High-Performance Healthcare Network
By Aspire Integrated Healthcare

Summary
Aspire Integrated Healthcare develops and operates the High-Performance Healthcare Network with all of the solutions, tools and resources that supports the success of Employers, Providers, and healthcare systems to reduce medical cost, improve quality healthcare performance and improve the health & wellbeing of our members. Our mission is to improve the health & wellbeing of individuals by improving the quality of the healthcare delivery system. Watch our **video!**

High-Performance Healthcare Network
The Aspire High-Performance Healthcare Network is a clinically integrated healthcare provider network that is focused on high quality outcomes and cost savings initiatives. Our Providers and care teams focus on early detection, prevention, wellness programs, disease management, and post-discharge programs that reduce hospital admissions, readmissions and much more. Our Providers deliver both lower costs and higher quality healthcare services through a patient-centered medical home model that is patient-centered, evidence-based, appropriate, and coordinated. Robust data-sharing and effective quality measurement play a critical role as well in identifying providers delivering quality care at a lower cost. Quality standards for our Networks are well-defined, rigorous, and derived from sufficient data in order to drive performance delivering quality outcomes and make a substantial impact on health care spending. This study by Health System Tracker outlines the current market for employer strategies to reduce cost through a High-Performance Provider Network. The Aspire High-Performance Provider Network can reduce the Employer's total annual medical cost spend by 20% or more.

Our mission is to improve the Employers healthcare delivery system, improve employee's health, reduce long-term total medical cost and lost workdays, we recommend a new strategy for Employers to take control over their healthcare delivery and provider networks for their Employees. The Aspire Provider Network gives Employers a lifetime collaboration directly with healthcare providers for a healthcare delivery model that is based on three principles:

1. High-Performance, Integrated Healthcare Providers that are collectively accountable for the entire continuum of care for the entire Employee population, overall costs, and quality of care for Employee's.
2. Provider payment models that reward Providers for quality improvements and slow spending growth, while avoiding excessive new financial risk for Employers, and
3. Reliable performance measurement and technology tools to support improved health outcomes and lower costs that are achieved with better care.

Employer Data Analysis
Our initial Employer Analysis stage will integrate historical claims data, census data and medical information if accessible, into our AI modeling toolkit to identify high-risk employees, high-cost providers, and opportunities to implement medical cost savings initiatives. See sample here!

Employer Strategic Plan
Using the analytics results, we will develop the Employer's strategic plan that will detail the Employer's current situation and a detailed strategy to implement improvements for their employee's healthcare delivery system and medical cost reduction opportunities. Many of our Aspire programs can be implemented quickly, regardless of the Employer's current health plan or network with tax reductions using the Health Reimbursement Arrangement program.

Aspire Health Portal & App
The Aspire Health Portal is an effective and easy way to connect and enroll our customers, members, and providers. The Toolkit offers a variety of clinically based, integrated virtual health personal health and wellbeing tools that improves the health and well-being of individuals! It is easy to register here!

Employer Direct to Provider Medical Arrangements
Aspire offers the Employer Direct Medical Arrangement option which provides an alternative to traditional FFS-based primary care models, and it improves the patient-doctor relationship, reduces the fragmentation of patient care, and improves both personal and professional satisfaction for physicians. This alternative primary care arrangement generates systemwide reductions in health care utilization including hospitalization rates, emergency department usage, unnecessary radiology and diagnostic tests, and specialist care, leading to broad-based health care cost savings. Advantages of the Employer Direct to Provider are according to the study by Society of Actuaries a) reduces unnecessary healthcare services over 12%, b) reduces Emergency Room visits over 40%, and c) reduces unnecessary Hospital admissions by 20% or more!

Clinically Integrated Network

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Our Clinically Integrated Network, Technology and analytics solutions improve the performance of our Provider and care teams by sharing patient medical information for a more efficient team approach to healthcare delivery, reducing duplication of health services, improving prompt healthcare delivery, reducing unnecessary hospital and other healthcare services.

Provider Performance Standards

Robust data-sharing and effective quality measurement play a critical role as well in identifying providers delivering quality care at a lower cost. Quality standards for our Networks are well-defined, rigorous, and derived from sufficient data in order to drive performance delivering quality outcomes and make a substantial impact on health care spending. We follow the Medicare and American Family of Physician guidance on quality measure programs for our Providers.

Nationally Recognized Evidence-Based Treatment Guidelines

The American Academy of Family Physicians (AAFP) develops evidence-based clinical practice guidelines (CPGs), which serve as a framework for clinical decisions and supporting best practices. Clinical practice guidelines are statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence, and an assessment of the benefits and harms of alternative care options. CPGs should follow a sound, transparent methodology to translate best evidence into clinical practice for improved patient outcomes. Additionally, evidence-based CPGs are a key aspect of patient-centered care.

Technology Solutions

With more than 30 years' experience in clinical quality improvement and cost savings, we have the strategic advisory expertise, healthcare analytical capabilities and operational experience to help our clients determine what insights they should derive from their analytics, what actions they should take to drive improvements, and how they should prioritize and plan for success. Our solutions include clinical integration, health data analytics and modeling, provider and patient portals, virtual health and more.

Network Design & Development

We have designed a highly efficient Provider Network Development and Management process for a local or large-scale network with the ability to manage thousands of provider managed care contracts. Our Provider Selection process is determined by our client with our expert advice which includes the most current industry standards and regulatory compliance to ensure the highest quality Providers are selected, and that they continue to maintain this level of performance. We will assess the established and targeted geographic service areas to determine panel adequacy requirements and industry standards to provide the highest quality of medical care to current or potential Members. Employers to have network Provider access options such as: Tiered Narrow Networks based on quality, cost or other measures, Patient Centered Medical Home or Primary Care gatekeeper, access to a wrap PPO Network and other options.

Aspire Healthcare will contract with targeted Providers that meet the quality standards and credentialing requirements based on Medicare, URAC and NCQA provider credentialing requirements. We perform the following steps in developing each of our networks:

1. Market Research to identify the specialties and quantity of providers necessary to treat our members,
2. Utilize all available panel adequacy and capacity planning resources including the Medicare adequacy standards,
3. Research current employer customer provider panels to identify qualified providers to be in the new network to limit any provider changes for the customers or members.
4. Evaluate each Employer customer's Employee population, industry trends data, claims history data, Medicare Quality Performance Scores, employee satisfaction and overall Employer census to determine panel adequacy requirements prior to customer implementation date,

We offer Providers a simple and easy enrollment and contracting process in our Network Development efforts which include the following steps:

1. Provider contracting outreach campaigns using email, fax, and direct calling to send the Provider recruitment packet.
    a. Providers select here or an easy link for an easy online enrollment, or other system setup by you
    b. Provider contracts are emailed for easy Adobe e-sign and key terms are bookmarked for quick review using our contract management solution, with redlining and negotiation workflow tools
    c. Provider applications and credentialing process is easy and fast, using our software or access to Availity or CAQH
2. We have project management tools for network development status reporting and to track Provider contracting.
3. We have a robust new provider implementation process and continue to support new providers to achieve high-performance measures.

Network Management Value Based Model

We build partnerships with network providers that are given incentives to meet high-quality performance goals, medical cost management, integration, PCMH and care team/navigator whole person care model using nationally recognized treatment guidelines.

We will develop the provider network oversight board and committees to collaborate closely with each provider to coach, engage, collaborate and guidance to ensure they optimize treatment standards. Our Provider Relations teams collaborate closely with all

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providers. We meet and review scores and offer ways to improve them. Our advanced data analytics and provider portals and apps give each provider real-time access on our members to keep up with their health status, get notifications when health events or crisis events occur, and communicate closely with our Care team, CM UM, and oversight board.

Key components to support the Provider High-Performance goals and standards include:

1. Our focus is on the health and wellbeing of our members instead of corporate profits.
2. Patient-Centered Medical Home model with a Care Coordination team, Health and Wellness monitoring and programs have better clinical outcomes and results that prevent illness and managed our populations health better.
3. Providers use Nationally Recognized, Evidence Based Treatment Standards, we monitor their performance,
4. Provider Reimbursements are based on value, quality performance measures, shared risk options with Primary Care, and shared savings of the Employer's Population Medical Cost Trend annual reductions.
5. Direct Employer-Provider collaborative relationship have lifetime relationship results in better care and long-term medical cost management.
6. Clinical Integration, analytics and technology solutions that engage employee is in their health, and providers and care teams that promptly provide the appropriate health and wellness services for improved health outcomes.

Provider Reimbursement Models (Value Based Care)

Providers are contracted based on their quality performance using the nationally recognized Provider Performance Incentives adopted by Medicare, which include the Medicare Hospital Value-Based Purchasing (VBP) Program, Medicare Physician Quality Payment Program and the American Association of Family Physicians. Additional customize Value Based Contracts or incentive programs including pay for performance, shared savings (upside risk), shared risk (downside risk), episodic/bundled payments, and capitation/global payments. Our objective is to lessen the burden on our Providers by adopting these current VBC programs they have with other Payers. We have adopted the following Medicare Physician Quality Payment Programs and we may adopt additional VBC models based on the Providers unique situation to meet our High-Performance Network goals for our Employers. We can help each client to design the optimal provider reimbursement models:

1. Risk share arrangements
2. Value Base Care model including Pay for Performance, Alternative Payment Models, Bundled Payments and more!
3. Fee For Service

Whole-Care Model

Our care model both enhances and optimizes healthcare services by focusing our resources specifically on personalized proactive care and coordinating the information with Providers and Care Teams. We operate within our framework to manage our complete care responsibilities and then interface the meaningful data to our healthcare partners to provide the most current clinical data and trending information for action.

Population Health Management

Our Population Health platform allows users to perform Health Management and Care Management Services, including Closing Gaps in Care, Transitional Care Management, and improving evidence-based guidelines. It includes its own aggregate data analytic tools with drill down to the patient and, if available, the provider level so users can evaluate program performance at all levels and take immediate action. It also houses eRefer, a referral management tool for clients who do that type of patient outreach. We do not do any patient outreach ourselves, but support those who do to get the best outcomes.

Proactive Care Management

Care Coordination Services is our "high- touch" care management model. With hands-on, face-to-face care coordinators, the quality of care is improved, unnecessary spending is reduced, including reduced readmissions for the demographic group responsible for the highest resource utilization rates. Our care navigators help patients navigate the healthcare system and the challenges of daily living to drive better health outcomes. OverSightMD's Care Navigator solution is a market leader in empowering patients to better manage their health and overcome daily obstacles they encounter. Our care navigators are patient advocates that specialize in understanding social determinants of health and how they impact the compliance of care plans.

Member and Patient Engagement Tools

Our innovative and proprietary technology enables us to provide customized experiences for each of our clients via web, tablet, and mobile app. Our Wellness Portal can be branded with your company's logo, color scheme, content, and custom wellness program services. The Portal is a one stop solution for all things wellness, from Health Risk Assessments to wearable device synchronizing to incentive progress tracking and more. Our member and patient engagement tools let our Wellness Portal be the one stop solution for your employees to engage in their wellness program. From personalized incentive management and tracking, fitness device integration, health and mental wellbeing assessments, employee risk strategy, to e-learning with health coaching; our wellness portal provides your employees with a comprehensive, user-friendly interface and mobile app to track their success throughout their wellness program.

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Max by Aspire Health! Max is an Artificial Intelligent bot that is fun, friendly and does not just ask for feedback, it offers healthcare solutions based on that feedback! Research indicates that some people will be more open about their feelings and health with a bot instead of a person.

Employee Health Risk Assessment

Precision medicine is only possible when there is a complete picture of a patient's health, including medical decisions, treatments, practices, and products so healthcare can be customized for each individual. Our clinical expert partners will conduct a comprehensive whole person assessment (body, mental, lifestyle and social determinants) to establish an effective care plan with your Employees, our care teams, and the Providers.

Behavioral Health Network

We are developing a new Aspire Behavioral Health Network Behavioral Health Provider Network integrates with primary care and the entire care team. Patients demonstrate improved outcomes when physical and mental health are treated together in an integrated care model. This network includes the Videra Health solutions for these providers, and our providers can also support those Videra Health clients that do not have OP Behavioral Health providers. Aspire Providers are included in the Aspire Mental Health Toolkit for Hospitals, Employers, Networks, Medical Groups, ACO's, Communities, Schools, and other target customers. This is a new revenue opportunity for Behavioral Health providers to help reduce hospital admissions and improve outcomes using our Videra Health remote patient monitoring tool. Watch the video!

> *The Aspire Mental Health Toolkit offers a variety of clinically integrated virtual health, telehealth, analytics, assessments, patient monitoring, provider and personal mental health tools that improves quality outcomes through enhanced Mental Health & Wellbeing care programs. Our solutions combined with Health & Wellness Behavioral Risk Assessment's (HRA) represents a groundbreaking approach proactively diagnosing and subsequently treating Mental Health issues more effectively, reducing hospital admissions and improving quality outcome measures. Watch our video!*

Employer Data Analysis Sample

Cost Savings from implementing an Employer Direct Provider Medical Arrangement (PCP only)

APC Estimated Savings - 75% Participation

(1,250 Insured and $13,122,011 Total Medical Spend – 18 Months)

The APC estimated cost and/or savings based on a 75% participation ranged from -$278K to $1.1m.

Replacement Percentage	75%								
			18-Month Analysis						
Service Benchmark	**% T-Spend**	**Gross $**	**Adjusted $**	**From%[2,3,4,5]**	**To%[2,3,4,5]**	**From$**	**To$**	**% Spend**	
In/Out-Patient Services	67.0%	$8,793,936	$6,595,452	-15%	-25%	($989,318)	($1,648,863)	-7.5%	-12.6%
Pharmacy	15.9%	$2,081,787	$1,561,340	-10%	-20%	($156,134)	($312,268)	-1.2%	-2.4%
Specialists	3.1%	$407,362	$305,521	-15%	-30%	($45,828)	($91,656)	-0.3%	-0.7%
Primary Care	1.8%	$231,431				($173,573)	($173,573)	-1.3%	-1.3%
Other Non Fac Services*	12.3%	$1,241,202							
	100.0%	**$13,122,011**	**$9,841,508**			**($1,364,853)**	**($2,226,360)**		
Non-Claims Based Displacement Costs									
Displacement TPA B LCM/CC Mgmt (PMPM)**	$0.00	$0							
Telemed/Telehealth (PEPM)**	$0.00	$0							
Total Non-Claims Cost									
Total Savings						($1,364,853)	($2,226,360)	-10.4%	-17.0%
PMPM APC Services	$65.00					$1,086,833	$1,086,833	8.3%	8.3%
Potential Savings Through APC/APC					**Savings $**	**($278,020)**	**($1,139,528)**	**-2.1%**	**-8.7%**
					Savings PMPM	**($12.47)**	**($51.11)**		

Savings calculations are based on:

- **Variables in blue colored cells**
- **Primary Care: Percent & Money of Non-APC PC displaced by APC penetration**
- ****Heath Management program costs being displaced by APC did not apply for this population**
  - Excludes Chronic Care, Large Case, Telehealth, Behavioral Health & Maternity, Pre-authorization & Concurrent Review, & any other programs like Smart Shopper type programs.
  - Dollar Savings are based on Adjusted Spend
  - **% Savings are based on Gross (Not Adjusted Med$)**
- Benchmarks (see page 15) for Benchmark Reference sources cited
- Variable participation rates as designated
- APC CPT code identification and medical event logic
- MM = Member Months
- *Non-Facility (anything designated as a facility, e.g., inpatient, outpatient hospital, ambulatory surgical centers, etc. = not provided in a facility setting
- An 18-month calculation was used to mitigate confounding factors

Population			
Insured	**Member Months**	**Med$**	**PMPM**
1,250	22,294	$11,040,224	$495.21
Subscribers	**Member Months**	**Med$**	**PMPM**
500	8,926	$4,044,975	$453.17

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Portal Dashboard - Member

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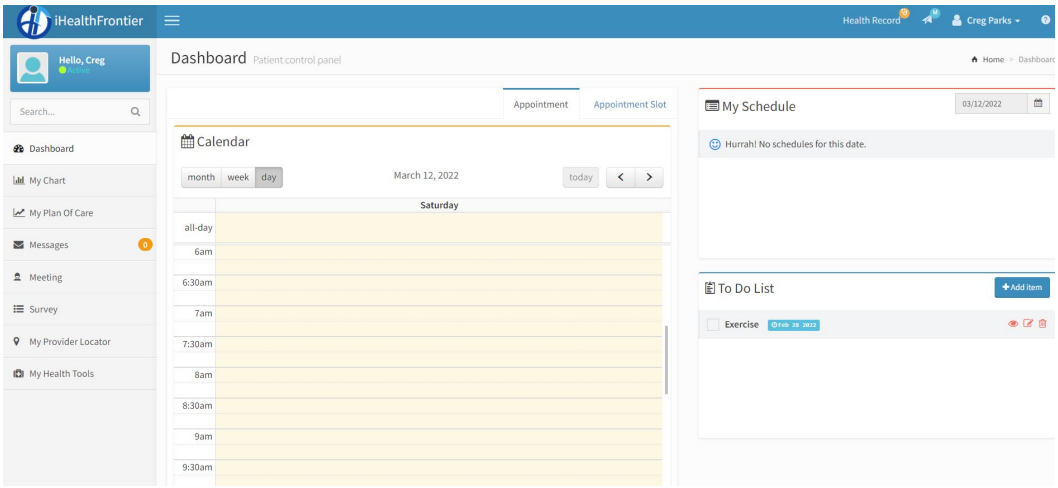
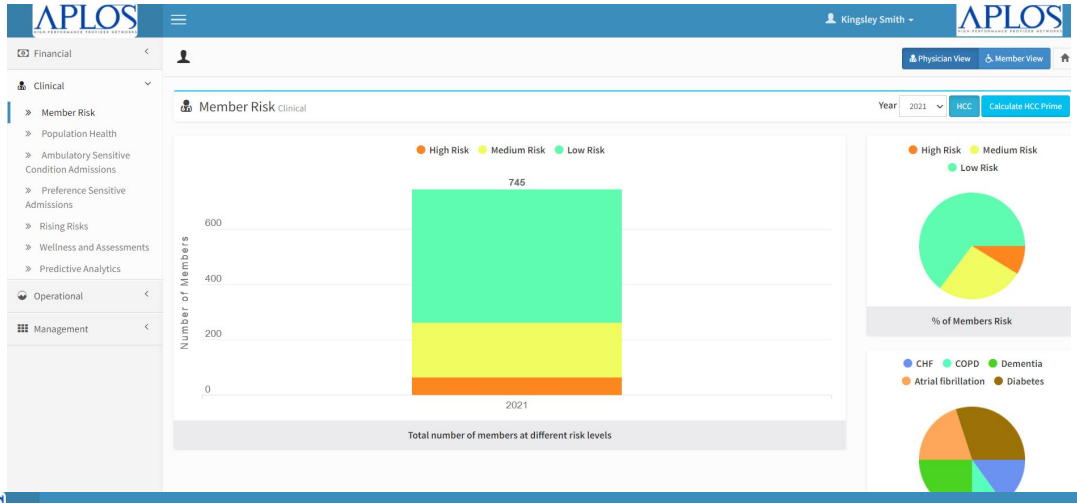


Portal Dashboard - Provider



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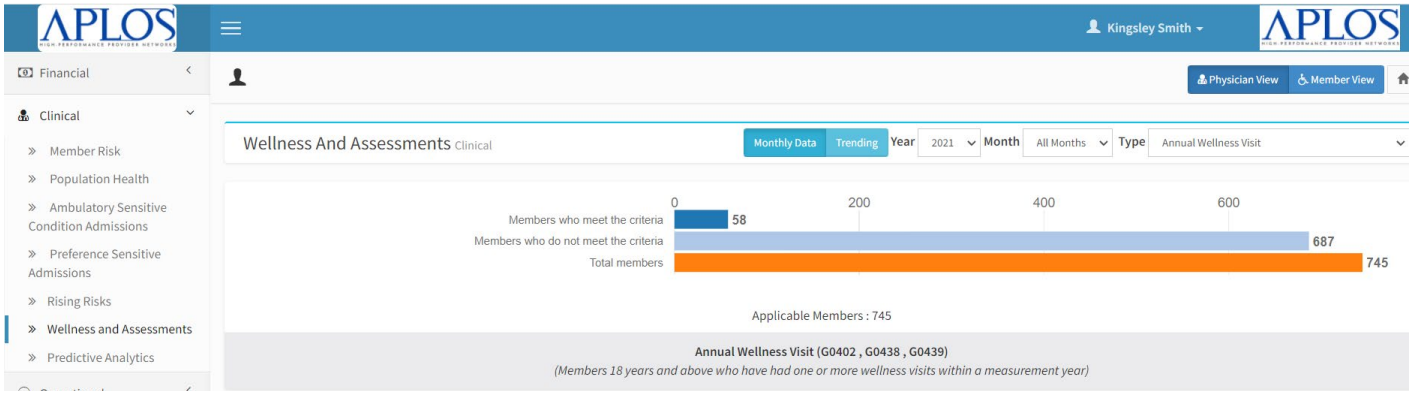
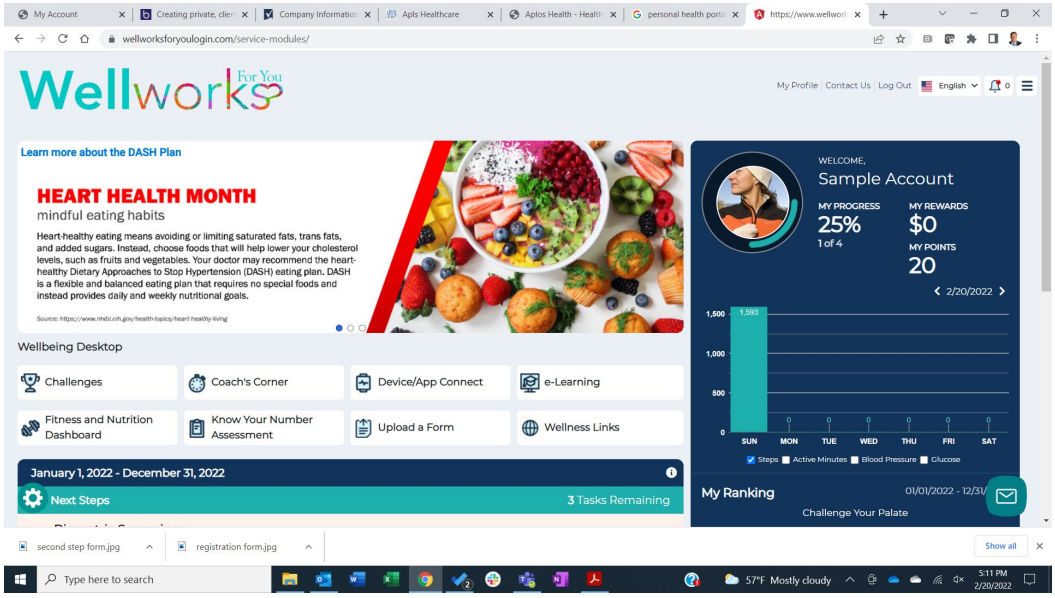
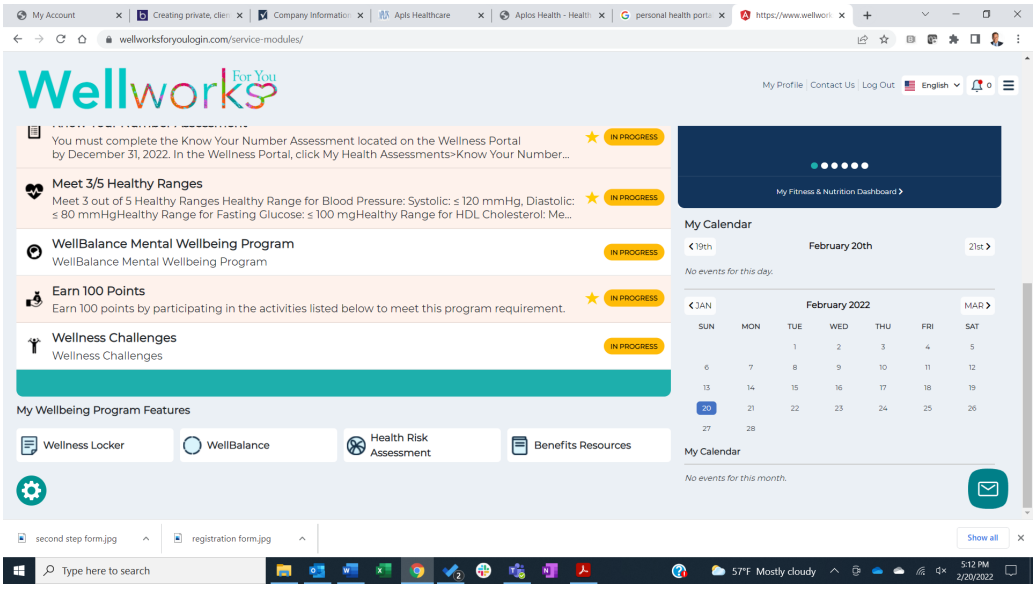


Wellworks Health, Wellness & WellBallance Portal





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Our Partners and Affiliates

- iHealthFrontier is our technology partner that powers the Aspire Healthcare Technology solutions that include clinical integration, patient-provider portals, analytics, population health management and more.

- MyCatalyst is our technology partner that provides system and service support for data warehousing, integration, population health, prescriptive and actionable analytics, and meaningful reporting, resulting in optimal financial and healthcare outcomes for populations served. Our reputation is based on clean and accurate data integration, and collaborative problem solving to ensure client and program success.

- WellBallance by WellWorks For You - our WellBallance solution helps Individuals to engage in their mental health & wellbeing program. From personalized incentive management and tracking, fitness device integration, health and mental wellbeing assessments, employee risk strategy, to e-learning with health coaching; our portal provides you with a comprehensive, user-friendly interface and mobile app to track your success throughout your health program.

- Symptomate by Infermedica is our Health Symptom Checker - your body is sending you important signals about your health. Understand, manage, and get health and medical care for symptoms with trusted medical expertise in minutes. Powered by Infermedica. You can share results with your healthcare Provider!

- Humaxa is the developer of Max, our chatbot that communicates with our members and providers to support our goals to improve the health and well-being of our members and customers.

- Videra Health - The Videra Health platform enables providers to monitor and measure healthcare interactions through automated clinical workflows (screenings, monitoring, evaluations, follow-ups, triage). Leveraging asynchronous video, Artificial Intelligence powered analytics, and automation, providers can improve their efficiency and reach while receiving valuable insight about patients to intervene and improve quality mental health outcome measures. Install App!

- Medicus Telehealth is our Tele-Psych partner by Dr. Shawn Ghodsian our Medical Director. Medicus is the first and only treatment program that allows clients to obtain complete substance abuse treatment, mental health treatment or both in the comfort of their own home through live bi-directional video. Treatment includes integrated pain management, neurology, medical and psychiatry specialists to treat all aspects of a disorder. The program has undergone rigorous clinical trials to ensure its safety and effectiveness.

- Opeeka - has developed the Person-Centered Intelligence Solution which allows progress tracking on any domain of well-being. This tool is an assessment and outcomes management tool designed to help social and human services and mental/behavioral health care agencies and their staff to plan and guide person-centered care while measuring progress along personal trajectories of recovery and resilience.

- Azara Healthcare - leading provider of data-driven analytics, quality measurement and reporting for more than 1,000 Community Health Centers, physician practices, Primary Care Associations, Health Center Controlled Networks, and clinically integrated networks in thirty-six states to improve the quality and efficiency of care for more than twenty-five million Americans through actionable data.

- OversightMD is a national leader in proactive care management and has become the platform to establish a continuum of care solution for our clients and partners. Our TeleCare Enterprise platform provides a comprehensive product and services suite that empowers hospitals, managed care organizations, post-acute providers, and in-home care companies to function as proactive healthcare delivery systems with the primary goals of reducing hospital readmissions and improving patient care.

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