UPMC’s mission is to serve our community by providing outstanding patient care and to shape tomorrow’s health system through clinical and technological innovation, research, and education.
UPMC: Our Commitment

UPMC started building an integrated delivery and financing system over 20 years ago to position for the new paradigm.

• Our strategy allows us to focus on what matters most:
  – Improving the health the communities
  – Implementing cost-effective solutions
  – Providing service excellence
  – Leveraging our unique structure to partner with all stakeholders: community providers, patients, members, employers . . .
• $10 billion integrated global health enterprise.
• Ranked #10 Best Hospitals U.S. News & World Report
• 23 hospitals - over 4,200 licensed beds; 187,000 admissions
• Affiliated University of Pittsburgh – ranked #5 in NIH funding
• 3rd largest GME program (1,360 residents)
• 4.6 million outpatient visits
• 2.0 million UPMC Health Plan members
• 400+ outpatient locations
• 55,000 employees
• 3,400 employed physicians and 1,800 affiliated physicians
• International Division – 9 countries
UPMC Insurance Services: A Diverse Product Portfolio

- 2nd Largest in Nation Provider Led
- 3rd Largest Operating in PA
- 2.0M Members
- Annual Revenues $3.8B (run rate)
- 8,800+ Employer Groups
- Fastest Growing Medicaid and CHIP Plan
- 10th Largest SNP Nationally
- Top 10 Nationally in Medicaid Quality
- Highest Ranked Provider Satisfaction (PA)
- J.D. Power Certified Call Center
- National Business Group on Health Platinum Winner
- 2012 Global Call Center of the Year Awardee (ICMI)
<table>
<thead>
<tr>
<th>Product</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial (ASO &amp; FI)</td>
<td>444,820</td>
</tr>
<tr>
<td>Medicare</td>
<td>133,331</td>
</tr>
<tr>
<td>SNP</td>
<td>21,386</td>
</tr>
<tr>
<td>Medicaid</td>
<td>387,201</td>
</tr>
<tr>
<td>Commercial Exchange</td>
<td>116,324</td>
</tr>
</tbody>
</table>
Why Shared Savings?

- Change Payment Paradigm
- Transition from Fee for Volume to Fee for Quality
- Leverage Health Plan’s ability to provide data on 3 main drivers of cost
  - Financial
  - Clinical
  - Quality
- Medicare = Defined Premium
- HCC Increase Revenue
- CMS STARS
- Increase Quality, Decrease Cost
Shared Savings Model, con’t

- Health Plan is paid a percentage of premium for administrative services.
- Spend for all services included in pool except pharmacy (part D)
- Monthly cost reconciliation with practice
  - Revenue minus Cost = Shared Savings
- Strict quality standards must be achieved before any annual Shared Savings payouts are made. Current metrics are based on CMS STARS rankings and HEDIS scores
Shared Savings Model – Quality Measures

- Breast Cancer Screening (process)
- Colorectal Screening (process)
- Osteoporosis Management in Women (process)
- Diabetes Care: Eye Exam (process)
- Diabetes Care: Kidney Disease Monitoring (process)
- Rheumatoid Arthritis Management (process)
- Plan All-Cause Readmissions (outcome)
- High Risk Medication (process)
- Part D Adherence for Oral Diabetes Medication (outcome)
- Part D Adherence for Hypertension Medications (outcome)
- Part D Adherence for Cholesterol Medications (outcome)
- Statin Therapy for Patient with Diabetes (Display Measure) (process)
Key Success Factors

- Highly engaged physicians/strong physician leadership
- Aligned incentives
- Well-defined network management
- Accurate practice membership rosters
- Individualized Education on HCC and CMS STARS optimization
• Strong Medical Management and Clinical Information to support physicians and population management

• Accurate coding and documentation

• Actionable and reliable data and information

• It’s all about the data

UPMC Health Plan Medicare/SNP Medical Expense Ratio-
Shared Savings Program v. Rest of Network
2011 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Shared Savings</th>
<th>Rest of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>87.3%</td>
<td>91.5%</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>90.1%</td>
</tr>
<tr>
<td>2013</td>
<td>89.8%</td>
<td>90.2%</td>
</tr>
<tr>
<td>2014</td>
<td>89.7%</td>
<td>91.3%</td>
</tr>
<tr>
<td>2015</td>
<td>89.0%</td>
<td>92.0%</td>
</tr>
</tbody>
</table>

UPMC Health Plan Stars Ratings -
Shared Savings Program v. Rest of Network
2011 - 2015

UPMC Health Plan
Professional & Ancillary Services

Hospital CLAIMS Savings

Operating Room Supply Costs

Hospital COST Savings

Quality Criteria

Quality Threshold (80 points)

Insurance Claims Expense
- Any savings shared between Health Plan and Physician
- Includes all claims 30 days pre-surgery, hospitalization and all claims 90 days post-surgery.

Physician Share In Savings

Operating Room Supply Costs
- Savings reduce Hospital costs during inpatient stay
- Based on best practice
Hip and Knee Pilot - Program Objectives

• Program Objectives:
  • Incentivize physicians to
    1. Improve quality of care by adhering to specified pathway
    2. Promote accountability for the entire episode of care (30 days pre-surgery to 90 days post-surgery)
    3. Choose the most cost effective implantable devices and supplies
  • Program design is focus on physician variation within an episode of care rather than control of overall surgery utilization

• Defining Program Characteristics:
  • Robust quality criteria that measure, track, and incentivize physicians based on actual patient experience outcomes
  • Targeting efficiencies within the hospital DRG payment by measuring hospital supply costs

UPMC Health Plan
Program Overview

- **Program Criteria:**
  - Total Hip/Knee replacement (MS DRG 469 & 470, ICD Procedure 81.51 & 81.54)
  - Episode of care includes 30 days pre-surgery, IP stay and 90 days post-surgery, *excludes the inpatient DRG payment*
  - Prior authorization required for medical necessity
  - Commercial FI/ASO or Medicare member
  - UPMC Health Plan is the patient’s primary insurer
  - Acuity Level 1 and 2 only (determined by APR DRG)
  - Discharged to home

- Pilot period Jul 2013 through Jul 2015

- Program Year 1 Surgery Volume (842 Total Surgeries):

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPMC Presby/Shady</td>
<td>282</td>
</tr>
<tr>
<td>Magee Women’s</td>
<td>279</td>
</tr>
<tr>
<td>UPMC St. Margaret</td>
<td>163</td>
</tr>
<tr>
<td>UPMC East</td>
<td>71</td>
</tr>
<tr>
<td>UPMC Mercy</td>
<td>47</td>
</tr>
</tbody>
</table>
Highlights of Year 1 Program Results

• Engagement and improvement with a core group of physicians
  – Significant quality improvements (pathway adherence, blood utilization, etc.)
  – Physicians who performed favorably to prior year improved by $1.1M year over year for total UPMC.
    • Net Total Savings for Year 1 $171K, including incentive payments
  – Long learning curve, but increased understanding of data and transparency into Year 2 shows progressive engagement.
Highlights of Year 1 - Quality

- Ranked in the top national quartile for physician-specific HCAHPS scores
- Near universal pathway utilization (95%)
- Inappropriate blood utilization decreased
- Only 1 SSI (Surgical Site Infection)
- 90-Day readmission rate 3.3% vs. goal of < 1.0% (only 8 related readmissions allowed to hit goal)
- Patient reported mental and physical well-being improved by average of 17 points
- 75% of Hip and 85% of Knee patients showed functional improvement
QUESTIONS?