the Chautauqua IDS entered into a total-cost-of-care risk model for Independent Health's Medicare Advantage line of business. Currently, the risk model is an upside risk arrangement only; however, in 2018 the model transitions to both an upside and downside risk model.

Another very important component of this arrangement is the inclusion of a quality scorecard that can enhance surplus-sharing opportunities, as well as erode any potential downside risk performance.

Independent Health and the Chautauqua IDS share a common vision for providing patient-centered health care and this relationship helps shift the paradigm to a more proactive, value-based, results-driven model of care for our Medicare members residing in Chautauqua County.

Like CMP, the goal of the Chautauqua IDS is to connect the components of a fragmented delivery system to help patients live well, and Independent Health believes this partnership will help its members focus on wellness, prevention, and greater personal responsibility, with a special emphasis on controlling chronic disease.

Although the initial agreement between Independent Health and Chautauqua IDS is for the Medicare line of business, both organizations are fully committed to expanding their collaborative efforts to implement a similar value-based model for Independent Health's commercial lines of business. With this value-based agreement, the Chautauqua IDS joins other forward-thinking provider practices and organizations advancing the concept of alternative payment models aimed at improving the quality, delivery and value of care.

TECHNOLOGY NEEDED TO TRANSITION TO VALUE-BASED CARE

Moving to a value-based reimbursement landscape requires a significant investment in information technology as all stakeholders in the health care system face an increased need to acquire, aggregate and analyze data. An integrated clinical and financial platform will be required to provide a common view of the patient across various care settings and over periods of time.

While CMS is moving to reduce the number of quality metrics providers are required to report as part of MACRA, the process won't be easy and will take time.

Greg Slabodkin, managing editor of Health Data Management magazine, said doctors and hospitals must figure out how they provide care under value-based payment. "What providers are finding is they are not technologically and organizationally prepared for the dramatic changes required to succeed in this new business environment," said Slabodkin. "Information technology such as EHR systems and health care analytics are the tools providers will need to drive better outcomes for patients, which is the ultimate goal of value-based care.

The ability to capture, organize and share data is fundamental to success in the post fee-for-service world."

A recent survey conducted by the Healthcare Information and Management Systems Society revealed only 3 percent of respondents believe their organization is highly prepared to make the pay-for-value transition.

At Independent Health, we have made significant and necessary investments in technology and our infrastructure including a multi-year system conversion to prepare for a more consumer-driven, retail marketplace and the move to value-based reimbursement. As a result, we are at the forefront of this brave new world of health care.

CONCLUSION

There is growing recognition among health care providers, health plans and the government regarding the need to deliver care that improves quality and efficiency.

Independent Health and other members of the Alliance of Community Health Plans (ACHP) have been leaders in the movement to value-based care for several years for primary care and specialty physicians. As a result, we are uniquely qualified to help providers and governmental agencies implement payment reform.

We recognize the importance of linking payment to meaningful measures and outcomes, involving physicians in the design and implementation of new and alternative models of care, and ensuring quality patient care is the key driver behind all payment innovation.

Through our experience, we have learned the transition away from traditional volume-based, fee-for-service care must be phased-in and linked to other efforts to create a higher degree of integration and collaboration among payers and physicians.

The transition is based in large part on the capacity to incorporate and use data to implement reform successfully, with information on quality, utilization, costs and patient characteristics captured and presented in a manner that is transparent, trusted and actionable.

Solo practitioners and small, independent or rural practice groups face some of the greatest challenges in complying with the data collection, infrastructure and reporting requirements associated with MACRA and the move to value-based care, raising concerns they will be forced to join hospitals or larger groups because of the analytics, information technology and review process that will be needed.

Through our collaboration with The Primary Connection, we are creating virtual high-performing networks that will allow these smaller and rural providers to operate independently while also benefitting from working as part of a larger group. Independent practice associations, like Catholic Medical Partners, also serve as another option for these solo practitioners and smaller groups.

The transition to value-based care is a work-in-progress and we will all need to make more adjustments as it continues to be implemented.

Payment reform that truly improves the quality of health care in the U.S. and throughout Western New York, while driving costs downward, is imperative to the financial sustainability and economy of our nation and region.

This will be more important than ever given advancements in medicine and technology, in tandem with our aging population.

At Independent Health, we are committed to being a catalyst for change in moving to a value-based model of health care delivery.

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