Macro Trends and Physician Alignment Strategies

December 2016

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Challenges in Today’s Health Care Industry
Estimated 2015 US Healthcare Spending by Payer Source

- Out of Pocket: $351 billion (11%)
- Medicaid: $555 billion (18%)
- Medicare: $646 billion (21%)
- Private Insurance: $1,100 billion (35%)
- Third Party Payers: $334 billion (11%)
- Other Insurance: $115 billion (4%)

Total Healthcare Expenditures: $3.24 trillion

Source: CMS’ Office of the Actuary

↑↑
- HD HP
- Hospital owned MD Groups
- Hospital owned ASC JVs
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 (Th!nk, One Retail, Online)
Physician/Hospital Alignment and Integration

The “Medical Ecosystem”
Increasingly aligned interests and the need to manage to “Meaningful Clinical Integration”

Pressures on Physicians
- Declining payer reimbursement/growth in self-pay %
- Declining revenue from ancillaries
- PCP shortages
- Specialist Shortages
- Recruiting challenges
- Increased practice overhead
- Growing regulatory requirements

Pressures on Hospitals
- Pluralistic medical staff
- Declining payer reimbursement/Self Pay % grows
- Increased competition from specialty hospitals
- Physician-sponsored OP competition
- Rise of P4P programs
- Increased consumer expectations
- Regulatory demands

Physician Community

Hospitals
Growing Profitability Crisis for Non-Dominant Providers

- Cost of care increasing 7-9% annually
- Mounting losses due to medical cost inflation
- NO ACTION
- Declining reimbursement over time

**DOING NOTHING IS UNSUSTAINABLE**

*Revenues and expenses per enrollees*
Providers Create Structures to Optimize Value-Based Care Participation

**New Provider Entities**

**Value-Based Reimbursement**

**New Payer Products**

**DEFINITIONS**

**CIN**
- FTC-compliant Clinically Integrated Network

**ACO**
- Accountable Care Organization Medicare Shared Savings Plan

**Specialty CIN**
- CIN for CV, Orthopedics, Oncology, CV, Spine and other key specialties

**Alignment of Quality Metrics with Financial Incentives**

**Clinical Model**
- Care Transformation
- Population Health Management

**Business Model**
- Fee-for-Service
- P4P
- APR DRGs
- Shared Savings
- Bundles
- Episodes of Care
- Global Risk

**Changes in Reimbursement**

**Expansion of Patient Population Coverage Creates New Products and Purchase Options**

**Commercial Insurance**
- Individual
- Small Group
- Mid-Size Group

**ERISA (ASO)**
- Mid-Large Group
- Private Exchange

**State and Federal Exchanges**
- Individual
- Small Group

**Medicaid**
- FFS
- Episodes of Care
- APR DRGs

**Medicare**
- FFS
- MSSP ACO
- Medicare Advantage

**KEY TAKEAWAY**

Hospitals and affiliated physicians have an opportunity to capture incentive-based reimbursement by entering into “value-based” contracts with payers. But to do that, they need to form a Clinically Integrated Network (“CIN”) that meets Federal Trade Commission standards.
Governmental Programs Have Focused on High Cost Medicare Beneficiaries – CV, Spine, Ortho, Oncology, End of Life Expenses Lead to the Expansion of Medicare Advantage Plans and Medicare Shared Savings Programs

Key Takeaway: The CIN must also have clinical models for the management of specialty care, including chronic care management and the management of episodic care.

Payer-Provider Partnerships Can Alleviate Provider Pressures

Current FFS Model

- Today (3-5% Operating Margin)
- Impact from Rate Pressures (Negative margin within 3-5 years)
- Unnecessary Utilization Reduction

Accountable Care Model

- Operating Cost Improvements
- Shared Savings
- New Growth (i.e., covered lives)

**Payer Pitch**

Narrow networks aggregate patients, ultimately leading to new growth that monetizes accountable care beyond FFS.
Potential Scope of Integrated Care Management Model

**COMMUNITY RESOURCES**

- Institutional Care
- Home Health
- School Clinics
- Eldercare Programs
- Social Worker Support
- Transportation
- Etc.

**PREVENTIVE HEALTH**

- Wellness support and preventive services for the community

**CASE MANAGEMENT**

- Patients with acute, time-limited medical needs

**DISEASE MANAGEMENT**

- Patients with single, non-complicated chronic conditions

**COMPLEX CARE**

- Patients with on-going medical and social concerns

**Network Development/Management**

**Care Plan Integration and Utilization**

**Program Management and Service Delivery**

**Program Support (e.g., Risk Stratification, Analytics, Performance Tracking)**
Narrow Networks – 1st Mover Payer Strategy (15% Hospital Discounts)
Risk Continuum for Existing and Proposed VB Payment Structures

Managing Risk Utilizes Tiered/Narrow Networks

- **Financial Risk**
  - FFS
  - Tier A: FTC compatible meaningful clinical integration infrastructure-baseline large network
  - Tier B: CIN network at least 15% smaller than tier I with more advanced CI capabilities
  - Tier C: CIN network at least 30% smaller than tier 1 and capable of global payments with performance risk, p4p, etc.
  - Tier D: CIN network at least 45% smaller than tier 1 and capable of accepting global payment with financial risk (e.g., MA capability)

- **Clinical Integration**
  - Consumers
  - Employers
  - Health Plans
  - Government Payors
  - Physicians
  - Medical Groups
  - Hospitals
  - Other Providers

*Modified from HFMA materials with SSB Solutions, Inc. proprietary data base*
Horizon Announces OMNIA Tier 1 Network
THE OMNIA HEALTH ALLIANCE

OMNIA HEALTH ALLIANCE TIER 1 PROVIDERS
Atlantic Health System
1. Chilton Medical Center
2. Morristown Medical Center
3. Overlook Medical Center
4. Newton Medical Center

Barnabas Health
5. Clara Maass Medical Center
6. Community Medical Center
7. Jersey City Medical Center
8. Monmouth Medical Center
9. Monmouth Medical Center Southern Campus
10. Newark Beth Israel Medical Center
11. Saint Barnabas Medical Center

Hackensack University Health Network
12. HackensackUMC
13. HackensackUMC Mountainside
14. HackensackUMC at Pascack Valley

Hunterdon Healthcare
15. Hunterdon Medical Center

Inspira Health Network
16. Inspira Medical Center Elmer
17. Inspira Medical Center Vineland
18. Inspira Medical Center Woodbury

Robert Wood Johnson Health System
19. Robert Wood Johnson University Hospital Hamilton
20. Robert Wood Johnson University Hospital New Brunswick
21. Robert Wood Johnson University Hospital Rahway
22. Robert Wood Johnson University Hospital Somerset

Summit Medical Group
613 physicians

ADDITIONAL TIER 1 PROVIDERS
AtlantiCare
23. AtlantiCare Regional Medical Center – Mainland
24. AtlantiCare Regional Medical Center – Atlantic City

Cape Regional Health System
25. Cape Regional Medical Center

Cooper University Health Care
26. Cooper University Hospital

Englewood
27. Englewood Hospital and Medical Center

Meridian Health
28. Bayshore Community Hospital
29. Jersey Shore University Medical Center
30. Ocean Medical Center
31. Riverview Medical Center
32. Southern Ocean Medical Center

Princeton HealthCare System
33. University Medical Center of Princeton

St. Joseph’s Healthcare System
34. St. Joseph’s Regional Medical Center
35. St. Joseph’s Wayne Hospital

Shore
36. Shore Medical Center

Tier 1 doctors, specialists and other health care providers
Payer/Provider Goals for VB Partnerships

Three Examples of Payer/Provider Goals:
1) Find NEW partners in CURRENT VB partnership categories
2) Find NEW partners in NEW VB partnership categories
3) Expand EXISTING partners into NEW VB partnership categories

Payers/Providers needs to assess intrinsic strategies, clinical models and capabilities.
While Value Based Programs (CINs/ACOs/Specialty CINs) Have Expanded – Why Have Regional Population Health Costs Not Decreased?

**New Jersey Medicare Cost per Beneficiary**

- New Jersey Market MLR
- High Performing Medical Group/CIN (SMG)

**2013**

- Δ = 8%

**2015**

- Δ = 22%

**Increased Hospital Based Billing**
- Medical Group Billing Structure
- Outpatient/Ancillary Billing
- Hospital/Physician Joint Ventures (e.g. Hospital ASC Rates)

**Increased Disease Burden**
- Cardiovascular
- Orthopedics
- Oncology – therapy/drugs
- Neurosciences /Dementia
# Telemedicine Will Vary by Program and Enabling Capabilities

Developing telemedicine capabilities that allow for consults, tele-ED and eICU across the state and develop closer relationships with referring physicians while minimizing travel time.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Initial Requirements</th>
<th>Enabling Capabilities</th>
</tr>
</thead>
</table>
| “On Demand” Consults | • Two-way video and audio  
• Provider’s and patient’s environment that ensures privacy  
• Specialty programs could include tele-derm – cardiology – pulmonary – neurology – radiology, etc. | Software, Hardware and Services        |
| Tele-ED            | • Credentialing (can be by proxy)  
• Telemedicine cart and trained staff  
• Contract to provide telemedicine services as a physician consult  
• Services could include tele-ED, tele-stroke, and trauma | Software, Hardware and Services        |
| eICU               | • Adequate bandwidth to support real-time video  
• High-resolution camera and a two-way audio system in each patient room  
• “Hot” phones provide ICU staff with immediate access to the intensivist - led staff in the eICU. | Software, Hardware and Services        |


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**SSB SOLUTIONS**

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“Next-Generation” Delivery Model—Maximizing Access to Quality Services Through Focused Asset Development And Deployment Strategy

MAIN CAMPUS(S)
- Tertiary and quaternary care facility caring for the most complex patients and includes:
  - ICU
  - CVICU
  - NICU
  - Med/Surg
  - ED
  - Specialty care
  - Advanced imaging
  - Interventional radiology
  - ECMO
  - Anesthesia
  - Infusion
  - Dialysis

SATELLITE ACUTE CARE SITE OF SERVICE
- Low to mid acuity inpatient facility serving as a referral center into main campus
- Licensed inpatient units or free-standing hospital
- ED

LARGE AMBULATORY SITE
- Specialty Care
- Urgent Care
- Rehab
- Sedated Imaging
- Infusion
- Nutrition
- Anesthesia
- ASC

PHYSICIAN SPECIALTY CENTER
- Specialty Care
- Primary Care
- Imaging
- After Hours Urg Care

RETAIL SPACES
- Store front space for select services (therapies, sports med rehab, imaging)

Integrate with e-Health and Virtual Care

Collaboration with HPI and Independent Physicians Creating System of Care

COSTS
- $25M - $100M
- $5M - $15M
- $2M - $5M
- $500K - $2M

SPACE
- 20,000 – 60,000 Sq. Ft.
- 10,000 – 35,000 Sq. Ft.
- 2,500 – 10,000 Sq. Ft.
- 1,000 – 5,000 Sq. Ft.
The Market Leader – Emphasizing Retail Expansion and Critical Mass

$4.9B Total Assets
$4B Net Operating Revenue
22,000 Employees; 5,000 Medical Staff

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
Super CIN, CIN and Specialty CIN Contracting Opportunities

Contracted Services
Enterprise, Site Specific, Specialty, etc.

CONTRACTING MATRIX

<table>
<thead>
<tr>
<th>CIN A/CIN B</th>
<th>Specialty CIN Contracts for</th>
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<tbody>
<tr>
<td>N/A</td>
<td>Complex Care Specialty PHM</td>
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<tr>
<th>Super CIN</th>
<th>Contracts for</th>
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<tr>
<td>Participate in Super CIN PHM Contracts</td>
<td>Complex Care Specialty PHM</td>
</tr>
</tbody>
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<tr>
<th>Payers</th>
<th>Specialty PHM Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct PHM Contract</td>
<td>Specialty PHM Contract</td>
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</table>

CIN-A hospitals
CIN-A physicians
CIN-A Co-mgmt. companies
Other entities focused on clinical integration/performance

CIN-B hospitals
CIN-B physicians
CIN-B Co-mgmt. companies
Other entities focused on clinical integration/performance

Specialty CIN-C hospital
Specialty CIN-C physicians
Specialty CIN-C Co-mgmt. companies
Other entities focused on clinical integration/performance
“Provider-Dominant” – Iowa Super CIN Value-Based Strategy

MHN Iowa Profile
- JOA: CHI and Trinity
- 27.5% Market Share
- 13,000 Employees
- $2.2 Billion FY10 Operating Revenues
- 11 Owned Hospitals
- 29 Affiliate Hospitals
- 142 Physician Clinics
- 625 Physicians
Current State

- Fragmented and inefficient programs
- Typically focused on a specific population
- Overlapping or inconsistent eligibility criteria
- Employ multiple processes for the same activity (e.g., claims processing)

Future State

- VHA Vision is to build a “System of Systems” to administer CCN
  - 4.3 Million Veterans/$12.3 Billion going to private systems for FY 17
  - High-Performing Network Systems
  - Integrated Customer Service Systems

Wild Card – VHA CCN Organizes Current Offerings into Single, Integrated Entity

Resources Integrated into Single Program

- Patient-Centered Community Care (PC3)
- Federally-Affiliated Facilities
- Emergency Care
- Retail Pharmacy Contracts
- National Dialysis Contracts
- Veteran’s Choice

Project ARCH

- Federally-Affiliated Facilities

.info
VA Community Care Regions and Estimated Eligible Veterans

The number of VA-Enrolled Veterans per state/territory is approximate as of September, 2014. The number of VA-Enrolled Veterans per region (provided in the key) is as presented in the Community Care Network Operations Manual and current as of November, 2015.
Timing and Speed of Market Shift Varies by State

Accelerators for value-based market transition
- Non-Federal default state-based exchanges (e.g., MA; CA)
- State-based Medicaid expansion (e.g., AZ)

KEY TAKEAWAY
Hospitals and affiliated physicians will have two revenue streams (FFS and VB) for many years, but over time, the VB stream will become larger than FFS.
Physician Clinical and Business Alignment Models

- Employed physician models
- Aligning independent physicians
- Next-generation physician alignment
Clinical Integration: Optimizing Continuum of MD Relationships

- Credentialed Staff
- Independent Physicians
- Teaching and Research Agreements
- Teaching Faculty
- Director Agreements
- Medical Directors
- Professional Services Contracts
- Radiology, Anesthesiology, ER, Etc.
- Contracted Physicians
- Employed Physicians
- Pluralistic Medical Staff

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## Alignment Models Focus on Clinical Integration

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<tr>
<th>Model</th>
<th>Attributes/Enterprise Orientation</th>
<th>Targeted Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYMENT PLUS VARIATIONS</strong></td>
<td>Employment, by the hospital, larger physician group or related organization (payer). Most effective in “value-based” environment.</td>
<td>Historically highly focused on PCP’s, recently expanded to virtually all specialties</td>
</tr>
<tr>
<td><strong>CIN/CO-MANAGEMENT</strong></td>
<td>Joint management of a hospital service line and/or operating entities between the hospital and a group of organized physicians. Works in both “value-based” and FFS environment.</td>
<td>CIN/Co-Management Structure. Historically, specific to the service line/COE but is becoming more expansive. Optimizes independent physician alignment</td>
</tr>
<tr>
<td><strong>JOINT VENTURES</strong></td>
<td>Economic venture where the asset or service are jointly owned by physicians and hospital. Increasingly subject to intense regulatory scrutiny.</td>
<td>Specific to the service of the JV. provider-based reimbursement can be lucrative to independent physicians wishing to sell ancillaries</td>
</tr>
<tr>
<td><strong>PRACTICE SUPPORT</strong></td>
<td>MSO, loans, recruiting support etc. To assist independent physician/groups practices. Most effective with independent physicians.</td>
<td>Historically focused on PCP’s but expanding to include specialists</td>
</tr>
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<td><strong>PAYER CONTRACTING</strong></td>
<td>Legacy vehicle is PHO and is designed to increase negotiating strength with payers. Increasingly ineffective. PHO transitioning to CINs.</td>
<td>Open to all qualified medical staff members. Segmentation often lacking. Without a goal of “single signature” contracting other alignment models more effective</td>
</tr>
<tr>
<td><strong>CONTRACTUAL</strong></td>
<td>Specific to single physician or group for a designated services. Examples include medical directors, hospitalists, PSAs, etc.</td>
<td>Aligned to specific service being provided. Alignment focus is evolving to more employment</td>
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Employed Physician Models
For the 3rd Consecutive Year, the Three Most-placed Providers Were Family Medicine, Internal Medicine And Hospitalists

<table>
<thead>
<tr>
<th>Year</th>
<th>Specialties</th>
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Placement Specialties 2016. Source: The Medicus Firm
### Integration Models for Physicians

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An increasingly critical option for key primary care and specialty physicians struggling with practice cost vs. reimbursement issues.
Hospital-Sponsored Medical Group Structural Options

**Model A: “Embedded” Medical Group**

Virtual stand-alone medical group with an advisory board, physician executive, and CAO, but embedded in a health system structure.

**Model B: Separate LLC / 501(c)3**

Medical group structured as a separate 501(c)3 or LLC legal entity sponsored by a stand-alone health system.

System board holds reserved powers over medical group.
Aligning Independent Physicians

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# Integration Models for Independent Physicians

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**Level of Integration**

Sweet spot hospital’s “anchor” services (e.g., cardiology, orthopedics, oncology)
Typical Flow of Fees and Incentive Payments for CM LLC

Incentive fees based on achieving specified and measurable metrics for:
– Clinical quality
– Budget-related goals
– Operational goals
– Program development

Shareholder distributions made as available and sanctioned by LLC board
Next-Generation Physician Alignment: CINs/CIOs/ACOs
Management of Specialty Care During FFS to VB Transition

- FFS Revenue Enhancement Strategies
- Management Company Key to Managing FFS & VB Specialty Care
- VB Revenue Strategies – Specialty CIN

Timeline:
- 2016
- 2017
- 2018
- Ongoing
Management of Ortho/Spine Services During Transition from Fee-for-Service to Value-Based Reimbursement

- **Past**
  - Focus is on management of service line in FFS environment

- **2016**
  - Fee-for-Service

- **2017**
  - Transition
    - Focus is on transition to Value-Based Reimbursement environment, clinical integration and development of the Specialty CIN

- **2018**
  - Value-Based Reimbursement
    - Focus is on contracting for value-based specialty services; Specialty CIN is the contracting vehicle

- **2019**
  - 

- **2020**
  - 

Specialty CIN Needed for VB Contracting*

**Management LLC**

**2 Missions:**
- Management of the Service Lines
- Management of the Specialty CIN

**Orthopedic Groups**

**Shared Ownership**
- 50%
- 50%

**Shared Governance**

**Specialty CIN, LLC Board of Managers**

**Financial Considerations:**
- Shared capital contributions
- Shared financial risk

**Ortho/Spine Service Lines**

**Payers**
- ACOs and CINs
- Government programs
- Commercial payers
- Direct contracts with employers

* Shared ownership model
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.

**Form CIN**
- Legal structure
- Organization/ownership
- Governance
- Infrastructure development
- Budgeting/financial modeling

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

**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

**Clinically Integrated Network**
- PCPs
- Specialists
- PHYSICIAN-SUPPORTED INITIATIVE
- PHYSICIAN-LED INITIATIVE

- Clinical Integration and Performance Improvement

- Form CIN
- Governance and Leadership
- Medical Staff Collaboration
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 cover 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.

Organizational Requirements

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

Membership
- Targeted at physicians whose participation has potential to maximize quality and efficient resource utilization

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

Legal Considerations

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
- Ownership and contractual arrangements must be at Fair Market Value

State Licensing/Regulatory Requirements
- Must comply with all state licensing and regulatory requirements with regard to ownership, financial arrangement and other statutes
Key Takeaway: Population health management is coordinated through a Patient-Centered Medical Home model of care and driven by data analytics to stratify the population.
## Critical Infrastructure and Technology Needs for CIOs/CINs/ACOs

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Key Capabilities</th>
</tr>
</thead>
</table>
| Population and Clinical Risk Management | Quantify patient risk, input to risk-adjusted payment methods, and ability to predict/tailor care needs and enable greater risk-sharing. | • Predictive modeling  
• Patient stratification  
• Clinical risk quantification  
• Patient attribution analysis |
| Financial and Network Management       | 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. | • Novel reimbursement model support  
• Network assessment  
• Contract development  
• Patient financial management |
| Clinical Model Design and Management   | Promote evidence-based care delivery, enable tighter care coordination, support for integrated treatment planning, and cost-effective use of resources and settings. | • Clinical process development  
• EBM pathway development  
• Protocol management  
• Bundled payment care management models  
• Care coordination/transition of care |
| Core Clinical Technology Infrastructure | Deploy and leverage robust clinical technology infrastructure to create seamless clinical integration across acute and ambulatory settings. | • Interoperable EMR  
• Shared clinical and administrative documentation  
• Referral and network management  
• POC decision support  
• Bundled payment tracking and reporting |
| Integrated Data Exchange              | Ensure integrated, secure, timely access to clinical and administrative data. | • Integrated access to clinical, financial, and administrative data – e.g. claims, encounter, cost/quality, EBM guidelines |
| Performance Management                | Enable robust, transparent performance management that allows root-cause identification of cost and quality gaps and ties payment to performance. | • Performance metric dashboards  
• Integrated cost and quality reporting  
• Provider performance profiling  
• Utilization/quality review |
| Patient Engagement                    | 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. | • Patient navigation and care collaboration  
• Intelligent scheduling/tracking/monitoring/alerts  
• Shared decision making  
• Information portals |
Provider Reimbursement Changes – Shared Savings/Patient Care Management Fees with Quality Metrics Create Value Based Models

From CMS/Commercial Payer Shared Savings through CIO/ACO (by creating savings and meeting defined performance targets)

From CIO/ACO to Network PCPs ($5.00-$40.00 PMPM)

From CMS/Commercial Payer to Hospitals and Physicians (in ordinary course)

Fee-for-Service

Shared Savings

PMPM Care Management Fees for CIO/ACO Patients
Providers Will Manage “New” Multiple Value Based Revenue Streams

PCP and Specialty Strategies will be employed by CIOs, CINs, ACOs, Specialty CIOs all should be structured to take advantage of the FFS revenue stream plus four additional revenue streams and payment methodologies.

Premium Revenue

Administrative Fees

- Admin Costs and Contingency
- Patient Care Management Fees

Fee-For-Service

- Qualifying Physicians Usually PCPs
- Other Specialists
- Hospitals
- Ancillary Providers
- Rx/Lab
- Other

Medical Loss Ratio (MLR)

Value-Based Performance Payments

- Shared Savings
- Clinical Quality Targets
- Patient Satisfaction Targets

New revenue stream
CMS Per Capita Spend Nationally

Source: Dartmouth Atlas
Revenue Implications—Next Generation ACO vs. FFS Medicare

NG ACO Assumes 5,000\(^1\) enrollees at $1,000 PMPM

$62 MM in Total Premium Revenue /Maximum Shared Savings are $9.3 MM or 15%

$ 1.39 of $9.3 MM in Maximum Shared Savings to CMS (15% Share)

$ 7.9 MM in Maximum Shared Savings to ACO (85% Share) plus telemedicine fees

<table>
<thead>
<tr>
<th>CIN/Provider Costs</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration/$15 PMPM</td>
<td>0.90</td>
</tr>
<tr>
<td>Totals</td>
<td>0.90</td>
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</table>

<table>
<thead>
<tr>
<th>Provider Revenue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Hospital)</td>
<td>20.03</td>
</tr>
<tr>
<td>Physician Services</td>
<td>15.76</td>
</tr>
<tr>
<td>Pharmacy/OP/Other</td>
<td>16.74</td>
</tr>
<tr>
<td>Totals</td>
<td>52.53</td>
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</table>

<table>
<thead>
<tr>
<th>Incentive Allocation Distribution (IAD)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS (15%)</td>
<td>1.39</td>
</tr>
<tr>
<td>Hospitals (35.1%)</td>
<td>3.26</td>
</tr>
<tr>
<td>Physicians (35.1%)</td>
<td>3.26</td>
</tr>
<tr>
<td>All PCP Physicians (5%)</td>
<td>0.46</td>
</tr>
<tr>
<td>Totals</td>
<td>8.37</td>
</tr>
</tbody>
</table>

(Net of CIN Admin Costs)

<table>
<thead>
<tr>
<th></th>
<th>CMS Savings</th>
<th>CIO Adm</th>
<th>Hospitals InPatient</th>
<th>Physicians</th>
<th>Pharmacy/OP/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare FFS</td>
<td>$19.5</td>
<td>$0.90</td>
<td>$25.80</td>
<td>$16.90</td>
<td>$17.40</td>
</tr>
<tr>
<td>Medicare ACO</td>
<td>$20.03</td>
<td>$1.39</td>
<td>$23.3 total</td>
<td>$15.76</td>
<td>$16.74</td>
</tr>
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</table>

Financial Impact on Key Stakeholders
Medicare FFS vs. Next Generation ACO ($MM)

\(^1\)For comparability only as Next Generation ACOs require 10,000 attributed lives.
**Revenue Implications – Medicare Advantage vs. FFS Medicare**

Assume 5,000 enrollees at $1,200 PMPM (HCC= 1.23) without additional “star” reimbursement

$72MM in Total Premium MA Revenue vs. $60MM in total FFS Premium Revenue

MLR = 85% (industry incentives) to providers/Humana Model*

<table>
<thead>
<tr>
<th>MA Health Plan</th>
<th>$MM</th>
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</thead>
<tbody>
<tr>
<td>Administration</td>
<td>7.2</td>
</tr>
<tr>
<td>Profit</td>
<td>3.6</td>
</tr>
<tr>
<td>Totals (15% MLR)</td>
<td>10.8</td>
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</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (Inpatient)</td>
<td>20.2</td>
</tr>
<tr>
<td>Physician Services</td>
<td>14.4</td>
</tr>
<tr>
<td>Pharmacy/OP/Other</td>
<td>14.4</td>
</tr>
<tr>
<td>Totals (68% MLR)</td>
<td>57.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incentive Allocation</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals (50%)</td>
<td>7.14</td>
</tr>
<tr>
<td>Physicians (50%)</td>
<td>7.14</td>
</tr>
<tr>
<td>Totals (17% MLR)</td>
<td>14.3</td>
</tr>
</tbody>
</table>

*Humana = 81% MLR: Aetna FL 83% MLR
Without 5 Star incentive allocation (4%+)

---

**Financial Impact on Key Stakeholders**

<table>
<thead>
<tr>
<th>Medicare FFS vs. Medicare Advantage ($MM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI/MA Hlth Pln</td>
</tr>
<tr>
<td>Hospitals</td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Pharmacy/OP/Other</td>
</tr>
</tbody>
</table>

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**Incentive Allocation**

<table>
<thead>
<tr>
<th>TPI/MA Hlth Pln</th>
<th>Hospitals</th>
<th>Physicians</th>
<th>Pharmacy/OP Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8 +400%</td>
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<td></td>
<td></td>
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**Medicare FFS**

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</tr>
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<td>Totals (68% MLR)</td>
<td>57.1</td>
</tr>
</tbody>
</table>

**Medicare Advantage**

<table>
<thead>
<tr>
<th>Providers</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (Inpatient)</td>
<td>19.6</td>
</tr>
<tr>
<td>Physician Services</td>
<td>12.0</td>
</tr>
<tr>
<td>Pharmacy/OP/Other</td>
<td>12.0</td>
</tr>
<tr>
<td>Totals (68% MLR)</td>
<td>43.6</td>
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</table>

**Incentive Allocation**

<table>
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*Humana = 81% MLR: Aetna FL 83% MLR
Without 5 Star incentive allocation (4%+)
Creating a Clinically Integrated “System of Care”

KEY TAKEAWAY
The vision for a clinically integrated “System of Care” is strategically inspired by the groundbreaking retail healthcare strategy being implemented successfully at “One Memorial Hermann.” A clinically integrated “System of Care” moves beyond the “traditional” CIN, which focuses primarily on integrating and connecting existing inpatient and outpatient facilities, clinics and physicians, but does not seek to provide expanded healthcare access points throughout the community.

“Traditional” CIN

Strategic network design process to create integrated system of care to extend service access and touch points (Hard assets and virtual)

Clinically Integrated System of Care

Freestanding EDs
Hospitals
Post Acute
Telemedicine
Online Consults
ASCs
Specialty Centers
Urgent Care
Minute Clinics
Payer Contracting
Network Management
Technology Support

CENTRALIZED SERVICES

Primary care
Ancillaries
Specialists
Hospitals

Key takeaway
The vision for a clinically integrated “System of Care” is strategically inspired by the groundbreaking retail healthcare strategy being implemented successfully at “One Memorial Hermann.” A clinically integrated “System of Care” moves beyond the “traditional” CIN, which focuses primarily on integrating and connecting existing inpatient and outpatient facilities, clinics and physicians, but does not seek to provide expanded healthcare access points throughout the community.
Humana—Medicare Advantage Transition Strategy for Providers

**KEY TAKEAWAY**
Humana provides a clear, 3-5 year strategy to evolve physician groups and committed CINs to greater risk and greater potential reimbursement for the Medicare population.

<table>
<thead>
<tr>
<th>1st Year—Phase I</th>
<th>2nd Year—Phase II</th>
<th>3rd Year—Phase III</th>
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</thead>
<tbody>
<tr>
<td><strong>Key Elements of Phase I</strong></td>
<td><strong>Key Elements of Phase II</strong></td>
<td><strong>Key Elements of Phase III</strong></td>
</tr>
<tr>
<td>Shared Incentives</td>
<td>Increased Incentive Opportunities</td>
<td>“15 cent Solution”</td>
</tr>
<tr>
<td>FFS reimbursement (e.g., 120% of Medicare)</td>
<td>FFS reimbursement (e.g., 120% of Medicare)</td>
<td>Humana pays CIN 85% of premium</td>
</tr>
<tr>
<td>Quality reporting</td>
<td>Larger incentives for quality performance</td>
<td>Baseline reflects higher HCC scores</td>
</tr>
<tr>
<td>HCC calculation</td>
<td>Larger incentives for HCC improvement</td>
<td>Significant upside and downside risk</td>
</tr>
<tr>
<td>Modest upside incentive opportunity</td>
<td>No downside risk</td>
<td>Opportunity for much higher total reimbursement (e.g. 160% of Medicare)</td>
</tr>
<tr>
<td>No downside risk</td>
<td>Opportunity for higher</td>
<td></td>
</tr>
<tr>
<td>Opportunity for higher</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Humana provides a clear, 3-5 year strategy to evolve physician groups and committed CINs to greater risk and greater potential reimbursement for the Medicare population.
Summary Conclusions
2016—Complex and Crowded FFS and Value-Based Environment

Data Aggregation and Intelligence

Risk Management and Analytics

Program Advisory and Implementation Services

Care Coordination and Patient Outreach

Source: Curating the Best of Digital and Population Health, Dr. Gordon Jones
http://www.slideshare.net/elcid84/phmslideshare2014?qid=331b8a6e-df33-4f6b-8bbf-ee7bc139c465&v=default&b=&from_search=3
Conclusions and Implications

National Implications:

- **Governmental ACOs/Plans** – As goes reimbursement structures for Medicare, so goes the commercial reimbursement structures as well. Look for Medicare Advantage and NG ACO’s to influence every provider in a similar “Value Based” manner.

- **Health System CINs** – All large systems will emulate a “One Memorial Hermann” Model but their success will depend on their survival of “Narrow Networks” and their “Capability to build out the right mix Retail Health and existing assets.”

- **Multi-Specialty Group CINs** – Need dominant critical mass (e.g., 800 pound gorilla) in a pluralistic hospital and payer environment. Otherwise they need to be associated with a large Health System(s) CIN that helps them achieve critical mass.

- **Payer Relationships** – Pluralistic until they start down the “Narrow Network”/Value Based Product/Population (At Risk) pathways then they will segregate by population (Medicare Advantage) and Specialty Product (CV Specialty CIN for Joints, CHF, IHD, CABG’s, etc.)

- **“Wild Card” – Veterans Healthcare Administration Community Care Network (VHA CNN)** – 4.3 million veterans using (VHA CCN) 4 regions, $12.3 billion into the private delivery system FY 17
Critical Takeaways

Prioritize key Initiatives to fulfill the following objectives:

• Preserve and grow a dominant critical mass of patients, facilities and technology to sustain and enlarge an optimal regional footprint

• Significant resource investments will be required to support the development of additional value-based products

• Be prepared for a “zig-zag” expansion pathway which will require multiple starts and stops to ultimately develop numerous successful models
Memorial Hermann Accountable Care

211 Locations

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

COMMERICAL

MEDICARE

Gr Houston >11,000
MHMD 3,500
CI 2,900
ACO 2,700
PCMH 304

CMS Shared Savings
- 45,000 attributed beneficiaries
- Focus Patient Centered Medical Home

Medicare Advantage
- 19,600 covered lives

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.
Aetna Whole Health Product with Banner

Banner/Aetna Products

Stand Alone or Turn-Key Solutions

Any Payer Any Insurance Segment

Aetna Whole Health

Provider Branded Health Plan

Strategy Development and Change Management

Business Models

HIT/HIE
- Care Team Suite
- HIE
- CDS
- PHR / Patient Portal
- Analytics & Reporting
- Implementation Services

Care Management
- Telephonic / Embedded
- UM, DM, CM, BH, MM Training, Staff and Programs
- Wellness and Lifestyle
- Clinical / IT Platform
- Implementation Services

Health Plan Services
- License
- Claims
- Member Services
- Sales and Marketing
- Actuarial / Underwriting
- Implementation Services

Physicians

Hospitals

Outpatient Facilities

Pharmacy

Home Health
## CIN Strategy: Banner Health Moved the Phoenix Market in 2011 and the Arizona Market in 2014 to Become a Statewide CIN

<table>
<thead>
<tr>
<th>CIN</th>
<th>Banner Health Network (&quot;BHN&quot;) with FTC Approval in 2011</th>
</tr>
</thead>
</table>
| 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

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

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

*Banner Health owns 50% of Banner PHO*

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 #2: BCBS-AZ and Banner Health Network**  
(50/50 JV)
- Purpose is joint development of value-based products
- Mutual exclusivity for value-based products
Given program vision and scope, available resources, and size of the at-risk population (now and in the future), Aspirus needs to identify the sweet spot with regard to balancing key program design considerations.

**Selected Design Considerations**

- **Approach to Risk**
- **Degree of Centralization**
- **Heterogeneity of Clinical Resources**
- **Level of Integration**

**Program Design Requires Consensus on Form and Function**

**Centralized Delivery of Services**
- **Targeted, Siloed Programs**
- **Disease-focused**

**Specialized Clinical Team**
- **Patient-focused**

**Clinically Integrated Program Supporting a Range of High-Risk Patients**
- **PCP Office Based**

**Broad Clinical and Behavioral Team and Community Resources**
SSB Case Study: Multi-Hospital System Leveraging Stanford Model

Health system studied and adapted best practices and tools from the Intensive Outpatient Care Program developed at Stanford University.

PROGRAM HIGHLIGHTS

- Care coordination built on focused discipline and a defined structure
- Dedicated care coordinators with specified responsibilities
  - Hybrid model—some care coordinators employed full-time by the CIN, and others employed either by practices or the health system
- Patient-centric rather than disease-centric
- Two separate programs—chronic care and care transitions

Care Coordination Support Hub

POST ACUTE CARE SERVICES

Discharged Pts.

Transitional Care Managers

Payer Services and Programs

Practice A

Practice B

Practice C

EMBEDDED CARE MANAGERS
Care Management Models Must Balance Goals and Perspectives

- The goal of care coordination is to facilitate the appropriate and efficient delivery of health care services both within and across systems of care.
- While stakeholder share a common goal, key groups may also have different perspectives and expectations about the relative value and success of different approaches/interventions as well as organization of resources.

Initial focus in model development is to ensure at the outset that stakeholder perspectives and expectations are broadly understood and aligned.

Source: Agency for Healthcare Research and Development
## Four PHM Purchase Categories for Providers

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENTERPRISE DEVELOPMENT PLATFORM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated data capture, analytics and communications platform to be used by multiple constituencies across the enterprise</td>
<td>Caradigm, Health Catalyst, Healthcare Data Works, Recombinant (Deloitte), IBM</td>
<td></td>
</tr>
<tr>
<td><strong>ANALYTICS-AS-A-SERVICE</strong></td>
<td>Outsourced PHM analytics and data management to support PHM strategies and benchmarking</td>
<td>Explorys, Humedica, Lumeris, Premier (Verisk), Truven</td>
</tr>
<tr>
<td><strong>POINT SOLUTIONS</strong></td>
<td>Standalone components with narrow but deep functionality and subject matter expertise</td>
<td>Altasoft, Medventive, Midas+, MedeAnaltyics, Cloudera</td>
</tr>
<tr>
<td><strong>EMR SUB-MODULE</strong></td>
<td>Integrated PHM analytic and process routines within the provider’s EMR</td>
<td>Epic, Cerner, MEDITECH, AllScripts</td>
</tr>
</tbody>
</table>

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