Today's Discussion

- The Proliferation of Clinically Integrated Consortia
- Key Imperatives for Network Success and Sustainability
- Questions
Seeking Benefits from Meaningful Scale

Continuing economic pressures including the push towards value have driven providers to build meaningful scale and the trend will likely continue into the future.

Benefits of Meaningful Scale

Cost Position
- Unit
- Sourcing
- Fixed Assets

Strategic Position
- Geographic
- Physicians
- Payors
- Providers

Capability and Competency Enhancement
- Higher Acuity Services
- Clinical Outcomes
- Technology / Innovation

Access to Capital
- Relative Use of Resources
- Cost of Capital
- Return on Capital

Value-Based Models Reinforce These Benefits and Add New Ones

+ Share the investments to build new capabilities for value-based care
+ Better position for participation in new payment models
  - Capacity to manage a larger population
  - Increased access points, close to where populations live
  - Ability to pilot new payment models on large employee base
+ Add lower cost settings in network

Proliferation of Traditional – and New – Forms of Integration

Providers are seeking scale in traditional ways but increasingly also through new “ACO” models – often aiming to achieve clinical, rather than financial, integration.

Traditional M&A: Though total deal activity slowed in 2013, the number of hospitals involved continued to climb as a result of several recent ‘mega-mergers’

Proliferation of ACOs: Independent health systems, hospitals, and physicians, many of which have historically competed for market share, are coming together to participate in value-based contracts

Hospital Transactions, 2010 – 2013

Government and Commercial ACOs, 2012 and 2014

Consortia Models: Options for Collaboration

If organizations do not want to financially integrate, they may pursue clinical integration or looser models of collaboration.

Why NOT Financial Integration?

- Multiple health systems want to collaborate but do not want to merge for strategic, operational, and/or cultural reasons – or cannot do so because of anti-trust concerns
- Physicians don’t want to be employed
- Providers are interested in value-based contracting – but don’t want the amount of financial risk considered sufficient to achieving financial integration through contracting

Why Clinical Integration?

Many consortia are opting to pursue Clinical Integration, which allows providers to retain their independent organizations yet come together to jointly deliver and demonstrate value, jointly contract, and jointly offer new health plan and product options for payors, employers, and individuals seeking value-based care.

Why NOT Clinical Integration?

Some consortia have pursued other, more limited partnership approaches – for example, learning collaboratives, group purchasing of supplies or shared services, or messenger-model only contracting arrangements. These tend to require less commitment or investment than CI, but their benefits are more limited as well.

Consortium Models

Among these “CINs” or “ACO” models is emerging a particular variety categorized as “Consortium” models. In these approaches, health systems that historically have been competitors are coming together to explore new opportunities to collaborate around value-based care.

Sole Health System Model:

Single health system and its employed and independent physicians create a Clinically Integrated Network

Health System

Employed Physicians

Independent Physicians

Health System

Employed Physicians

Independent Physicians

Health System

Employed Physicians

Independent Physicians

Health System

Employed Physicians

Independent Physicians

SUPER CIN

CIN A

CIN B

CIN C
Consortium Models – Recent Examples

Increasingly, health systems and hospitals are coming together into such consortium model networks.

Examples of Multi-System Collaborations

Many Consortia Forming, Yet with Few Demonstrated Results

Numerous large regional and statewide networks and collaborations are emerging across the country, though many have not yet delivered results.

<table>
<thead>
<tr>
<th>Status</th>
<th>Organization</th>
<th>Description</th>
</tr>
</thead>
</table>
| Disbanded in May 2014 | • Formed in 2012 in response to launch of The Indiana University ACO  
• 3 systems, 30+ hospitals, 3,000+ physicians, ~$4B net revenue  
• Before disbanding, secured 12 contracts (6 of which were with member hospitals), hired a CEO and a staff of 8  
• “The member organizations believe they can more effectively meet the expectations of the market as individual health systems.” |
| Slow to Gain Traction | • Formed in 2012 in response to Aurora Health Care ACO  
• Currently includes 7 health systems; 3 systems have left network, including 2 founding organizations  
• 34 hospitals, 4,500 physicians, ~$7B net revenue  
• First contract Jan. 2014: United (55k lives), plus self-insured (30k)  
• In May 2014, changed name and launched small group product |
| Too Early to Tell | • Announced in September 2013  
• 7 systems, 25 hospitals, ~2,000 physicians, ~$10.5 B net revenue  
• Founding initiatives: “population health management” and “group purchasing/sourcing and distribution”; no publicized plans to pursue clinical integration or product development  
• $7M+ initial investment |
In Some Markets, Networks are Starting to Move Members

While it is too early to see results from many recently launched, provider-led large regional and statewide efforts, payor experience suggests that networks can move members – and change a state’s healthcare landscape.

**Case Study: A statewide network in Texas converted nearly 660,000 public sector employees and their dependents from BCBS TX to Aetna.**

<table>
<thead>
<tr>
<th>Background</th>
<th>Action</th>
<th>Results</th>
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<tbody>
<tr>
<td>Teacher Retirement System of Texas (TRS) provides health and disability benefits for public education employees across the state, both active and retired.</td>
<td>In a targeted and staged effort to convert all retiree and active health benefit business, systems across the major metropolitan markets partnered with Aetna to create a statewide “accountable care” network.</td>
<td>Successful in winning over 660,000 members in total over a three year combined sales effort, capitalizing on the value delivered from the partner “accountable care” networks across the state.</td>
</tr>
<tr>
<td>• Responsible for investing funds, delivering benefits to members via a defined benefit plan</td>
<td>• Houston: Memorial Hermann Health System&lt;br&gt;• Dallas: Baylor Quality Alliance&lt;br&gt;• San Antonio: Quality Partners In Care (Baptist/Tenet, Health Texas)&lt;br&gt;• Austin: Seton Healthcare</td>
<td>• 2013: 240,000 retirees and dependents&lt;br&gt;• 2014: 420,000 active members and dependents</td>
</tr>
<tr>
<td>• Serves over 1.3M members in total</td>
<td>Benefits administered by BCBS TX for over 20 years prior to 2014</td>
<td></td>
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</tbody>
</table>

**Today’s Discussion**

- The Proliferation of Clinically Integrated Consortia
- Key Imperatives for Network Success and Sustainability
- Questions
We believe there are five key imperatives for a consortium model network to achieve success and sustainability.

1. Define the Consortium’s Objectives and Confirm the Market Opportunity to Deliver Against these Objectives

2. Anticipate and Plan for the Competitive Response from other Providers and Payors – including Established Entities and Possible New Entrants

3. Achieve Alignment Along Multiple Dimensions, Within Each Participating Organization, and Across Partners

4. Make the Economics Work

5. Engage Care Teams to Transform Performance

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### 1. Consortium Objectives and Market Demand

#### Defining Consortium Objectives

- **Clearly-Defined, Tangible Objectives:**
  - What specifically is the Consortium aiming to achieve?
  - What are the goals for the Consortium of each participating organization?
  - What will be the measures of success?

- **Network Scope and Focus:**
  - What is the Network going to do to support these objectives?
  - What is the Network not going to do?

- **Timeline:**
  - What, if any, timing expectations exist for the Network to achieve its objectives?
  - How do objectives change over the short term? Over the longer-term?

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#### Confirming Market Demand

- **Segment Size and Distribution:**
  - What are the relevant segments?
  - How large is each segment?
  - What is the geographic distribution of lives within each segment?
  - Is segment projected to grow or contract?

- **Buying Characteristics:**
  - Where and how are decisions made?
  - How price sensitive is each segment?
  - To what degree does each segment value brand? Network composition?
  - What degree of change will segment decision makers/members consider?

- **Channels:**
  - What channels does each segment use currently? How might new channels affect purchasing behavior?
1. Consortium Objectives and Market Demand

Define the Consortium’s Objectives and Confirm the Market Opportunity to Deliver Against these Objectives.

- Are there specific market segments the consortium is best configured to attract?
- How can we best integrate transformational clinical and business processes across the entire network to deliver on the value proposition?
- What products and features should we offer to attract membership and enable us to successfully deliver higher-value care?
- Does the consortium have the geographic footprint and network configuration that meets both adequacy requirements and market expectations?
- What products can the consortium offer to meet the needs of sellers, influencers and purchasers?
- What brand do we use for the consortium? Should we build on existing brand equity or create a new brand?
- What is right pricing for our products? How may new products affect existing business?
- How can we best integrate transformational clinical and business processes across the entire network to deliver on the value proposition?

What is the product construct that best aligns market needs with the consortium’s capabilities and objectives?

Network Composition

Value Proposition

Branding

Pricing

Product Type & Plan Design

Sustainability

Target Market Segment(s)

2. Prepare for the Competitive Provider Response

Anticipate and Plan for the Competitive Response from other Providers and Payors – including Established Entities and Possible New Entrants

Wisconsin: A Tale of Two Consortia Networks

Recent Headlines

June 2014: Quality Health Solutions Changes Name, Contracts with Health Plan – IHN to be proprietary network and care model for Ownership Rewards, a self-funded health care plan for employers with 20 or more employees

Aug 2014: Froedert Seeks Co-Ownership of Ascension Health Plan Affiliate – The health plan would be tied to a network of hospitals and physicians... that would compete with a similar new network tied to Aurora Health Care

Aug 2014: Six Health Systems Create Pact, Aim for ACO – Six of the most prominent healthcare systems in Wisconsin have created a new partnership, jumping on the nationwide bandwagon of forming strategic alliances to share information, while remaining independent.
## 2. Prepare for the Competitive Payor Response

### Anticipate and Plan for the Competitive Response from other Providers and Payors – including Established Entities and Possible New Entrants

- Heartland Healthcare in St. Joseph, MO launched its newly branded Mosaic Life Care organization to market a portfolio of competitively priced health insurance products specific to their network in 2012
- BCBS KS artificially lowered premium levels for their competing products to stifle growth of Mosaic’s offerings
- Mosaic’s offerings ceased being actively offered to the market in 2014

- Aurora’s Accountable Care Network (AACN) worked with two payors to offer health insurance products specific to AACN’s network in 2013
- The dominant payor in the market, United Healthcare, effectively lowered pricing on all competing renewal business to ensure AACN’s products with competing payors would not gain traction in the market
- AACN continues to explore additional partnerships and marketing efforts to establish the brand

- In 2014, IBC teamed with DaVita HealthCare Partners to create Tandigm, a joint venture designed to align primary care providers and support cost reduction and quality improvement
- The new company utilizes HealthCare Partners care models coupled with strong economic incentives and data sharing to affect primary care referral patterns
- The Philadelphia delivery systems perceive this new entrant as a direct response to the continued development of their employed physician platforms as well as clinically integrated networks

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## 3. Alignment at Multiple Levels and Along Multiple Dimensions

### Achieve Alignment Along Multiple Dimensions, Within Each Participating Organization, and Across Partners

#### Achieving Alignment:

- **On Multiple Dimensions**
- **Within Each Organization and Local Region**
- **Across Partners and Throughout State**

#### Consortium Network

- A
- B
- C
- D
- E
- F
4. Make the Economics Work

**Make the Economics Work**

**Illustrative**

- What pricing is necessary to support a successful product launch?
- Magnitude of value created is highly sensitive to volume
- How much will utilization be reduced for the target population? For other patients?
- How much can you reduce leakage through benefits design and active network management?
- Can you access new populations through product or payment innovation?
- How much will utilization be reduced for the target population? For other patients?
- What pricing is necessary to support a successful product launch?
- Improved Efficiency Revenue Impact
- Improved Efficiency Operating Cost
- Shared Savings / Incentives
- Additional Services

**Current Earnings**

- Start Up & Operating Costs
- Unit Price
- Increased Steerage Volume
- Net New Patient Volume
- Improved Efficiency Revenue Impact
- Improved Efficiency Operating Cost
- Shared Savings / Incentives
- Additional Services

**Key Funds Flow Decisions to Be Made**

- How would payments from payor to individual providers be affected, if at all?
- If payments flow through Network, what is retained to cover central costs?
- How would funds be distributed to members?
- Under what scenarios would Network owe money to payor and how would this be handled? (e.g., in risk / downside arrangements, or cases when there is an overpayment that must be reconciled)?
- If funds are insufficient, how do partners cover additional central Network costs (i.e., beyond either initial enrollment fee or annual membership fee)?
- Will any funds flow from Network to out-of-network providers?
### Engage Care Teams to Transform Performance

#### Key Questions:
1. **How will responsibility be delegated and resources managed across the network and local systems?**
2. **How will local systems and providers be motivated to adhere to guidelines? To change behavior?**
3. **In what ways does a regional or even statewide network facilitate – or hinder – the transformation of care delivery?**

<table>
<thead>
<tr>
<th>Intensive Care Management</th>
<th>Complex Chronic Care</th>
<th>Chronic Disease Management</th>
<th>Acute / Preventative Health &amp; Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Regular provider contact (MD, NP, PA)</td>
<td>• Care transition management</td>
<td>• Scheduled chronic care visits</td>
<td>• Well adults over 65</td>
</tr>
<tr>
<td>• Care transition management</td>
<td>• Care Team conference/planning session</td>
<td>• Standardized chronic disease education</td>
<td>• Well adults under 65</td>
</tr>
<tr>
<td>• Referral for social work/community services</td>
<td></td>
<td>• Physician-led teams (that adhere to standard principles regarding roles and responsibilities of team members)</td>
<td>• Healthy children</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Acute care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Preventive visits/child and teen checks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Prenatal care</td>
</tr>
</tbody>
</table>

| | | | 65% |
| | | | 25% |
| | | | 8% |
| | | | 2% |

- Well adults over 65
- Well adults under 65
- Healthy children
- Adults with 1-2 chronic conditions
- Children with 1-2 chronic conditions
- Multiple chronic conditions
- Recurring unplanned events
- Multiple critical conditions
- Significant unplanned events
- High-cost

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**Questions?**