

INSPIRIS

An IAH Type Program For Managed Care



INSPIRIS

INSPIRED CARE

Who We Are

- Founded in 1998
- Headquartered in Brentwood, TN
- Provider & care management organization that delivers innovative, provider-driven, patient centric healthcare solutions designed for high risk, medically complex populations
- Old fashioned house calls combined with modern day analytics, technology, best practice guidelines, etc.

Who We Serve

- INSPIRIS currently partners with Managed Care Organizations
 - Medicare Advantage (HMO, PPO, PFFS, Dual SNPs plans)
 - Medicaid (ABD, MLTC, Dually Integrated plans) 5% of the population in this country drives 50% of the medical spend
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- Underserved, vulnerable population - frail, elderly, chronically ill, medically complex, cognitively impairment, behavioral health challenges, assistance with daily living needs, care giver support issues
- We take health care to the patient



Focus and Strategy

- INSPIRIS contracts on a “value creation” basis vs. the traditional FFS approach
- Strong analytic capabilities to establish baselines, identify target patients, demonstrate outcomes/value
- INSPIRIS has a long and consistent track record of rapid implementation, early and substantial impact, strong outcomes, and satisfied customers associated with our program offerings
- Due to the provider-driven nature of INSPIRIS’ offerings, health plans allocate all INSPIRIS fees to medical (vs. administrative)
- INSPIRIS has a strong track record of innovation and new program design to meet additional health plan needs. Multiple health plan needs can be addressed by one partner
- INSPIRIS is committed to quality care and improving the lives of the patients we serve, resulting in substantial financial improvement for the health plan
- INSPIRIS is amenable to the full spectrum of risk/reward contracting structures, including full risk



INSPIRIS House Call Programs

CarePlus

- Physician/Nurse Practitioner led care and care management of community and facility based high risk patient

Transitions

- Bridges gaps in care between acute facility, skilled facility, and home

CarePlus Program™

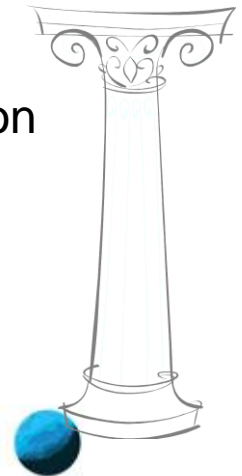
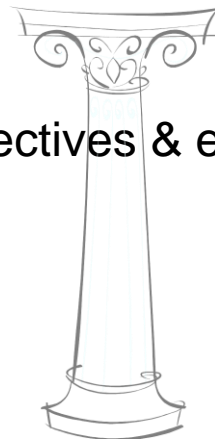
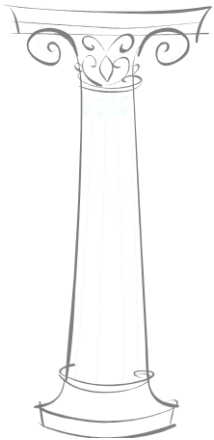
- Initial comprehensive assessment completed by INSPIRIS Provider in patient's home (drives care planning)
- Initial care management plan developed between INSPIRIS Provider, Care Manager and PCP
- In-home provider visits scheduled depending on patient acuity
 - Average 1.3/mo. - Unscheduled Visits occur as needed to keep patients out of the hospital-reduction of readmissions visits also a focus
- Telephonic care management / coordination
 - patient/family education, symptom monitoring, care plan compliance, bridging the gap with specialist and other care givers
 - Average 3.2 telephone contacts per month with patient and care givers
- PCP communication
- 24/7/365 access to INSPIRIS Provider and Team



CarePlus Program™

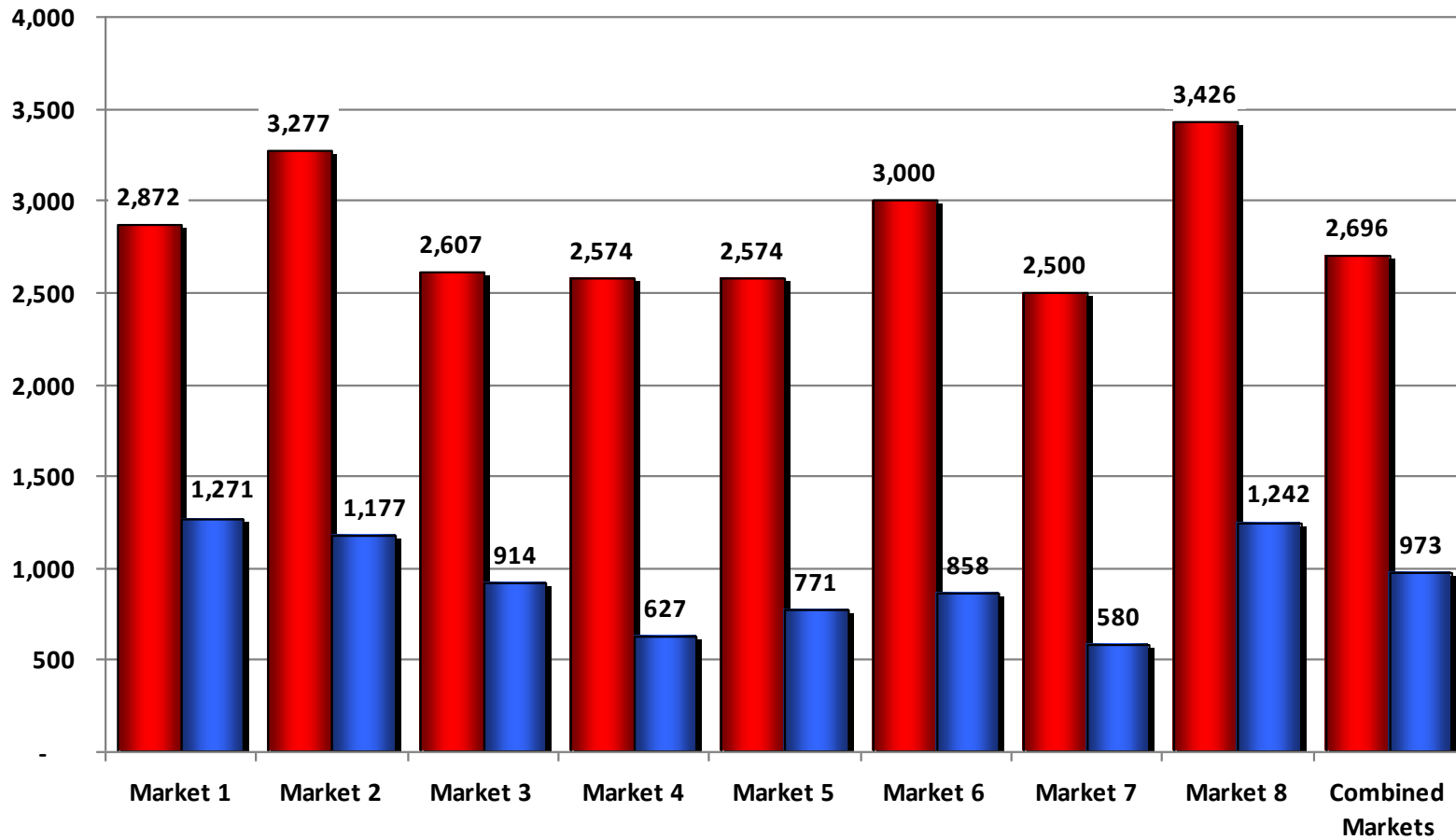
Enhanced quality, satisfaction, reduced medical expenses driven by three pillar approach

- Proactive care and care management – regular visits from home visiting provider to improve patient care and reduce number of exacerbations
- Urgent visits as needed to provide immediate access to a provider when exacerbations do occur-also a heavy focus on reducing readmissions with visits within 48-72 hours of a hospitalization
- Focus on advance directives & end of life education



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Impact on Acute Admits – Medicare Advantage Plans



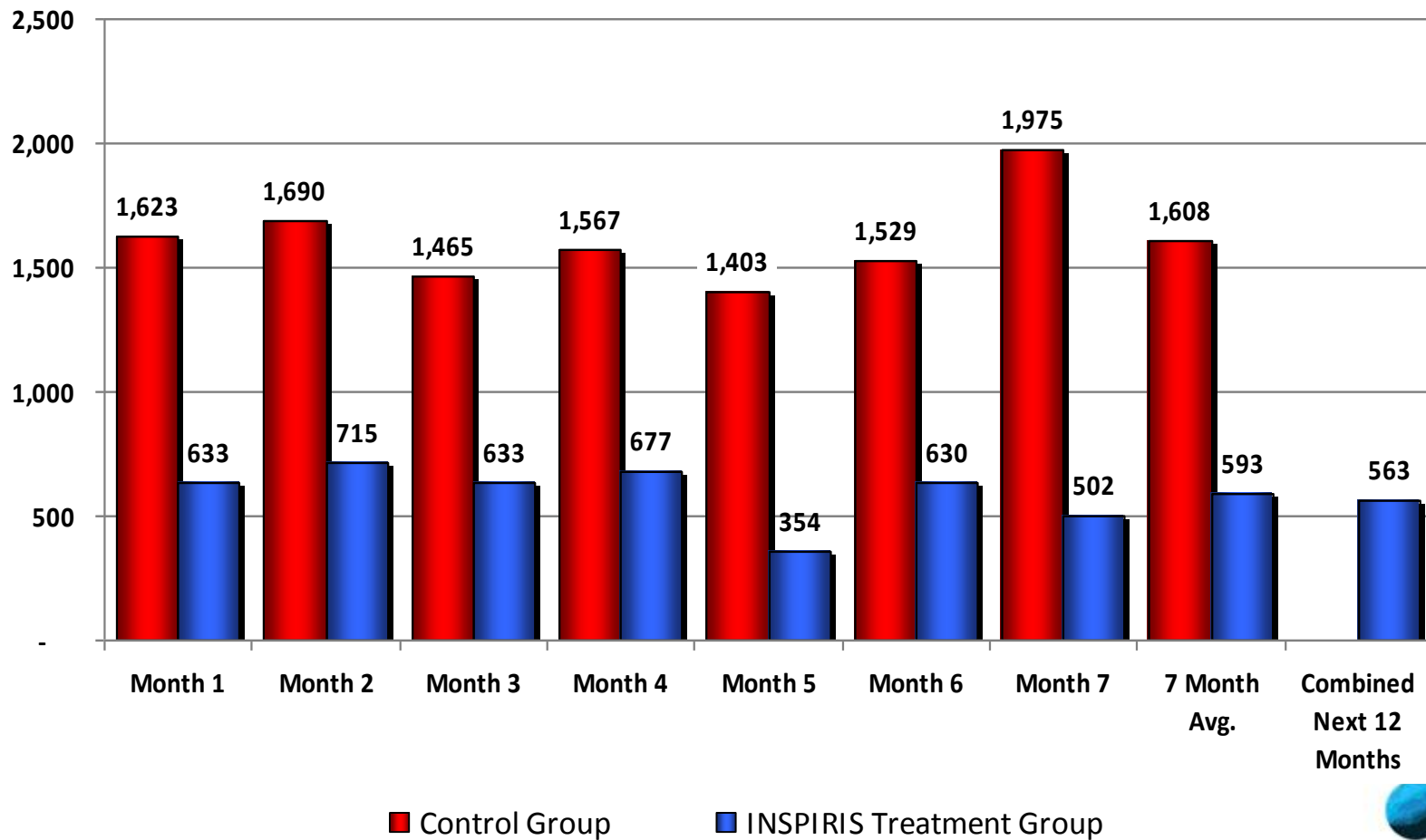
■ Baseline admits/1,000

■ Program admits/1,000

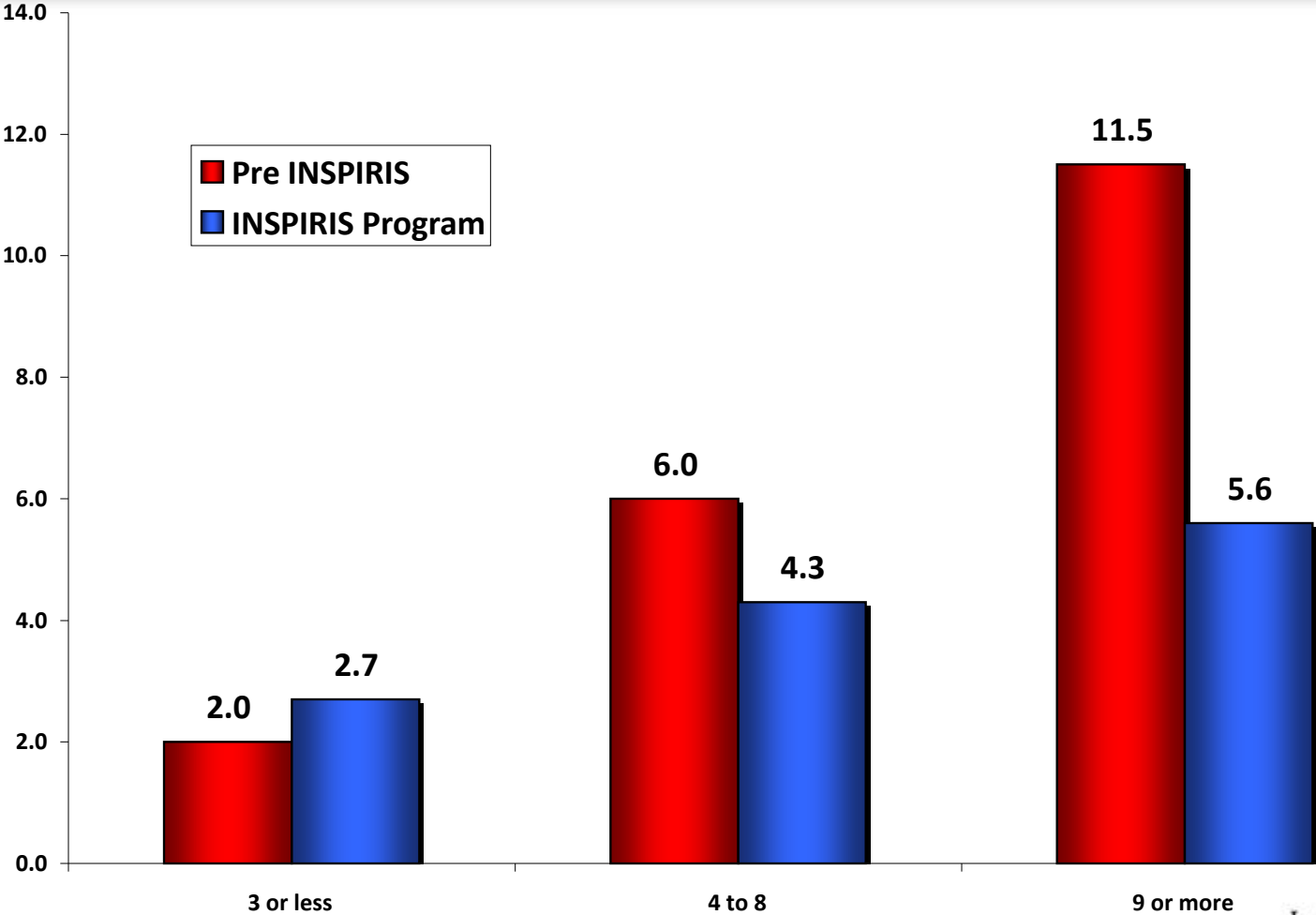


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Impact on Acute Admits – Dual SNP

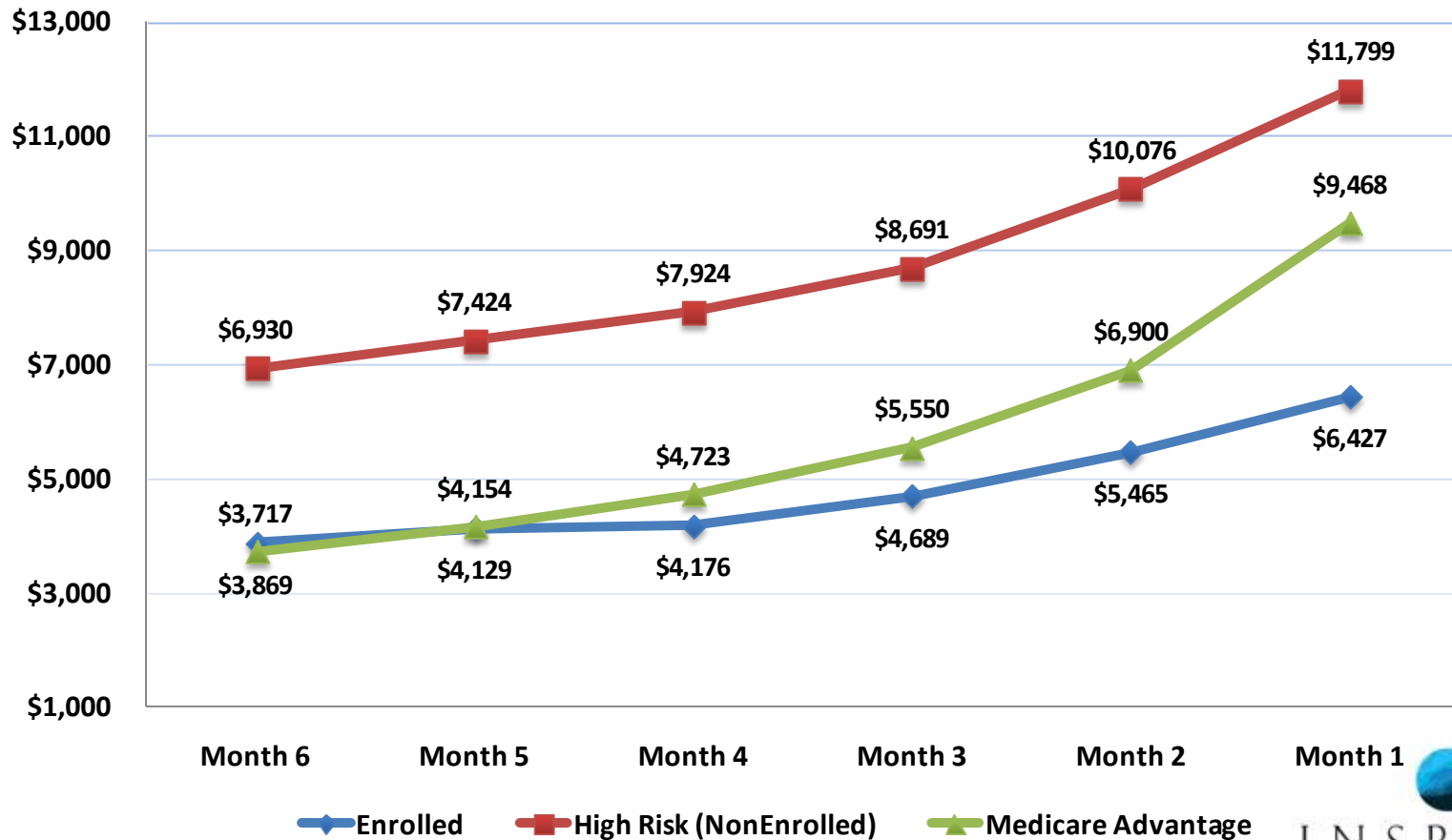


Impact on Medication Management

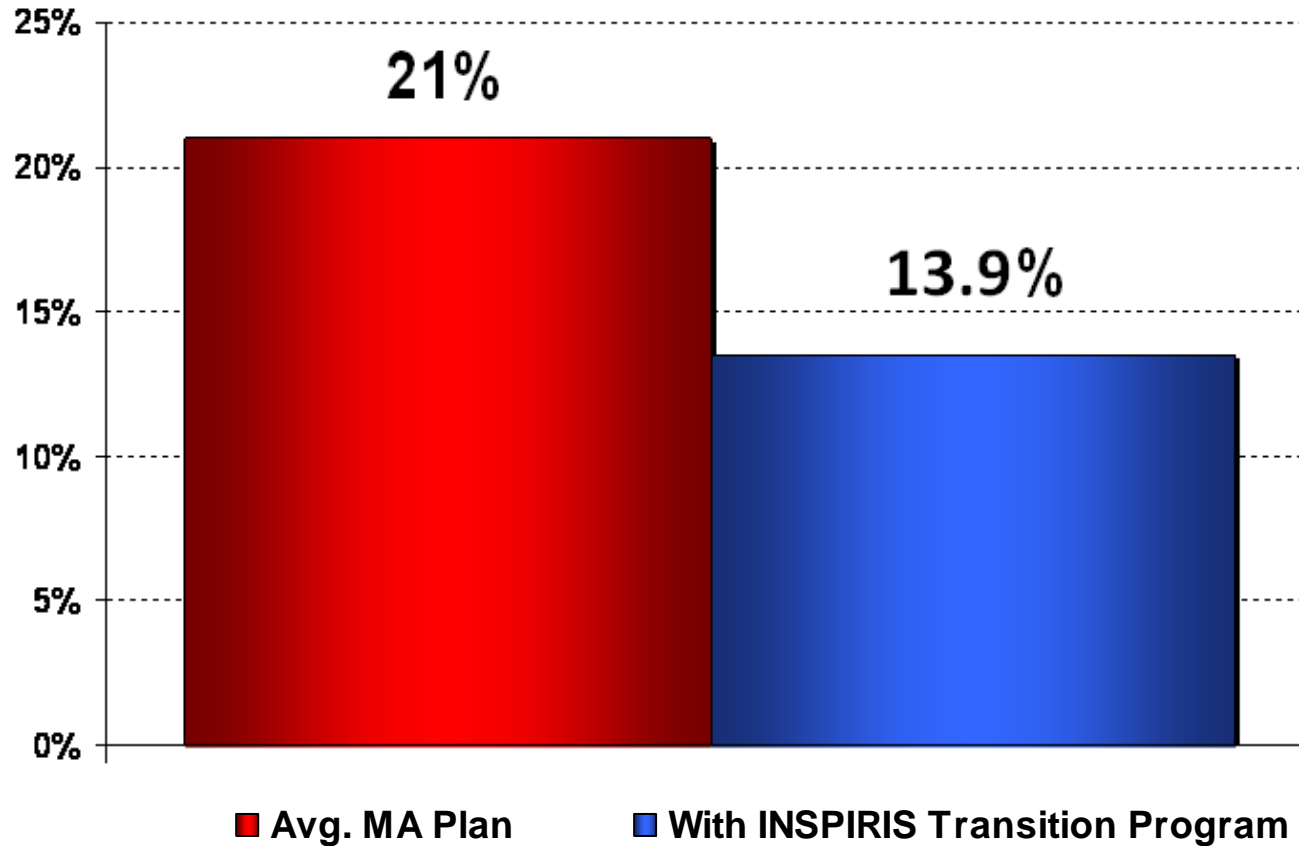


Impact on End of Life Costs – Medicare Advantage Plan

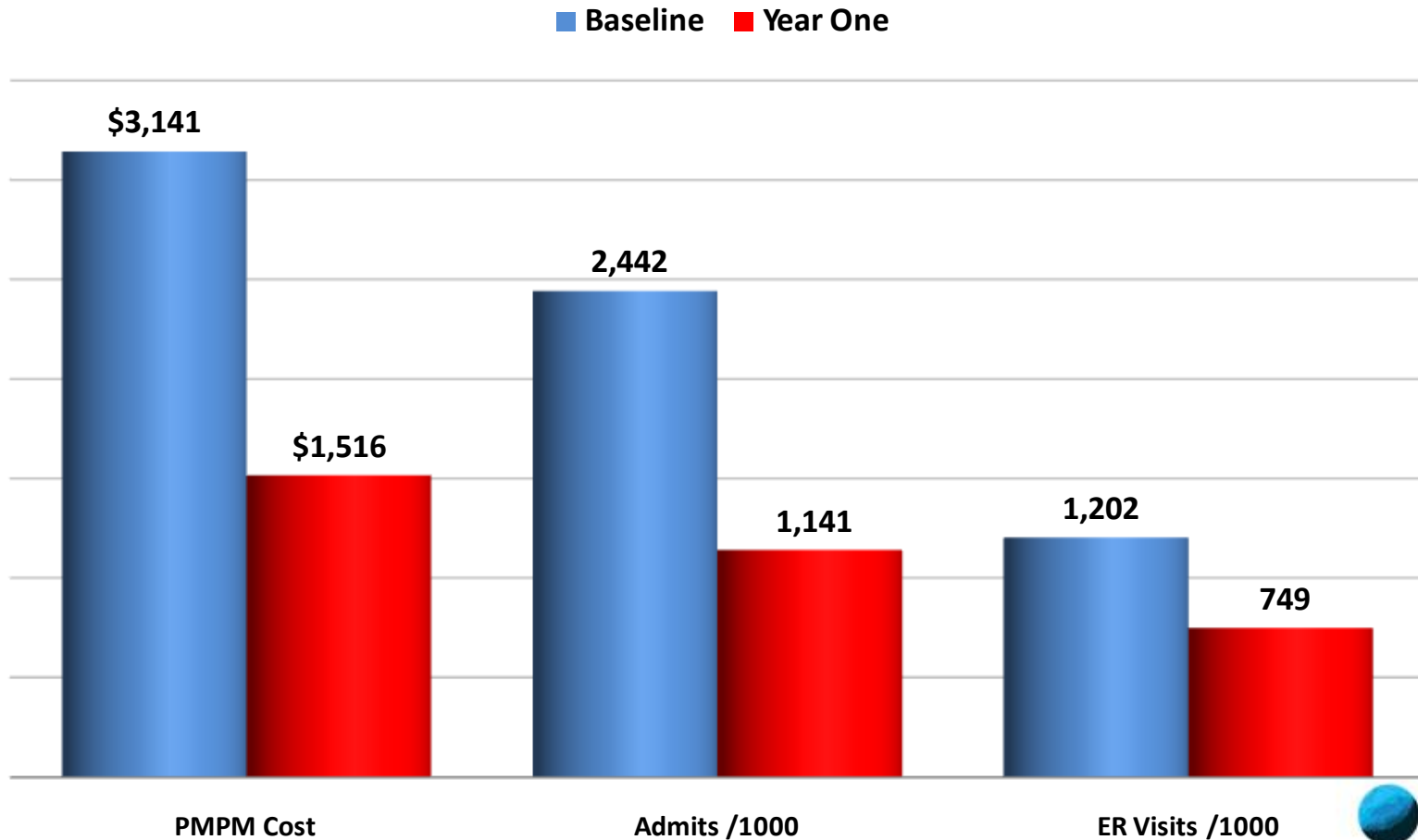
End of Life - Palliative Care



Impact on Readmissions – Medicare Advantage Plan



Impact on Total Costs & Key Utilization Metrics – Medicaid Plan (Age, Blind, Disabled Population)



New Frontiers/Growth Opportunities

- Direct to Government (85% of the high risk/high cost patients in the U.S. are not in managed care)
 - Independence at Home
 - Other pilots and demos, some pre-packaged, some home grown
 - Rapid expansion of managed Medicaid
 - 5. Recently announced dual pilot for SNF patients (custodial & post acute)
- ACOs/Exchanges
- At Risk Providers
- Hospitals (readmissions, bundled payments)