BayCare Physician Partners 2019 Value Report

BayCare
Physician Partners

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Letter from Our President

It's a pretty exciting time in health care right now. We've come a long way with BayCare Physician Partners (BPP) and have a fantastic group of providers who are engaged and improving health care. I'm very proud of the success we've had thus far, but I'm even more proud that during this time of growth, our quality also has improved.

BPP has proven that we can improve, connect and coordinate care to bend the cost curve and generate savings.

With all of the changes in the market, we're in a position to take a proactive approach and set the standard for providing an extraordinary health care experience.

To use an analogy from the technology sector, BPP is now in version 2.0.

Our updated vision statement reflects that: **BayCare Physician Partners is a collaborative, high-quality and collegial network of physicians that makes it easier to deliver consistent, extraordinary, coordinated care.**

We're getting more sophisticated with data and analytics. We're more effectively managing population health by deploying tools such as remote monitoring and telemedicine. We're getting physicians what they need to take even better care of their patients, including a more integrated EMR. Our care management team is getting more robust and we're continuing to add value-based contracts.

We're adding more primary care physicians, who are crucial to managing the holistic health of patients. We're creating high-value networks with our specialists to clinically integrate and empower them to care for their patients.

We're also working to remove the roadblocks that prevent providers from giving the best care to their patients. Health care is a broad and complex field, and we're actively working to reduce the administrative and financial hurdles so they can do their best work.

There are two basic principles guiding our future:

- Continue to make health care better by improving the patient experience, providing our customers with more affordable options and improved access to care.
- Simplify the process for our excellent providers to provide extraordinary care.

We've built capabilities to manage the health of people. Our health coaches help modify the behavior of a patient rather than simply focusing on a lab result. We've proven that once we identify patients with kidney issues, we can get them to the right place and delay or even prevent the need for dialysis. And we have a dedicated group of care managers who are committed to improving the quality of life of their patients.

As we transition to the future, I'm excited about all of the opportunities within BPP. I'm looking forward to continuing this journey with you.

Sincerely,

Nishant Anand, MD, FACEP
President, BayCare Physician Partners
EVP/Chief Medical Officer
BayCare Health System

Who We Are

BayCare Physician Partners (BPP) consists of a Clinically Integrated Network (BPP CIN) and a Medicare Shared Savings Program ACO (BPP ACO).They are two separate physician-led entities that bring together physicians, hospitals and a network of health care facilities dedicated to improving the health care, safety and outcomes for patients across greater Tampa Bay.

BayCare Physician Partners by the Numbers – 2019

2 Provider Networks

1,840 Providers

35 Performance Partner Skilled Nursing Facilities

45 Physicians in Governance

11 Value-Based Contracts

$70 Million in Total Savings Since 2014

185,000 Patients

4.5 Average Medicare Advantage Star Rating

13 Hospitals

178 Practices Across 4 Counties

$1.4 Billion Total Medical Spend Under Management

Population Health Capabilities

As BayCare Physician Partners (BPP) continues to mature, creating a comprehensive portfolio of resources and programs that enables our organization and participating providers to succeed is critical. Over time, the infrastructure required to meet the needs of our patient population has organically developed. Today, our population health capabilities support patient care throughout the care continuum and support our providers in delivering high-quality care. This section describes our current programs and capabilities which are critical to achieving our population health goals.

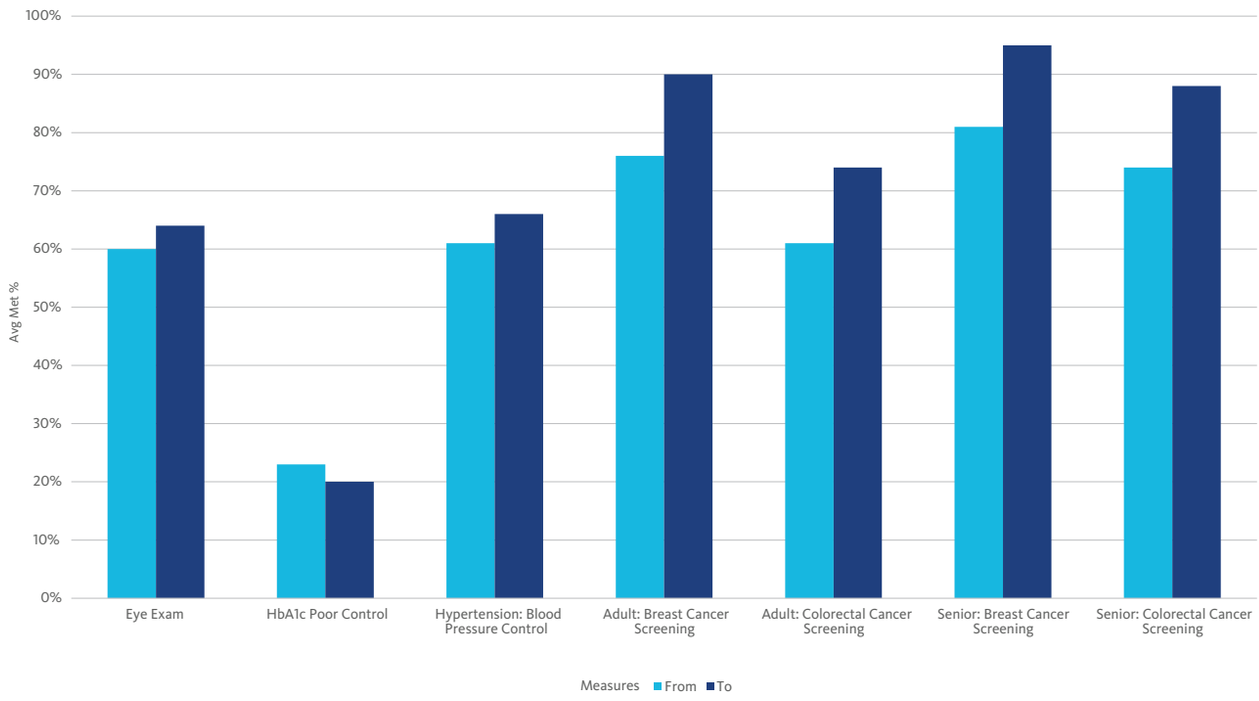
Population Health Information Technology

The ability to enable information and technology to guide our pursuit of improved outcomes, enhanced patient experience and lower costs is essential in value-based care. The BPP Information Technology team made progress this year by expanding our ability to access and use data to optimize patient care as follows.

Clinical Integration

Clinical integration is a foundational component of transformative care. We've spent the last few years working hard to integrate claims data from our payer partners and clinical data from the health system into our Cerner HealtheIntent Population Health platform. This year our focus was on integrating with additional providers who use the eClinicalWorks (eCW) EMR platform to enrich the information we have in our analytics platform. By the end of 2019, 57 practices and providers were clinically integrated from eCW.

As a result of this integration, providers on eCW saw on average a 12 percent increase on gap closures within the registry, which provided them more accurate information to manage their patient populations.



Quality Registries

Our registry system is a leading indicator of our performance and helps us proactively manage care gaps for our patients. The integration of the eCW practices has enhanced the data within the registries which gives us a more accurate and actionable picture of our opportunities for outreach and collaboration in closing care gaps for our entire population.

In July 2019, we commissioned a study of our registry data in order to identify opportunities and understand if we're improving as a collective network of physicians. The results were very positive and further our belief that we're on the right track.

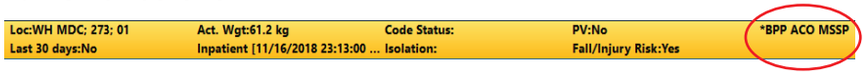
The graphs on the right show our performance distribution for diabetes eye exams, breast cancer screenings (Adult) and colon cancer screenings (Senior) between 2018 and 2019. The study found statistically significant improvement while reducing our standard deviation which demonstrates we're improving our ability to help manage care gaps for our members.

Point of Care – Clinical Support (Banner Bar Identifier)

As value-based care and associated programs continue to grow throughout the health system, it becomes increasingly important to identify these patients at the point of care. Accordingly, the Population Health IT team built an identifier in the inpatient EMR banner bar to dynamically identify members from all our plans to ensure program support through the entire health system.

Understanding that a patient is part of a value-based care contract both alerts and empowers the patient's care team that there are extra resources available to care for the patient.

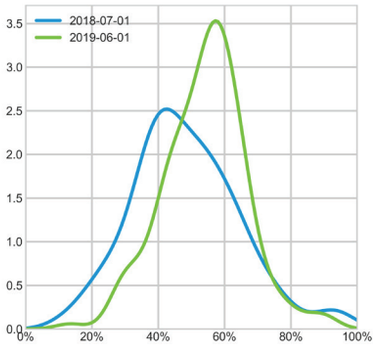
Banner Bar Identifier



Hierarchical Condition Category Tool

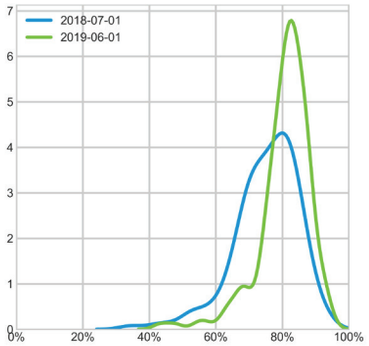
Ensuring our providers are appropriately capturing their patient's chronic conditions for our Medicare Advantage and ACO patients is key to our ability to manage risk effectively in value-based payment models. Offering technology support with identification of persistent chronic conditions is viewed as a value-add from our providers. Therefore, an added solution was implemented early in 2019 to provide point-of-care decision support, proactive identification of conditions based on clinical indicators (e.g. BMI, medications, lab results, etc.), identification of conditions that haven't been addressed in the current year and an analytics package that helps identify chronic condition trends. This tool has elevated the importance of appropriate diagnosis capture in value-based contracts for our providers which in turn improves population risk stratification and identification of subpopulations for inclusion in population health-based programs.

Diabetes Mellitus Annual Eye Exam



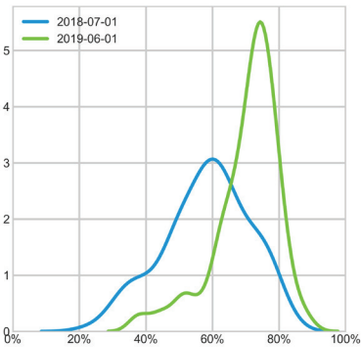
There was a significant increase of 5.7% MM across 157 providers while standard deviation saw a decrease of 3.7%.

Adult Wellness Breast Cancer Screening



There was a significant increase of 5.4% MM across 158 providers while standard deviation saw a decrease of 1.9%.

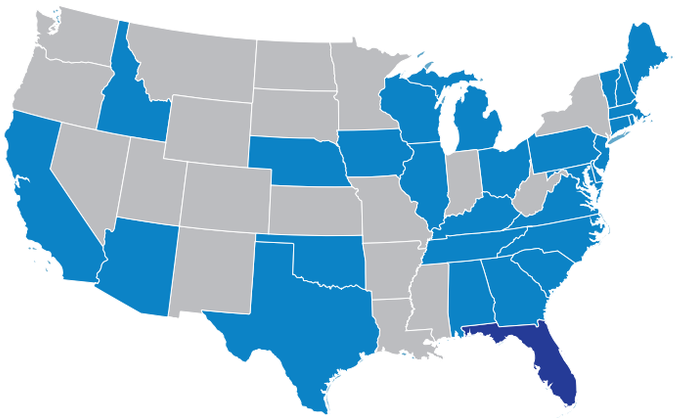
Adult Wellness Colorectal Cancer Screening



There was a significant increase of 12.0% MM across 151 providers while standard deviation saw a decrease of 3.0%.

Patient Ping

In late 2018, we implemented a post-acute and out-of-network patient tracking technology to help us improve the coordination of care after discharge. This solution has enabled improved visibility into the post-acute space where historically we were limited. Additionally, we subscribed to the Florida State HIE's Event Notification Service which gives us emergency and inpatient admission/discharge notifications for our patient population throughout Florida. The ability to track when and where patients are going for care allows us to proactively coordinate the care they need and ensure they have seamless transitions of care.



Care Setting	Pings	% of Total Pings
HOS Emergency	80,585	49.20%
HOS Inpatient	44,336	27.07%
HOS Observation	19,255	11.76%
HOS Other	991	.61%
SNFs (incl. LTC/ALF)	5,219	3.19%
Home Health	11,884	7.26%
Other	1,528	.93%
Grand Total	163,798	100%

Over the last year, the BayCare team has received over 160,000 real-time event notifications from nearly 1,000 different facilities across all of our connected states.

- **163,798** total pings received between July 5, 2018, and July 31, 2019
- The real-time pings came from **854** unique facilities across **28** different states.

163,798 Total Pings received

419.9 Average pings received per day

38,127 Unique patients

512 Hospitals

164 SNFs

126 HHAs

Enterprise Care Coordination

The majority of BayCare Physician Partners' care coordination efforts are managed within the Enterprise Care Coordination Office (ECCO). The goal of this team is to manage our patient population across the care continuum and provide the appropriate level of care and support at every stage.

Care Coordination/Disease Management

Chronic Complex Care

The Chronic Complex Care department is a multidisciplinary team composed of 11 registered nurses and three social workers. One of the social workers functions as a health advocate who assists patients with addressing advance directives, and provides emotional support through the process of end-of-life decision making.

The goal of the team is to assess, plan, implement, monitor and evaluate actions required to meet the patient's health and social needs. Patient-centered, behaviorally specific SMART-goal care plans are established with patients and ultimately guide patient care. The team collaborates with providers, Population Health pharmacists and social workers to connect patients with needed support, education and resources.

Points of entry into the program include hospital transitions, community-based programs, inpatient case managers, Population Health pharmacists and physician referrals.

HealthMap

BPP partnered with a vendor to launch a Kidney Health Management (KHM) program in January 2017 to deliver improved outcomes to chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients. The program applies a complex population health management approach to improve the physical and psychosocial well-being of patients and address health disparities through reduced costs and patient-centered interventions.

Beyond the numbers, this program has made a meaningful impact in the quality of life and health care delivered to its patients. For instance, a 78-year-old male with chronic kidney disease, stage four and congestive heart failure was gaining a pound a day, but was hesitant to reach out for help because he didn't want to be a difficult patient. The program flagged the patient as high risk. When the Care Navigator spoke with the patient, she convinced him to allow her to contact a BPP physician on his behalf. The BPP physician reacted quickly by calling the patient and coordinating the appropriate primary and specialist care within a 24-hour period, likely avoiding a hospitalization.

In 2019, we've had over **250** primary care providers and nephrologists participating in the program with **5,765** enrolled patients. As a result, we've reduced ED visits by over **3.7 percent** and reduced inpatient admissions by **11.5 percent**. In the first quarter of 2019, these improved outcomes achieved a **6 percent** cost reduction thus far.

3.7%
Reduction of ED visits

11.5% Reduction of inpatient admissions

$6.2 million
Reduction of medical costs

Patient with a diagnosis of hypertension and history of stroke was on a call with her care coordinator. She shared with her care coordinator that she fell and hit her head. On that same day she had two separate conversations and the recipients told her she wasn't making any sense. The care coordinator noted that she was on Plavix and asked her if she notified anyone of her fall and symptoms. She had not. The care coordinator urged her to go to the ER; however, the patient didn't want to go. The care coordinator called the patient's physician and made them aware of the situation. The office then reached out to the patient and had her come in for an appointment. At that appointment, she was exhibiting stroke-like symptoms and was taken by ambulance to the local ER. Thanks to our care coordination team, a fatal outcome was avoided.

Gaps in Care

Stay Healthy Program

ECCO's Stay Healthy team assists with closing care gaps for our covered lives. The Stay Healthy team reaches out to patients and providers to coordinate appointments, schedule preventive screenings and address any barriers to care by making appropriate referrals to pharmacy and complex care. The Stay Healthy team also retrieves and uploads quality data to BPP-contracted payor portals to satisfy compliance with HEDIS quality measures. This team's focus on HEDIS measures helps improve CMS STAR ratings for our payor partners.

Health Support

Transitions in Care

ECCO's Health Support team helps safeguard a successful transition for patients from hospital to home. Transitional Care Management (TCM) outreach to patients is completed within 24-48 hours after an inpatient hospital discharge. During the outreach, nurses address a host of patient needs, including home health care, durable medical equipment, medications, social determinates of health, barriers to follow-up care and scheduling of follow-up appointments. Health Support will refer patients to pharmacy, social services, health advocacy and complex care for additional resources and support as needed.

ECCO at the Bedside

ECCO at the Bedside extends the reach of the ECCO team into BayCare hospitals, supporting transitions for high-risk BPP patients with warm handoffs and referrals for readmission risk reduction. Meeting patients at the bedside allows for a more in-depth assessment of needs and potential barriers to safe and effective transitions.

Patient with advanced stage IV cancer was referred to care coordination for assistance with diet modification. After reviewing the chart, the care coordinator noted that the patient was very sick and really needed palliative or hospice care. The care coordinator reached out to the patient's primary care provider and discussed their recommendation with the physician. The care coordinator connected the provider with a health advocate who answered some of the questions the provider had around the process. The provider was able to approach the delicate subject with both the patient and their family. This collaboration and recommended treatment plan benefited the patient and their caregiver.

31,700 Charts reviews

19,100 Closed gaps in care

ECCO Health Support Social Services

Social Service Intervention

- Emotional Support for Patients Identified at Risk
- Community Outreach
- Homeless/Indigent Patient Support
- Connection to Resources to Improve Overall Quality of Life
- Advance Directives/ Living Will
- Diabetic Supplies and Support Groups
- Address Psychosocial Barriers to Patient's Care

Social Service Intervention

- Moms Meals/Meals on Wheels
- ALF Placement
- SNF Placement for Readmission Prevention
- Emergency Preparedness/Funding for Utilities
- Transportation
- Additional Support for Noncompliant Patients
- Domestic Violence Support

Cerner Message Center

- Referral Pool: HeC Enterprise Care Coordination Social Services

Alert sent to physicians by Care Coordinator:

"If your patient's basic psychosocial needs are not met, they are not going to be able to focus on their physical health. We are here to support you and your patients by connecting them with needed resources and support to increase engagement in their care."

Remote Monitoring

Remote patient monitoring (RPM) is a critical capability within a value-based payment environment. To effectively and efficiently manage and coordinate care for very complex patients across the care continuum and to support an earlier transition to home, post-acute care hospitalization, the ability to actively monitor patients, is required. Remote patient monitoring has been shown to improve patient care and safety in patients with complex conditions such as heart failure and has been used for BayCare HomeCare (BCHC) patients for many years. BCHC has demonstrated reduced readmission and acute care hospitalization rates for patients with heart failure and COPD compared to similar patients without home telemonitoring. This service will also be used for BPP-attributed patients.

Pharmacy

The Population Health pharmacy team consists of three full-time pharmacists focused on supporting the BPP patient population. This team leverages analytic data to determine which patients would benefit from interventions and/or support. Using the data, pharmacists can collaborate with providers to promote guideline-directed medication and disease state management for chronic disease states.

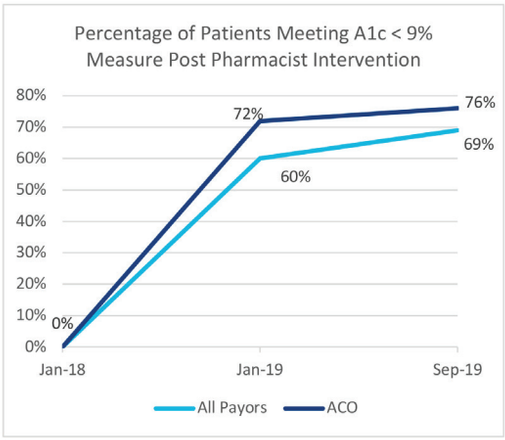
The Population Health pharmacy team works closely with ECCO to provide patients with comprehensive medication reviews and ongoing support. They also provide education to providers about medication-related quality measures and serve as a resource for providers with drug information questions and patient outreach needs.

Pharmacy Diabetes Program

The Pharmacy Program provides value to patients and physicians by assisting in medication and disease state management for chronic disease states. The Population Health pharmacists complete medication reviews, medication education, disease state education and assistance in obtaining medications.

The Diabetes Program was initiated in late 2017 to help reduce the number of patients with uncontrolled A1C (>9 percent). Currently, there are almost 3,800 patients who have been enrolled in the program.

Patient with diabetes needs a knee replacement and was told that he couldn't have it due to his elevated HgA1C levels. He was frustrated. His care coordinator shared a great book on diabetes management and this made the patient very happy. On the care coordinator's next call, the patient reported a loss of 18 pounds since his hospital discharge and he had read the entire book. He was motivated to make changes and was very happy we were here to send him the information.



3,800+ patients with uncontrolled A1C (>9%) at enrollment

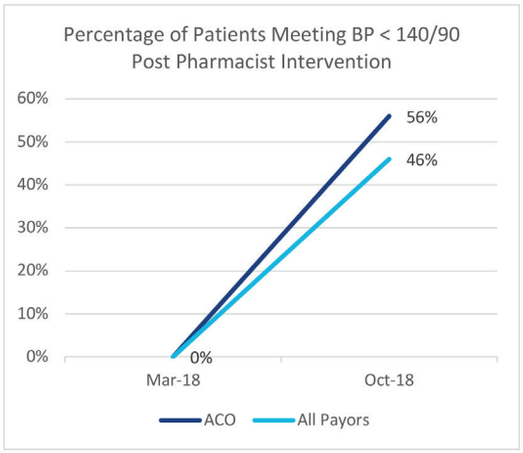
3,800
Patients enrolled

69%
Reduction in number of patients with A1C > 9 percent amongst all payers

76%
Reduction amongst ACO patients

Pharmacy Hypertension Program

In addition to diabetes, Population Health pharmacists also collaborate with primary care providers to improve outcomes for patients with hypertension. To date, we've impacted 239 patients who were pharmacist identified through the use of analytics as not meeting the blood pressure goals or didn't have a reading in the past 12 months. The outcomes are presented in the chart below: 56 percent improvement in ACO patients, and 46 percent improvement overall.



230+ patients with uncontrolled BP (>149/90) at enrollment

Pharmacy Medication Assistance Program

The Medication Assistance Program is dedicated to ensuring patients have access to affordable medications. This program helps patients review assistance resources available to them, apply for eligible programs and obtain medications at a lower cost. Resources may include drug manufacturer patient assistance programs, drug copay or discount cards, or the utilization of a retail pharmacy discount drug list. The Medication Assistance Program is a team of four medication assistance coordinators and a pharmacist who are available to review patients' medication lists and to develop medication access plans. Anyone can contact the medication assistance program to determine if they're eligible for medication assistance.

Risk Adjustment Program

Ensuring our providers are using appropriate coding and documentation for our Medicare Advantage and ACO patients is key to our ongoing success and our ability to manage risk effectively in value-based payment models. Therefore, in May of 2019, BPP launched a Risk Adjustment/ Documentation Support Program that works directly with our member providers and Medicare Advantage payors to coordinate and deliver provider education and support to ensure our providers enter proper and complete diagnosis codes and documentation for our attributed patient populations.

The Risk Adjustment team also provides pre-visit chart reviews for upcoming patient appointments to aid providers in identifying and addressing persistent conditions, potential undocumented conditions that may need to be addressed and gaps in care during the patient visit. Improving the accuracy and specificity of our coding and documentation helps us to risk stratify, and improve the management of our population in conjunction with the providers, leading to the development of patient interventions and support which optimizes their care. Additionally, on-going education is shared at all Provider Pod meetings on selected documentation and coding topics. The team is always available to meet with providers one-on-one to help them understand difficult topics and regulatory requirements.

This program increases our ability as an organization to accurately capture the disease burden of our patient population which translates into better patient care and accurate patient risk profiles.

2,120
New patients

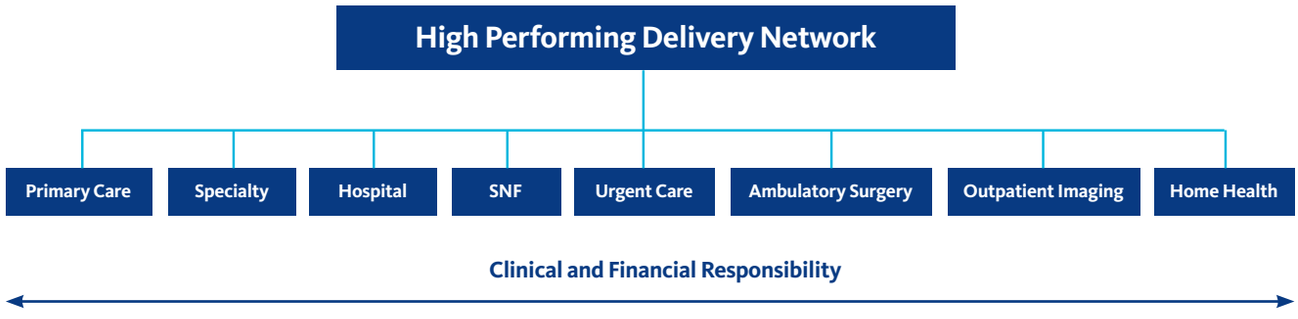
3,528
Medications for Assistance

$3.4 million
Estimated saved on medications

High Performing Network

Recent pushes from providers and payers toward higher quality, lower cost care has prompted health care organizations to offer care in a more coordinated setting, changing how the delivery of health care services is provided and managed. In response to these pushes, BayCare Physician Partners has initiated formation of a High Performing Network (HPN). This is a formal system comprised of providers and sites of care where a patient can obtain comprehensive health services from one single 'brand' of high-quality, low-cost and integrated health care providers.

A HPN is a system of providers and sites of care that provides coordinated health care services to customers in a defined geographic area.

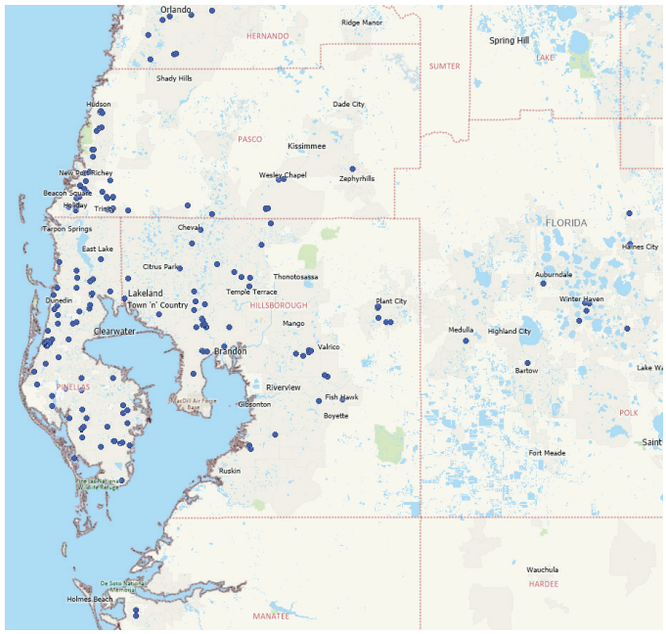


As BayCare Physician Partners Clinically Integrated Network (BPP CIN) and BayCare Physician Partners Accountable Care Organization (BPP ACO) continue to transition from fee-for-service to value-based care, an accelerated approach has been placed on the development of a HPN to manage the population's health by offering a continuum of care that caters to the broadest set of patient needs. Cost containment and value is achieved through provider alignment, clinical integration, market presence, managing risk and offering an extensive breadth of services.

Primary Care Physicians

In 2019, BayCare Physician Partners grew their primary care footprint by nearly 100 percent. We added close to 200 new primary care physicians (PCPs), which brings our adult primary care total to 444 physicians.

PCPs participating in both BPP CIN and BPP ACO influence and direct the high-quality care delivered in our communities. A strong and engaged PCP network is essential for our success; therefore, targeted strategies are being implemented to further develop and support our primary care physicians.



BPP Primary Care Provider Footprint

PCP Engagement Strategies

Tiering Strategy

One of these strategies includes tiering of the PCP network. Criteria for advanced participation will include increased citizenship, quality and cost-efficiency performance measures and operational requirements. Participants will benefit from enhanced support services and increased performance-based incentives.

PCP Pod Meetings

Initially developed in 2017, the PCP Pods that group primary care physicians into physician-led organized, collaborative units are still going strong today. These units encourage collaboration among the members and provide a forum for engagement with one another and sharing of best practices for managing risk and improving quality of care. In 2019, a total of 45 in-person meetings were held during the year throughout the four-county area with between 10-45 attendees in each pod. Pod meetings focused on improving clinical quality metrics, understanding risk and hierarchical condition category (HCC) coding, chart reviews for appropriate documentation and office best practices. Pod attendance has been tied to provider citizenship requirements, as meetings in this collaborative setting are crucial to providing ongoing education and assisting with the transformation from volume to value.

High-Value Specialty Networks

High-Value Specialty Networks (HVSN) are another important component of an overall High-Performing Network. This is a way to create specialty-specific networks in order to develop standardized clinical pathways and clinical measures that can support Population Health goals. Having a network that's high performing allows primary care physicians to refer patients to high-quality, low-cost providers, ultimately leading to a reduced spend in value-based care.

The first HVSN to be launched is in cardiology services. There are approximately 125 cardiologists within eight practices in the four-county area who were asked to participate based on a variety of quality and utilization performance metrics. Participants in this network are given the opportunity to develop models that are economically beneficial for the group and the patient population. Since this group is high performing, in the future they'll be able to participate in enhanced incentive programs negotiated with payor partners, such as bundled program and specialty capitation.

In the following year, we'll be launching additional HVSN in behavioral health, nephrology and pediatrics.

Pediatrics

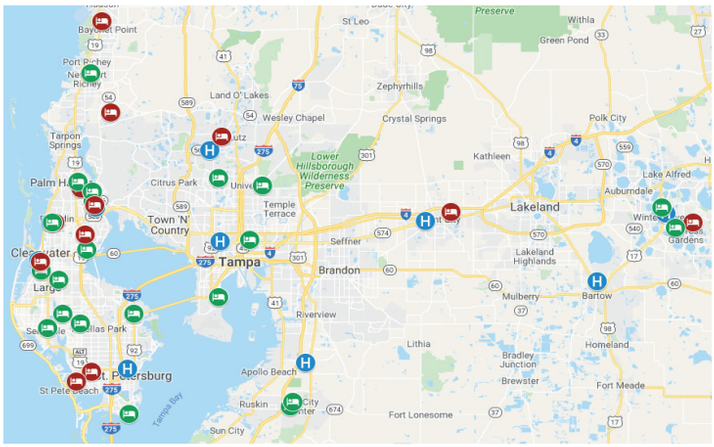
Pediatricians are also a valuable component of BPP CIN's overall PCP network. Pediatric patients account for approximately 20 percent of BPP CIN's patient population. In 2019, BPP also offered pediatric-focused pod meetings, which were tied to citizenship requirements. Thanks to the input from many highly engaged pediatricians, BPP was able to direct meaningful, relevant discussions around pediatric-specific topics.

Performance Partner Network: Post-Acute

A robust post-acute care strategy is also vital to our ongoing success. Skilled nursing facility (SNF) admissions and length-of-stay (LOS) are two metrics that significantly impact overall total cost of care which affects a variety of value-based care payment models. In order to assure appropriate SNF admissions and LOS, the BayCare SNF Performance Network was developed using several key metrics to ensure that patients and physicians have access to SNF partners committed to providing high-quality, cost-efficient care across our footprint.

We'll have greater alignment for ACO 3-Day waiver placements, allowing patients and physicians more choice in accepting facilities as we complete our hospital rollout and expand into the community setting.

As the SNF Performance Partner Network continues to grow and evolve to meet the needs of our community, we have processes to continuously monitor to ensure the most efficient and collaborative partnerships are in place. All of the participating SNFs collaborate around BayCare clinical pathways, ensuring a consistent best practice standard of care across the continuum.

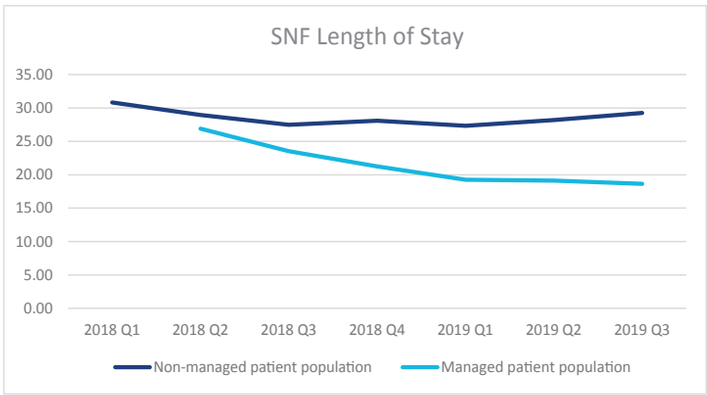


BPP Performance Partner Network Map (ACO Waiver facilities denoted in red)

BayCare recognizes that the need for excellent care doesn't end in the acute setting, and in addition to the SNF Performance Partner Network we'll be creating a Home Health Care Performance Network that will allow for greater opportunity to support and impact the care of our patients as they transition across the continuum of care.

Post-Acute Care Team (PACT)

PACT is staffed by a dedicated group of nurses and social service specialists who follow all Medicare patients who are discharged from a BayCare hospital to a Performance Partner Network SNF. This team follows the patient at the SNF, collaborating with our SNF partners to identify barriers to discharge, avoidable delays in care and opportunities to prevent avoidable readmissions. This team's efforts have resulted in reduced SNF length of stay and readmissions, which has also had a positive impact on our Medicare Spend per beneficiary. PACT has expanded to provide coverage at all Performance Network facilities and plans to support additional facilities in meeting BayCare's goals. Our population will also evolve to support BPP ACO patients who are discharged from non-BayCare hospitals, and additional identified populations.



SNF length of stay reduced in patient population managed by Post-Acute Care Team (PACT)

Electronic Post-Acute Care Consult (ePACC)

The ePACC Program is a free program for our SNF Performance Partner Network that provides after-hours telemedicine support to the SNF Bedside Care team seven days per week, with the goal of reducing avoidable readmissions and ED utilization.

The team is committed to supporting our patients during their transition into the SNF setting. We focus on applying rapid interventions early to avoid unnecessary hospitalizations. The ePACC currently supports 13 SNF Performance Partners and will expand to support 15 additional facilities within the next year. In 2019, the ePACC team has had great success. Year-to-date, the team has fielded approximately 15,000 after-hours calls from SNFs. Of those calls, 97.8 percent remained in the SNF, with only 2.12 percent transferring to a hospital.

Contracts

Recognition

Our payor partner, UnitedHealthcare, believes that Accountable Care Organizations hold tremendous promise to address some of the major issues plaguing the U.S. health care system, namely the rapidly rising costs of care. That's what prompted them to establish its Accountable Care Summit, where it convenes more than 100 of its ACO partners to share best practices and celebrate those partners that have demonstrated significant success with their models.
At this year's summit, held in June, UnitedHealthcare presented an award to our Enterprise Care Coordination office for improving the experience for patients transitioning into Medicare with additional outreach and follow-ups from its Transitions in Care team, which contributed to an improved readmission rate.

Maria Lenis, PharmD accepts United HealthCare award.

Product Performance Workgroup

The Product Performance Workgroup is charged with analyzing cost and utilization data for BayCare's and BayCare Physician Partners' at-risk contracts including the ACO, CIN, Bundled Payment Initiatives and Hospital Incentive Payment programs. Using data as our guide, we're developing initiatives to improve contract performance. The workgroup consists of representatives from BPP, BMG, ECCO and Pharmacy with ad hoc members invited as needed. Our first initiative was a review of the utilization of in-office infusions for the treatment of rheumatoid arthritis, macular degeneration and osteoporosis with education, development of best practices and individual physician data distribution as interventions to be developed for BPP providers.

In addition to a focus on Part B drugs, the team is working on identifying opportunities in ED utilization, inpatient utilization and readmissions. As opportunities are uncovered, continuing medical education sessions are developed that help to educate our providers on these topics and how we can capitalize on the opportunities. In addition, outreach programs, changes in workflows or new initiatives are being created to address what we find in analyzing the data.

2018 Performance

U.S. health care costs skyrocketed to $3.65 trillion in 2018. BayCare Physician Partners continues to demonstrate notable results in bending the health cost curve through better management of patient conditions and care coordination and increasing use of technology. While U.S. health care costs rose 4.4 percent in 2018, BayCare Physician Partners were able to control and lower costs for payers, employers and individuals participating in the CIN and ACO.

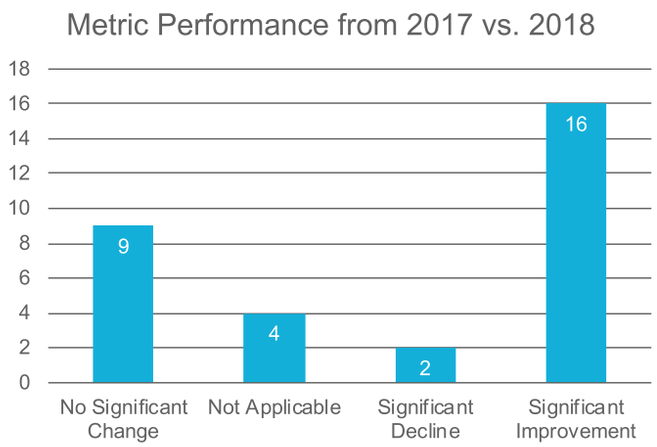
In 2018, BayCare Physician Partners, ACO, transitioned our Accountable Care Organization (ACO) Track 1 to the Medicare Shared Savings Program (MSSP) Track 3 model, introducing significant downside risk.

This agreement with the Centers for Medicare and Medicaid Services (CMS) reinforces incentives for BPP and hospitals to deliver high-quality care at an efficient cost. BPP had success with MSSP Track 1, saving taxpayers more than $50 million between 2015 and 2017, and another $9 million in 2018, while delivering top decile quality outcomes.

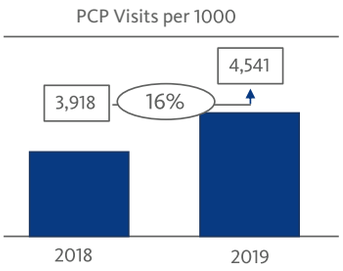
BayCare Physician Partners, CIN, also held costs below the U.S. and local market growth rate, resulting in generating shared savings in many of the contracts.

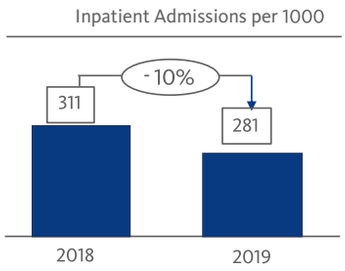
BayCare Physician Partners has generated

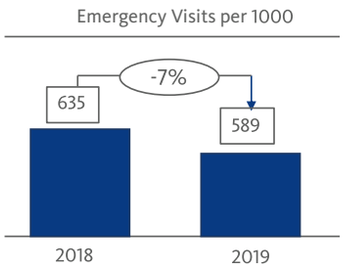
$70 million in savings since 2014



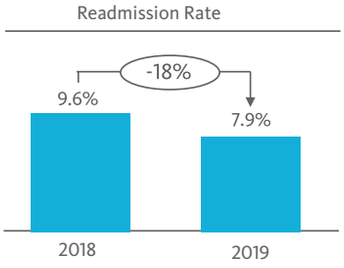
ACO/Medicare

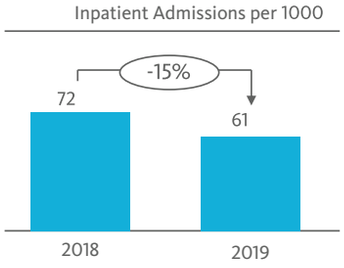


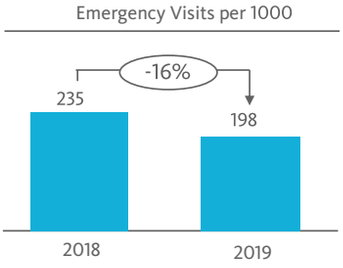




CIN/Commercial







Looking Forward

2019 was an exciting time for BayCare Physician Partners (BPP). Through the work of physician-driven committees and BPP leadership, we've aligned around key clinical strategies and data analytics capabilities that position us for success in a value-based environment. We continued to develop our Integrated Delivery Network of aligned physicians, hospitals and post-acute partners who are committed to driving success through value-based contracts.

We've made a measurable impact on the more than 185,000 lives who we've touched with our model of care coordination to date, and have seen decreased readmission rates and reduced acute care utilization, and driven top decile quality outcomes.

In 2020, we're planning considerable advancements and maturation of our Population Health management capabilities. The goal of Population Health management is to address each individual's health needs and deliver high-quality, efficient care in a coordinated fashion at every point along the continuum.

We intend to focus on four key strategies that are vital to success in the fee-for-value environment:

- Enhancing care coordination efforts for the high-risk and rising-risk patients
- Improving physician documentation, coding and care gap closure
- Reducing unwarranted clinical variation
- Reducing costs in the post-acute setting

One of the outcomes of the Affordable Care Act is that our nation's health care system is rapidly evolving into one that emphasizes value over volume. The health care industry, almost 10 years later, continues to see substantial changes. BayCare Physician Partners (BPP) remains committed to supporting our physicians through all major health care policy changes.

As health care costs continue to rise, those paying for doctor and hospital costs are rapidly moving to new models of delivery that require medical care providers to be measured, rated and scored. We don't expect the shift from volume to value to slow down, rather the opposite. Next year we expect more and more reimbursement to be based on patient outcomes. Providers with higher quality measures will receive better reimbursement than those with lower quality measures; likewise hospitals and post-acute providers that have lower readmission rates will receive better reimbursement than those with higher readmission rates.

Fundamental to BPP is the belief that bringing employed physicians, independent physicians and hospital/health system resources together into a more clinically and financially aligned business model, one that is centered around the patient, will in fact deliver superior care and greater value to our customers. I look forward to a successful road ahead,

Ethan Chernin, MBA
Chief Operating Officer, BPP
Vice President, Population Health, BayCare

2019 BayCare Physician Partners Participants

BPP Accountable Care Organization and BPP Clinically Integrated Network Participants

Abraham Totah, MD, PA
Academic Alliance in Dermatology, Inc.
Agnes Ubani, Inc.
Alan A. Smith, MD, LLC
All Florida Orthopaedic Associates
Anthony I. Sebba, MD, PA
Arthritis & Rheumatism Associates, PL
Atit Neurology, PA
B2 Orthopedics
Bay Area Chest Physicians, PA
Bay Area Emergency Physicians, LLC
Bay Area Gastrointestinal Endoscopy and Liver Specialists, LLC
Bay Surgical Specialists, PA
BaySide Emergency Physicians, PA
Beth Hanrahan, MD, LLC
Biggers Family Medicine, PA
Bond Clinic, PA
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Clearwater Cardiovascular and Interventional Consultants, MD
Comprehensive Foot and Ankle Center, PA
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Diabetes Thyroid and Endocrinology Center, PL
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Elias Kanaan, MD, PA
Emergency Medical Associates of Tampa Bay, LLC
Family Medical Specialists of Florida, PLC
Florida Musculoskeletal Surgical Group, LLC
Foot and Ankle Physicians, PA
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Michael T. Reilly, MD, PA
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Nabila Niaz, MD, PA
Neurophysiology Center, PA
Omar Aref, MD, PLC
Palm Harbor Dermatology, PA
Pasco County Emergency Physician, LLC
Pediatric Intensive Care
Pinellas Arrhythmia Associates, PA
Pinellas County Primary Care and Hospitalists, PLLC
Pinellas Radiation Oncology Associates
Plant City Cardiology Associates, LLC
Radiology Associates of Clearwater, MD, PA
Raymond D. Hansen, MD, PA
Respiratory Specialists, PL
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Stephen J. Shields, MD, PA
Stephen L. Scranton, MD, LLC
SunCoast Retinal Consultants, LLC
Sunshine Pulmonary and Sleep Medicine, PA
Surgical Associates of West Florida, PA
Sylvia D. Campbell, MD, PA
Tampa Bay Orthopedics
Tampa Bay Pulmonary Medicine, PA
Tampa Bay Renal, LLC
Tampa Eye Clinic and Associates, PA
Tampa Lung Specialists, PA
The Advanced Cardiovascular Center of Tampa Bay, PA
The Eye Physicians of Pinellas, PA
Tidewater Foot & Ankle Associates
Timothy C. Runyon, DPM, PA
Town & Country Internal Medicine, PA
Trinity Pain Center, LLC
Urology Professionals, LLLP
Victor Arboleda, MD, PA
Wellspring Cancer Center, LLC
West Central Gastroenterology, LLP
West Coast Infectious Diseases, PA
West Florida Cardiovascular Center, Inc.
West Florida Medical Specialists, PA
William C. Brown, MD, Inc.

BPP Clinically Integrated Network Participants

Alexander Orthopaedic Associates
All Podiatry Group, Inc.
All Star Pediatrics, Inc.
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Arroyo Palm Harbor Pediatrics
Atta U. Butt, PA
Bay Area Cardiology Associates, PA
Bay Area Heart Center, PA
Bay Dermatology and Cosmetic Surgery, PA
Bay Pediatrics, PA
Bayfront Cardiovascular Associates
Comprehensive Pain Management Partners
Countryside Pediatric Care, PA
DO Sleep Solutions, Inc.
East Lake Pediatrics, PA
Eaton Orthopaedics, LLC
EmCare, Inc.
Equbal Kalani, MD, PA
Eye Site of Tampa Bay, PA
Florida Cancer Specialists & Research Institute, LLC
Florida Coast Foot and Ankle, PA
Florida Digestive Health Specialist, LLP
Florida Kidney Physicians
Florida Med Clinic of Clearwater, Inc.
Florida Pediatric Associates, LLC
Florida Urology Partners, LLP
Florida Woman Care, LLC
G. Cosentino, Inc.
Gold Primary Care, LLC
Gubernick Allergy Asthma and Immunology Associates, PA
Gulf West Medical Associates
Harborside Gastroenterology, PA
Hypertension Kidney and Stone Center, LLC
Internal Medicine & Nephrology Associates, PA
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Kids First Pediatric Care
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Lifetime Family Urgent Care, LLC
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Michael J. Buscemi Jr., DO, PA
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OB Hospitalist, LLC- FL
Olayinka Bankole, MD, PA
Orthopaedic Medical Group of Tampa Bay
Orthopedic Specialists
Palm Harbor Plastic Surgery Center
Partners in Pediatrics, PA
Pasco Cardiology Center, Inc.
Pautler, Cohen, Findlay and Eichenbaum, MDs, PA
Pediatric Associates of Tampa Bay, LLC
Pediatric Pulmonary Specialists, PA
Pham Hasell, PA
Pinellas Pediatrics, PA
Pinellas Primary Care, Inc.
Premier Dermatology
Premier Heart and Vascular Center
Radiology Associates of St. Petersburg
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Sarah Digby, DO, PA
Select Physicians Alliance, PL
Sinus & Nasal Institute of Florida, PA
Stern, Drake, Isbell and Associates, PA
Sunarc, Inc.
Tampa Bay Surgical Group, LLP
Tampa Bay Uveitis Center
Tampa Obstetrics, PA
Trinity Doctors Group, PA
West Coast Ear, Nose and Throat, Inc.
William W. Huntley, MD, PA

BPP Accountable Care Organization Only Participants

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Tampa Bay Pulmonary Associates, PA

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