Reference Slides

- Medicare’s Market Changing Influence
- Payer-Dominant Market Strategies
- Provider-Dominant Strategies


- Marketplace Dynamics Five Years After the Affordable Care Act
### Reading the Puck in Healthcare Today and Tomorrow

#### LEVEL OF CRITICAL MASS LEADS MARKET ACCELERATION
- Critical Mass of and between Physicians/Physician Groups
- Critical Mass of and between Physicians/Hospitals
- Critical Mass between Physicians & Hospitals/Payers

#### DIRECTION
- Declining Reimbursement
- Increased Clinical Risk
- Narrow Networks
- Greater Transparency
- Enhanced Connectivity

#### EXTERNAL FORCES
- Consumer Choice and Access
- Payer Metamorphosis
- Provider Consolidation
- Primacy of Primary Care
- New Care Delivery Options (Think, One)

### Significant Shifts in Value Based Payer Reimbursement Occurring*

<table>
<thead>
<tr>
<th>Pre-2014</th>
<th>ACA “ROLLOUT”</th>
<th>2015 and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ERISA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>Medicaid</td>
<td>18%</td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>Uninsured</td>
<td>12%</td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>25%</td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>Medicare MA</td>
<td>25%</td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>Medicaid VBP</td>
<td>25%</td>
<td>$%^&amp;</td>
</tr>
<tr>
<td>MA Products</td>
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<td>$%^&amp;</td>
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<tr>
<td>Medicare FFS VBP</td>
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<tr>
<td>Public Exchanges</td>
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<td>$%^&amp;</td>
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<tr>
<td>VBP</td>
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<td>$%^&amp;</td>
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<tr>
<td>ERISA VBP</td>
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<td>$%^&amp;</td>
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<tr>
<td>Care Delivery</td>
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<td>$%^&amp;</td>
</tr>
<tr>
<td>Planned/Unplanned</td>
<td></td>
<td>$%^&amp;</td>
</tr>
</tbody>
</table>

* Source: Developed from SSB Proprietary Data Base 2014

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**KEY TAKEAWAY:**
These are preliminary estimates of how payer mix will be changing in the typical market as a result of payment reforms.
Physician Leadership and Engagement Essential to CIN Success

**KEY TAKEAWAY**
Aligned physicians will need to become engaged in all facets of CIN development and will need to provide significant clinical leadership.

- Governance and Leadership
  - Effective governance and management
  - Member education and engagement
  - Managing member dynamics and relationships

- Medical Staff Collaboration
  - Staff education and engagement
  - Integrating/collaborating with CIN quality initiatives
  - Delegated functionality

- Clinical Integration and Performance Improvement
  - Population Health Management and Value-Based clinical models
  - Care transformation
  - Care coordination
  - Provider compensation
  - Enabling technology
  - Performance tracking

---

Value-Based Contracting Requires FTC-Compliant “Clinical Integration”

**KEY TAKEAWAY**
For the hospital and affiliated physicians to engage in joint, value-based contracting, they collectively must meet FTC requirements for “clinical integration,” which covers a combination of organizational and legal touchstones. CIN will need a formal organization structure (usually an LLC) and provider participation agreements that define participation requirements and performance expectations for network service providers.

- Clinical Scope
  - Encompasses full continuum of care (inpatient, outpatient, alternative care, and collaborative care settings)

- Performance Improvement
  - Designed to improve quality and reduce costs through protocols adherence supported by comprehensive data collection and reporting

- Capital Requirements
  - Significant investment required to develop and deploy technology infrastructure (clinical and financial) to support improved care delivery

- Market Power Concentration
  - Clinically integrated networks which materially reduce competition may be subject to challenge

- Fraud and Abuse Issues
  - Must satisfy Anti-Kickback Statute and Stark rules

- State Licensing/Regulatory Requirements
  - Must comply with all state licensing and regulatory requirements with regard to ownership, financial arrangement and other statutes
New Capabilities and Priorities Required by Providers

**TRIPLE AIM**
- Product and Contracting Strategy
- Provider Group/System

**CARE COORDINATION**
- Population health analytics
- Deployment of best-practices
- Active patient engagement and communications
- Care transitions
- Quality tracking and reporting
- Communication among providers

**SUPPORTING INFRASTRUCTURE AND TECHNOLOGY**
- Geographic coverage
- Continuum of services
- Patient attribution
- Performance analytics
- Credentialing
- Ongoing provider communications

---

Evolution of PHM Networks and Associated Capabilities

To stay competitive, providers are compelled to move up the curve ahead of changing market so core capabilities are in place to accept value-based contracts

**Quality**
- Documentation
  - Implement EHR
  - Collect data at point-of-care
  - Focus on episodic care
- Organization and Measurement
  - Aggregate and normalize data
  - Measure against payer-driven programs
  - Focus on overall organizational performance
- Collaboration and Improvement
  - Target high-value opportunities
  - Prioritize high-risk patients
  - Initiate care management
  - Identify gaps in care
  - Patient outreach
- Optimize Clinical and Financial Outcomes
  - Utilize predictive modeling
  - Assess organizational risk
  - Manage cost and utilization
  - Improve the patient experience

**Aggregation and Measurement**
- Pay for Performance (Shared Incentives)
- Bundled Payments
- Capitation

---

Spring Managed Care Forum | April 2016

PROPRIETARY AND CONFIDENTIAL

8/30/2016
Critical Infrastructure and Technology Needs for CINs/ACOs

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Key Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population and Clinical Risk Management</strong></td>
<td>Quantify patient risk, input to risk-adjusted payment methods, and ability to predict/tailor care needs and enable greater risk-sharing.</td>
<td>Predictive modeling, Patient stratification, Clinical risk quantification, Patient attribution analysis.</td>
</tr>
<tr>
<td><strong>Financial and Network Management</strong></td>
<td>Facilitate transfer, disbursement, incentive alignment, and contract management of value-based payments. Tightly track costs across the care continuum to support operation of a high-performing network.</td>
<td>Novel reimbursement model support, Network assessment, Contract development, Patient financial management.</td>
</tr>
<tr>
<td><strong>Clinical Model Design and Management</strong></td>
<td>Promote evidence-based care delivery, enable tighter care coordination, support for integrated treatment planning, and cost-effective use of resources and settings.</td>
<td>Clinical process development, EBM pathway development, Protocol management, Bundled payment care management models, Care coordination/transitions of care.</td>
</tr>
<tr>
<td><strong>Core Clinical Technology Infrastructure</strong></td>
<td>Deploy and leverage robust clinical technology infrastructure to create seamless clinical integration across acute and ambulatory settings.</td>
<td>Interoperable EMR, Shared clinical and administrative documentation, Referral and network management, POC decision support, Bundled payment tracking and reporting.</td>
</tr>
<tr>
<td><strong>Integrated Data Exchange</strong></td>
<td>Ensure integrated, secure, timely access to clinical and administrative data.</td>
<td>Integrated access to clinical, financial, and administrative data – e.g. claims, encounter, cost/quality, EBM guidelines.</td>
</tr>
<tr>
<td><strong>Patient Engagement</strong></td>
<td>Enable patient-focused programs and tools that promote self-management and allow for cost and quality-conscious healthcare decisions, particularly for at-risk and chronically ill patients.</td>
<td>Patient navigation and care collaboration, Intelligent scheduling/tracking/monitoring/alerts, Shared decision making, Information portals.</td>
</tr>
</tbody>
</table>
Four PHM Purchase Categories for Providers

**ENTERPRISE DEVELOPMENT PLATFORM**

Integrated data capture, analytics and communications platform to be used by multiple constituencies across the enterprise

Examples
- Caradigm
- Health Catalyst
- Healthcare Data Works
- Recombinant (Deloitte)
- IBM

**ANALYTICS-AS-A-SERVICE**

Outsourced PHM analytics and data management to support PHM strategies and benchmarking

Examples
- Explorys
- Humedica
- Lumeris
- Premier (Verisk)
- Truven

**POINT SOLUTIONS**

Standalone components with narrow but deep functionality and subject matter expertise

Examples
- Altasoft
- Medventive
- Medas+
- MedeAnalytics
- Cloudera

**EMR SUB-MODULE**

Integrated PHM analytic and process routines within the provider's EMR

Examples
- Epic
- Cerner
- MEDITECH
- Allscripts

Source: Adapted material from the Advisory Board “Overview of the Healthcare Analytics Market” (2014)

http://www.slideshare.net/elcid84/phmslideshare2014?qid=331b8a6e-df33-4f6b-8bbf-ee7bc139c465&v=default&b=&from_search=3

Transition from FFS to Value Based Care Accelerates Consolidation – Growth of Healthcare M&A Deals 1995 - 2015

Value $425B in 2015
24% off total U.S. M&A deals

Source: WSJ October 28, 2015
Value-Based Market Dynamics Lead to Healthcare Consolidation

Acquisitions targeting U.S. health-related companies are helping drive what could be a record year for M&A transactions.

**PHARMA & BIOTECH** Walmart and others have struck more than $240 billion worth of U.S. deals this year.

**HOSPITALS** Tenet and rival hospital operators are starting to consolidate the still fragmented industry.

**INSURANCE** The proposed Aetna-Humana and Anthem-Cigna tie-ups leave three U.S. giants.

**DRUG STORES** Walgreens Boots’ $9.4 billion purchase of Rite Aid would create a chain with over 12,000 U.S. locations.

For the 3rd Consecutive Year, the Three Most-placed Providers Were Family Medicine, Internal Medicine And Hospitalists

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Medicine</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>2. Hospitalist</td>
<td>Hospitalist</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>3. Internal Medicine</td>
<td>Internal Medicine</td>
<td>Hospitalist</td>
</tr>
<tr>
<td>4. Gastroenterology</td>
<td>Obstetrics/Gynecology</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>5. Orthopedic Surgery</td>
<td>Physician Assistant</td>
<td>Obstetrics/Gynecology</td>
</tr>
<tr>
<td>6. Physician Assistant</td>
<td>Pediatrics</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>7. Neurology</td>
<td>Orthopedic Surgery</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>8. Gastroenterology</td>
<td>Cardio-Thoracic Surgery</td>
<td>General Surgery</td>
</tr>
<tr>
<td>9. Psychiatry</td>
<td>Gastroenterology</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>10. Obstetrics/Gynecology</td>
<td>Neurology</td>
<td>Pulmonary Critical Care</td>
</tr>
</tbody>
</table>

Placement Specialties 2016. Source: The Medicus Firm
**Medicare’s Market Changing Influence**

- FFS Medicare
- Medicare Shared Savings Program (MSSP)
- “Next Generation” MSSP
- Medicare Advantage Plan

**Federal Healthcare Costs Rising**

*Medicare and Health as a Percent of Total Federal Spending (Fiscal Years 1976-2015)*

Source: OMB
National Priorities Project

Est. 27.7% in 2015
Financial Funds Flow—MSSP Plan

Medicare Shared Savings Program

CMS pays a portion of shared savings to the CIN (ACO) savings achieved based on:
- Cost performance for attributed beneficiaries
- Meeting quality performance metrics

CIN (ACO) pays Care Management Fees to PCPs for care coordination

CMS makes Medicare FFS payments directly to providers

Physicians

Hospital

CIN LLC

CIN distributes Incentive payments and bonuses

Medicare MSSP Revenue Attributes

- Medicare pays claims and provides claims data information to CIN (ACO)
- Retrospective reconciliation to determine the level of shared savings
- CIN Board establishes policies re: reserves, surplus distribution, risk management, etc.

CMS pays a portion of shared savings to the CIN (ACO) savings achieved based on:
- Cost performance for attributed beneficiaries
- Meeting quality performance metrics

CIN (ACO) pays Care Management Fees to PCPs for care coordination

CMS makes Medicare FFS payments directly to providers

Physicians

Hospital

CIN LLC

CIN distributes Incentive payments and bonuses

MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO × Track 1: 50% Track 2: 60% Track 3: 75% Performance Score Earned by ACO = MSSP Shared Savings Award Paid to ACO

Patient/Caregiver Experience (7 metrics)

Care Coordination

Patient Safety (6 metrics)

Preventative Health (8 metrics)

Managing At-Risk Populations (12 metrics)

ACO Benchmark $S

ACO Actual $S

Part A and Part B claims for beneficiaries attributed to the ACO
Benchmark projection based on 3 years of CMS data

In Year 1, requirement is complete and accurate reporting on all measures
In Years 2 and 3, a performance score is calculated for the ACO

ACO Portion of Shared Savings

ACO Portion of Shared Savings

Physicians

Hospital

Total award is capped at a % of Benchmark expenditures depending upon chosen track (Track 1: 10%, Track 2: 15%, Track 3: 20%)
Calculation of award occurs 6-9 months after end of year.

33 Total Performance Metrics
### Detailed Example | MSSP vs. Next Generation Quality Score

**What is the same?**
- The Quality Score for a Next Generation ACO is similar to the methodology used in an MSSP ACO:
  - Both programs use the same four domains (Patient/Care Giver Experience, Care Coordination/Patient Safety, Preventative Health, At Risk Populations)
  - The 32 Next Generation ACO quality metrics are the same as those used in the MSSP ACO program
  - The same methodology is used to calculate the Quality Score across the four domains

**What is different?**
- The Quality Score for Next Generation ACOs does not include the EHR metric as participants are expected to have met this performance metric
  - MSSP ACP program applies the Quality Score to the calculated savings while the Next Generation ACO program applies the quality score as a factor in adjusting the baseline costs to the benchmark

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>100%</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Achieved Savings</td>
<td>$50.0 million</td>
<td>$50.0 million</td>
</tr>
<tr>
<td>Available MSSP ACO Share (Track 1 50%)</td>
<td>$25.0 million</td>
<td>$25.0 million</td>
</tr>
<tr>
<td>Quality Score Factor</td>
<td>1.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Shared Savings (Available Share X Quality Factor)</td>
<td>$25.0 million</td>
<td>$17.5 million</td>
</tr>
</tbody>
</table>

30% reduction in the Quality Score reduces shared savings by $7.5 million

### Detailed Example | MSSP vs. Next Generation Quality Score

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>100%</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline PMPM</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>PMPM Adj. For Cost Trend (+1.5%)/Risk Score (+2.0%)</td>
<td>$1,035</td>
<td>$1,035</td>
</tr>
<tr>
<td>Quality Score</td>
<td>1.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Quality Discount [2%+(1-Quality Score)]</td>
<td>-2.0%</td>
<td>-2.3%</td>
</tr>
<tr>
<td>Benchmark PMPM</td>
<td>$1,015</td>
<td>$1,011</td>
</tr>
<tr>
<td>Covered Lives</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Benchmark</td>
<td>$1,218 B</td>
<td>$1,213 2 B</td>
</tr>
<tr>
<td>Actual Cost ($50MM savings from Baseline adjusted for risk score/cost trend)</td>
<td>$1.168 B</td>
<td>$1.168 B</td>
</tr>
<tr>
<td>Surplus</td>
<td>$50,000,000</td>
<td>$45,200,000</td>
</tr>
<tr>
<td>Shared Savings (80% Track)</td>
<td>$40,000,000</td>
<td>$36,160,000</td>
</tr>
</tbody>
</table>

Note: Assumes Regional and National Efficiency adjustments are neutral.

Impact: -$3.84 million
Next Generation ACO Fact Sheet

CMS selected 21 organizations to participate in the NGACO model:

<table>
<thead>
<tr>
<th>NGACO Model Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Coalition of Southeast Texas Inc.</td>
<td>Houston, Texas</td>
</tr>
<tr>
<td>Barona Accountable Care, LLC</td>
<td>Miami, Florida</td>
</tr>
<tr>
<td>Beacon Health</td>
<td>Brewer, Maine</td>
</tr>
<tr>
<td>Bellin Health DBA Physician Partners</td>
<td>Green Bay, Wisconsin</td>
</tr>
<tr>
<td>Cornerstone Health Enablement Strategic Solutions (CHESS)</td>
<td>High Point, North Carolina</td>
</tr>
<tr>
<td>Deaconess Care Integration</td>
<td>Evansville, Indiana</td>
</tr>
<tr>
<td>Henry Ford Physician Accountable Care Organization</td>
<td>Detroit, Michigan</td>
</tr>
<tr>
<td>Iowa Health Accountable Care</td>
<td>West Des Moines, Iowa</td>
</tr>
<tr>
<td>Optum Accountable Care Organization</td>
<td>Phoenix, Arizona</td>
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<tr>
<td>MemorialCare Regional ACO</td>
<td>Fountain Valley, California</td>
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<tr>
<td>OSF Healthcare System</td>
<td>Peoria, Illinois</td>
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<tr>
<td>Park Nicollet Health Services</td>
<td>St. Louis Park, Minnesota</td>
</tr>
<tr>
<td>Pioneer Valley Accountable Care</td>
<td>Springfield, Massachusetts</td>
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<tr>
<td>Prospect ACO CA</td>
<td>Los Angeles, California</td>
</tr>
<tr>
<td>Regal Medical Group</td>
<td>Northridge, California</td>
</tr>
<tr>
<td>River Health ACO</td>
<td>Harrisburg, Pennsylvania</td>
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<tr>
<td>Steward Integrated Care Network</td>
<td>Boston, Massachusetts</td>
</tr>
<tr>
<td>ThedaCare ACO</td>
<td>Appleton, Wisconsin</td>
</tr>
<tr>
<td>TriadHealthCare Network</td>
<td>Greensboro, North Carolina</td>
</tr>
<tr>
<td>Trinity Health ACO</td>
<td>Livonia, Michigan</td>
</tr>
<tr>
<td>WakeMed Key Community Care</td>
<td>Raleigh, North Carolina</td>
</tr>
</tbody>
</table>

Payer-Dominant Market Strategies

- National Perspective
- Aetna Example
- Optum Example
Ranking of the Top 15 Health Plans by Market Share*

Rank and Insurer
1) UnitedHealth Group
2) Kaiser Foundation Group
3) Anthem Inc.
4) Aetna Group
5) Humana Group
6) HCSC Group
7) Cigna Health Group
8) Highmark Group
9) Blue Shield of California Group
10) Independence Blue Cross Group
11) Centene Corp Group
12) HIP Insurance Group
13) BCBS of New Jersey Group
14) BCBS of Michigan Group
15) Guidewell Mutual Holdings Group

Source: National Association Of Insurance Commissioners

Aetna Imperative: “Our Business Must Evolve”

Insurance company
End user an employee or part of a larger population
Managing risk

Health care company
End user increasingly an individual with personalized care needs
Managing health
Healthagen Strategy: Enable Transformation of Care Delivery

- Population-based clinical intelligence, decision support and alerts
- Accountable Care Solutions
- Cost comparison and transparency tool
- Clinical Data Integration
- Secure Data Exchange
- Healthagen
- Compiles and transforms healthcare data into powerful, meaningful and actionable information
- Value-based care models for primary care physicians
- WellMatch
- Consumer facing tools for managing health and benefits
- bswift
- iTriage
- PayFlex

Three Pillars of Aetna’s Value-Based Care Model

**Plan Design**
- Offer narrow network plans designed to save customers 8-15% in the first year
- Employees access care through a tiered plan in which there is a financial incentive to use providers within the ACO

**Cost Structure and Volume Improvements**
- Providers discount their rates in exchange for Aetna marketing a plan whose preferred tier providers are all participants in the ACO
- Competitively priced health plan brings more volume to the provider network

**Clinical/Administrative Efficiencies**
- Technology and care management reduce waste, identify gaps in care, and improve the patient experience
- Where needed, Aetna offers providers proven tools and business services for making the transition from volume to value
Aetna’s Provider Collaborations

Aetna reports 200+ negotiations underway with potential ACO partners in markets covering 60% of the US population.

Aetna Worldview: Future State of Healthcare

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYER GOVERNMENT</strong></td>
<td>“Social contract” drives defined benefit</td>
</tr>
<tr>
<td><strong>PROVIDER</strong></td>
<td>Payors and providers are largely separate</td>
</tr>
<tr>
<td><strong>CONSUMER</strong></td>
<td>Employers and government are the primary decision makers</td>
</tr>
</tbody>
</table>

SOLUTIONS

- Private And Care Transformation
- Consumer Engagement
- Services And Technologies
- Exchanges
Consumer Choice Could Drive Half the Market by 2020

Based on Aetna estimates of industry
2014 Aetna Investor Conference | December 11, 2014

Consumer choice is the fastest growing segment in the marketplace

Consumer Choice
- Public / Private Exchanges
- Individual MA
- Medicare Supplement
- Managed Medicaid

Government
- Medicare FFS
- Medicaid FFS

Employer

Aetna’s Value-Based Contract Spending

On track to achieve VBC spend of at least 50% by 2018

Value Based Contracting Spend as Pct. of Total Medical Spend

~15%  ~25%  ~50%

2013 2014E 2018P
CIN Strategy: Banner Health Moved the Phoenix Market in 2011 and the Arizona Market in 2014 to Become a Statewide CIN

CIN
Banner Health Network ("BHN") with FTC Approval in 2011

Participants
- Banner Health (Hospitals) including U of A’s two hospitals
- Banner Medical Group and U of A Medical Group/Faculty Practice Plan
- Banner Physician Hospital Organization
- Arizona Integrated Physicians (IPA) owned by DaVita Healthcare Partners

Key Payer Relationship(s)
- Medicare (Pioneer ACO), Aetna, BCBSAZ (MA), Humana, HealthNet, United, Cigna
- Multiple products and plans including MSSP, global risk, MA, narrow network
- No Medicaid product at this time

Attributed Lives
- 200K commercial lives in 2012; 22K MA lives; estimated 500K - 750K lives by end of 2015; U of A Health Plan Members

Org Structure and Governance
- Physicians own 50% and Banner Health owns 50%; shared savings commensurate with ownership
- BPHO can engage in risk-based contracting
- BHN Board has representatives from all three physician entities and Banner Health; four subcommittees of the BHN Board: Quality/Clinical Integration; Finance; Operations and Contracting; and Information Technology

Key Points
- Aetna partnership is pivotal in building of BHN I/T infrastructure to support utilization management
- Arizona Integrated Physicians partnership charged with building clinical infrastructure on ambulatory side owned by DaVita/Healthcare Partners
- BHN pushing actively to develop narrow network products consistent with changing payer environment
- BHN has tried several types of risk models and plans to offer a capitated arrangement in the third year of the Pioneer program, as well as with several commercial offerings
Banner Health Network and BCBS-AZ Case Study

Key Elements of the BHN Partnership
- "Win/win" structure
- Terms are acceptable to AIP
- Formation of new company for all VBP contracting
- 50/50 ownership
- 50/50 governance
- AIP has leadership role
- AIP is exclusive to BHN for VBP contracts
- Banner is exclusive to BHN for VBP contracts
- Alignment of incentives
- 50/50 sharing of incentives and risk

JV #1: Banner Health Network
(50/50 JV Between Banner Health and Physicians)

- Banner Hospitals
  - 25%
- Banner Medical Group
  - 25%
  - 800+ Physicians
  - 120 PCPs
- Banner PHO*
  - 25%
  - 900+ Physicians
  - 170 PCPs
- Arizona Integrated Physicians
  - 25%
  - 600 Physicians
  - 150 PCPs
- Banner PHO*
  - 25%
  - * Banner Health owns 50% of Banner PHO

JV #2: BCBS-AZ and Banner Health Network
(50/50 JV)
- Purpose is joint development of value-based products
- Mutual exclusivity for value-based products

Banner and AZ Care Network (Dignity/Tenet/PCH) – Opposing Provider CIN/Networks in Phoenix and Tucson

Source: Aetna DocFind directory
Structural Overview of Optum

OptumCare management, integrated care delivery, and consumer solutions, including financial services

OptumInsight™ Delivers technology, operational and consulting services across healthcare industry

OptumRx™ PBM Services

OptumLabs™ Collaborative research and innovation partnership between Optum and Mayo focused on improving patient care

UnitedHealthcare Has Formed ACOs Across the Country

$30B of UHC provider spend is tied to ACPs, projected to grow to $65B by the end of 2018

Atlantic Health ACO to provide services for 16,000 UHC employer-sponsored plan participants in northern New Jersey
ACP partnership with Optum Health

Sources:
http://accountablecareanswers.com/
http://accountablecareanswers.com/newsroom/
Provider-Dominant Market Strategies

- Memorial Hermann Example
- Summit Medical Group Example
- Academic Medical Centers

Largest For Profit and Not-For-Profit Health Systems in US by Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>System</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kaiser (NFP)</td>
<td>$56.4 B</td>
</tr>
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<td>2</td>
<td>HCA (FP)</td>
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<tr>
<td>3</td>
<td>Ascension (FP)</td>
<td>$20.1 B</td>
</tr>
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<td>4</td>
<td>CHS (FP)</td>
<td>$18.6 B</td>
</tr>
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<td>5</td>
<td>Tenet (FP)</td>
<td>$16.6 B</td>
</tr>
<tr>
<td>6</td>
<td>CHI (NFP)</td>
<td>$13.8 B</td>
</tr>
<tr>
<td>7</td>
<td>Trinity (NFP)</td>
<td>$13.6 B</td>
</tr>
<tr>
<td>8</td>
<td>Providence (NFP)</td>
<td>$12.4 B</td>
</tr>
<tr>
<td>9</td>
<td>UPMC (NFP)</td>
<td>$11.4 B</td>
</tr>
<tr>
<td>10</td>
<td>Partners Healthcare System</td>
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<tr>
<td>11</td>
<td>Dignity (NFP)</td>
<td>$10.6 B</td>
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<tr>
<td>12</td>
<td>Sutter (NFP)</td>
<td>$10.2 B</td>
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<tr>
<td>13</td>
<td>Mayo (NFP)</td>
<td>$9.7 B</td>
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<tr>
<td>14</td>
<td>University of CA (NFP)</td>
<td>$8.5 B</td>
</tr>
<tr>
<td>15</td>
<td>Adventist Health System/FL (NFP)</td>
<td>$8.3 B</td>
</tr>
</tbody>
</table>
The Market Leader – Emphasizing Retail Expansion and Critical Mass

Inpatient Market Share

Market Share Ranking
1st: Aggregate Market Share
1st: Burns
1st: Cardiology
1st: ENT
1st: General Medicine
1st: General Surgery
1st: Neurology
1st: Neurosurgery
1st: Ophthalmology
1st: Orthopedics
1st: Rehab
1st: Thoracic Surgery
1st: Urology
1st: Vascular
2nd: Gynecology
2nd: Obstetrics
2nd: Neonatology
2nd: Spine
2nd: Oncology

Greater Houston MSA 6.36 million population, projected to 6.9 million by 2018

Memorial Hermann Accountable Care

• Clinically Integrated IPA
• Private, Employed & Faculty Integration
• Exclusive Contracting DOJ/FTC
• 211 Locations
• 260,000 covered lives
• BCBS, Aetna, Humana

Year 1 CMS Shared Savings $57,800,000 Savings
(#1 ACO in the US)
Memorial Hermann Health System CIN is Organized for Population Health Management Around Service Lines and Specialties

New Dimensions of Retail Medicine

- Critical to recognize the retail medicine goes far beyond clinic carve outs in drugstores or big box retailers
- Also encompasses population health management and array of retailer sponsored specialty services and analytics

Consumer-Centered Care at Walgreens

- Health screenings and testing
- Immunizations
- Medication therapy management
- Bedside RX delivery for inpatients
- Inpatient discharge solutions (Well Transitions)
- Adherence counseling
- HIV centers of excellence
- Broad access to specialty medications
- Infusion and respiratory services

Walgreens Physician Support

- Patient referrals
- Comprehensive Medicare member assessments coding support
- Medicare wellness exams
- Care gap closure
- Site of care optimization
- Consumer engagement programs
- Physicians education and alignment materials
- Adherence reporting

Back Office Data and Analytics

- Direct reporting/tracking of consumer interventions
  - Immunizations
  - Health testing
  - Gap closure
  - Infusion and respiratory services
- Analytics and predictive modeling for gap closure and working with targeted high-risk population
Growth of Retail Clinics

- 2013 survey estimates that one-third of Americans visited a retail clinic for clinical services
- Estimated 1,800+ clinics in 2014 anticipated to grow to 3,000 in 2016/17
- Staffed by NP, core menu of services generally includes:
  - Minor illnesses and injuries
  - Skin conditions
  - Common health screenings
  - Vaccinations and injections
  - Selected lab tests
- Regional clinic networks often linked or aligned with individual health systems, with intent to connect and data share
- Growing support for retail clinics by payers due to reduced cost of care vs. physician office

Top 6 Participants account for 90+% of the Retail Clinic Market

<table>
<thead>
<tr>
<th>Retail Clinic</th>
<th>Number of sites</th>
<th>Market Share</th>
<th>Health System Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS MinuteClinic</td>
<td>901</td>
<td>50%</td>
<td>47</td>
</tr>
<tr>
<td>Walgreens Healthcare Clinic</td>
<td>437</td>
<td>24%</td>
<td>6</td>
</tr>
<tr>
<td>Kroger Little Clinic</td>
<td>140</td>
<td>8%</td>
<td>4</td>
</tr>
<tr>
<td>Walmart Retail Clinics</td>
<td>103</td>
<td>6%</td>
<td>46</td>
</tr>
<tr>
<td>Target Clinic</td>
<td>80</td>
<td>4%</td>
<td>2</td>
</tr>
<tr>
<td>RiteAid RedClinic</td>
<td>30</td>
<td>2%</td>
<td>5</td>
</tr>
</tbody>
</table>


Proposed Service Model of Summit Health Management

SHM model for optimizing performance during transition from Fee-for-Service to Fee-for-Value

CULTURE  PEOPLE

Operations Management  Revenue Management

Governance & Leadership

Physician Management  Population Management

CLIENT

PROCESS  TECHNOLOGY

Infrastructure

Spring Managed Care Forum | April 2016  PROPRIETARY AND CONFIDENTIAL
A Multidisciplinary SHM Approach

Matching Patients and Interventions

- **High-Cost Patients**
- **Rising-Risk Patients**
- **At-Risk Patients**
- **Healthy Patients**

**Interventions**
- Centralized Care Management
- **PCMH**: Assign to embedded care manager
- Office Care Team
- Connect with risk modification services
- Patient or portal/mobile outreach for preventive care

Clinical Risk - Social Risk - Behavioral Risk

Source: Health Care Advisory Board interviews and analysis.

Integrated SHM Programs

Reducing “Circles of In-Accountability”

- Hospital
- **Rehab**
- Ambulatory Clinic/UCC
- **Home**
- ED
- Nursing Home

**Interventions**
- Hospitalist Program and UCC Programs
- Inpatient Physiatrist
- Transitions In Care Coordinator
- Care Management Telemonitoring
  - Home visits NP
- Geriatric Services

Source: Health Care Advisory Board interviews and analysis.
Progression of SHM Service Delivery Model

Diagnostic Assessment
Organizational evaluation to define issues, opportunities and a the path forward

Change Management Services
Working with client, facilitate and oversee critical practice changes and upgrades

Enterprise Management
Assume operational management of revenue cycle and related services, either by hiring local staff as SHM employees or centralizing functions in SHM-adjacent location

Business Process Outsourcing
Operational Risk Sharing

Demonstrating expertise and performance

Building trust