Adventist Health
Southern California Network

PREMIER

Physician Alignment Economics and Lessons Learned

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Physician Alignment Needs/Goals

- Deliver patients to the physicians (preferably profitable)
  - Get them busy
- Provide managed care infrastructure (ACO, CIN, MSSP, HMO patients, etc.) to the physicians
- Provide incentives to the physicians to assist the hospital to reduce resource consumption
  - Care model and support (people, IT solutions, clinicians, etc.)
  - Less costly provider setting
  - Shared risk pools
  - Performance criteria with incentives

Physician Alignment Models

- Bundle payment
- Co-management arrangement
- MSSP/Next Gen
- Shared risk pools
- Two-sided risk arrangements
- Clinically Integrated Network (CIN)
- Direct to employer contracting

Success Stories – Avera Health (St. Luke's Hospital) & Southwest General

Avera

(St. Luke's Hospital)

- **Episode Type:** Total Joint Replacement
- **Solution:** Physician engagement, accurate documentation, and transparency of data/information was key to success. Worked with physician champion and established multi-disciplinary team and oversight structure. Employed full-time nurse navigator.
- **Results:**
  - 40% reductions in PAC spend within 1 year.
  - Physicians feel they have a better handle on the health of their patients.
  - Focus has shifted from operational, within the four walls of the hospital, to a comprehensive strategy.

"Having the line of sight on all care for the patient is so important to us. Premier's Bundled Payment Solution, has been pivotal in helping Avera achieve our success."
– **Stacey Lenker,** Vice President, Payor Strategies, Avera Health

Southwest General
Partnering with University Hospitals

- **Episode Type:** Congestive Heart Failure
- **Solution:** Knew that aligning people, processes and technology would be the key to success. Setup process for PCs and Specialists received notifications when a bundle patient arrived and received support from the population health team. Transparent with SNF utilization and PAC spend data.
- **Results:**
  - 15% in 30-day readmissions
  - 17% reduction in 90-day readmissions
  - 9% reduction in unnecessary consults/associated costs
  - Positive NPRA allows for reinvestment into improving patient care.

"Our decision making related to our bundle is impacting our readmission rate, which has been decreasing. This increases our confidence in our work and the information we get from Premier's analytics tool."
– **Jill Barber,** Executive Director of Population Health, Southwest General

Bundled Payment: Direct to Employer

- Example: GE, Boeing, Lowe's, Pepsi, Verizon, Target, Walt Disney and Walmart
- Employer Goals
  - Improved patient outcomes
  - Reduced costs
- Payment model:
  - Bundled payments cover 100 percent of the charges of an episode of care (pre-surgery screening/work-up, travel to and from facility and recovery/rehabilitation)
  - Employers will sometimes use a third party to negotiate the contract or episode of care

Five Things to Know

1. Third parties have a rigorous selection process
   - Metrics
   - Request performance data
   - Subject to third party audit/verification
2. Rates are competitive
   - Negotiated before patient need between third party and provider
   - Volume guarantee for reduced price
3. Pre-surgery screening process to deny/confirm the need for the surgery
4. Results: better patient satisfaction and outcomes
5. Employers emphasize standardized care protocols and incentivize providers to use them

Co-Management Fundamentals

Governance

- The physicians form a management entity (PME) that contracts with the hospital and they, in turn, organize themselves into committees to effectively manage the hospital's service line and accomplish the fixed duties and performance metric goals

Fixed Duties

- Physicians are tasked with specific, non-clinical duties that further the goals of the service line and are paid for their time and effort

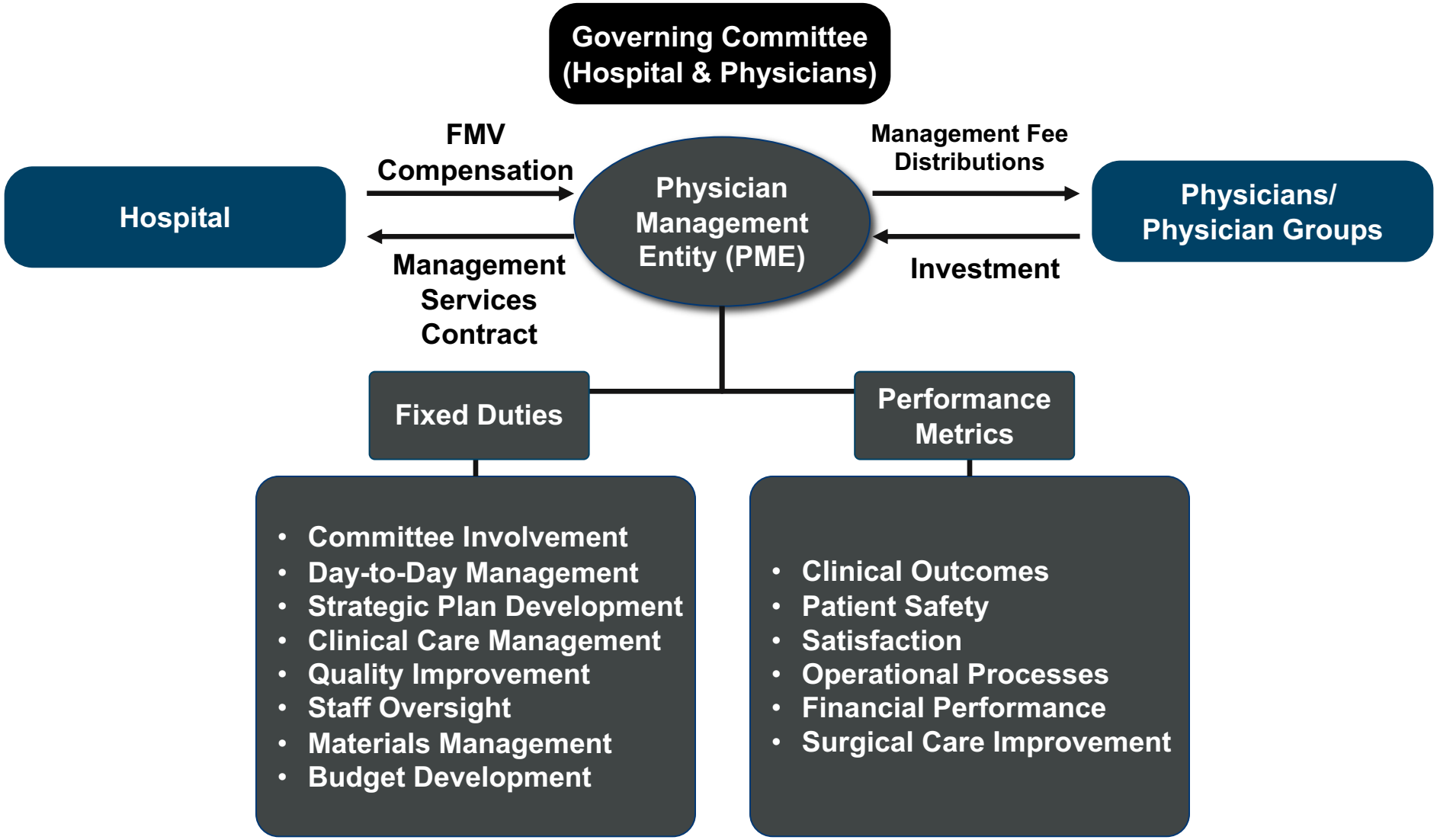
Performance Metrics

- Physicians are expected to improve upon historical performance in key areas such as clinical outcomes, quality, efficiency and satisfaction and are paid according to their level of success in achieving pre-determined targets

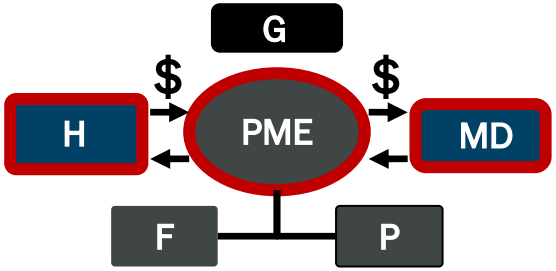
Valuation

- In return for provision of management services, physicians receive compensation at Fair Market Value (i.e., commensurate with what a full-time, 3rd party manager of the service line would command)

A Model of Clinical Co-Management



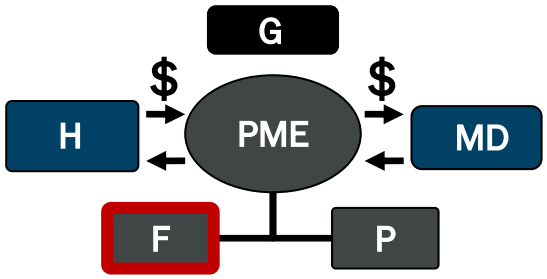
Governance



- PME formed (either JV with hospital and physicians or physician-owned)
- Physicians to capitalize PME start-up (costs typically minimal)

- PME contracts with the hospital to manage service line for FMV compensation
- Two components of management services commonly called fixed duties and performance metrics
- Term of contract must be at last 1 year, can extend up to 5 years (contingent upon hospital's bond covenants)

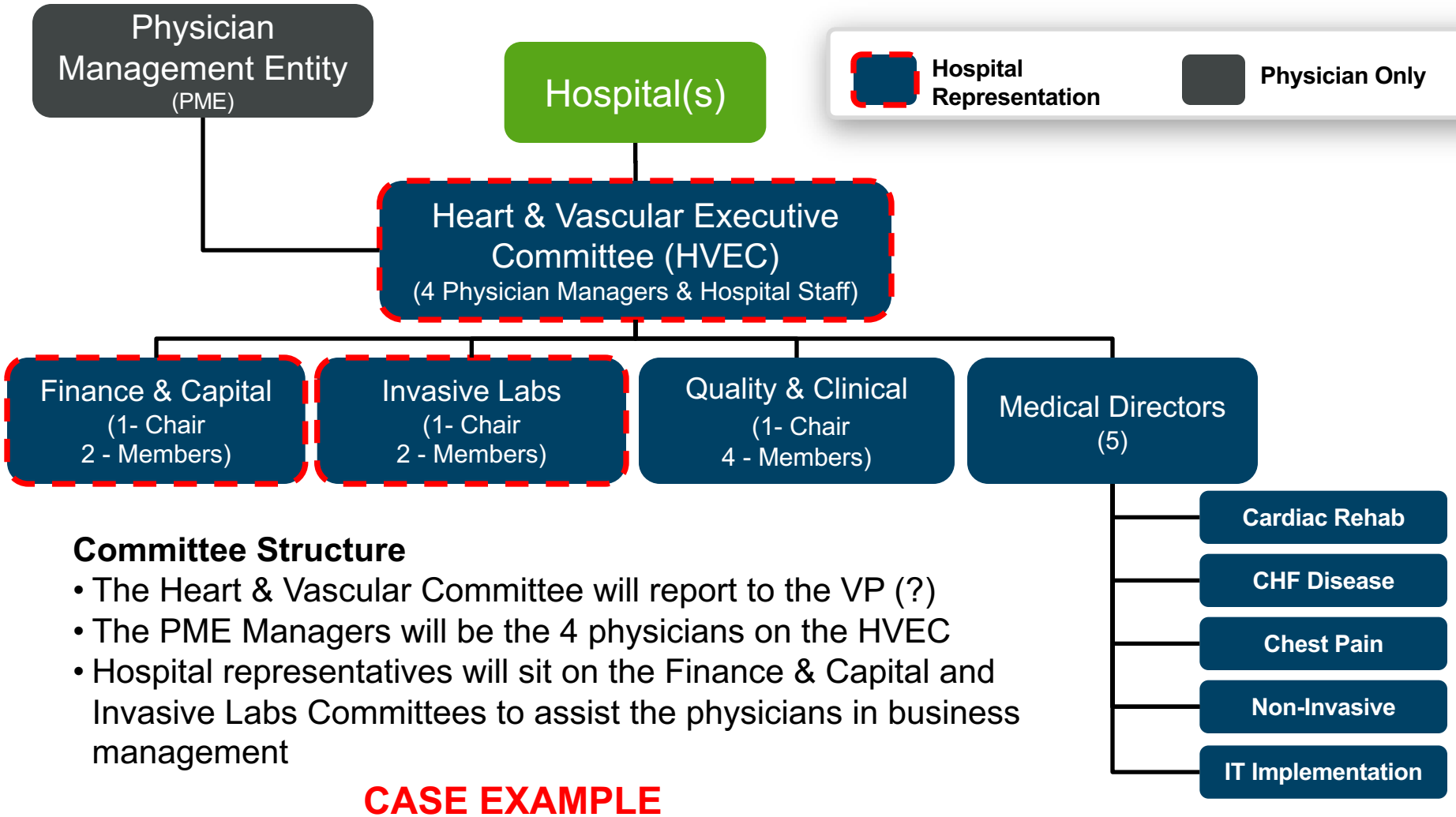
Fixed Duties



- Fixed duties involve the more typical day-to-day components of managing a service line
- Physician involvement often includes participation and leadership in joint hospital-physician committees and/or subcommittees

- Small contingent of physician leaders typically assume majority of responsibilities
- Physicians submit regular documentation of physician efforts
- PME may hire administrator to support its management efforts (LLC overhead)

Fixed Duties - Example

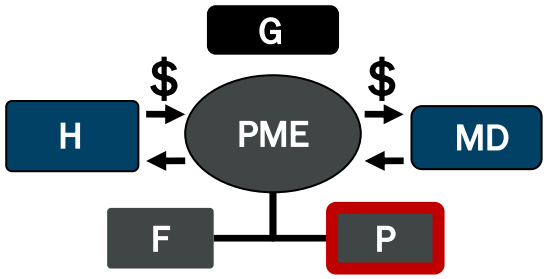


Committee Structure

- The Heart & Vascular Committee will report to the VP (?)
- The PME Managers will be the 4 physicians on the HVEC
- Hospital representatives will sit on the Finance & Capital and Invasive Labs Committees to assist the physicians in business management

CASE EXAMPLE

Performance Metrics



- Performance metrics link financial incentives to improvement from current performance in predefined clinical outcomes
- Physicians responsible for outcome of entire service line, not just PME member performance

- Metrics and targets can be changed or revised annually
- Metrics should:
  - Focus on service line needs
  - Drive improvement from baseline performance
  - Align with CMS core measures, national guidelines or international standards
  - Be within the scope of physician control
- Financial performance metrics cannot incentivize:
  - Rationing of care
  - Referrals, volume or revenue

Performance Metrics – Sample (Cardiology)

		Performance Metrics - Q4 FY12	BASELINE (2011)	Current	Performance Level	% Weight	Performance Total
Total Performance Compensation Available							***$ 798,000***
A	**Clinical Outcomes Metrics**					**35%**	
	1	CHF patients receiving discharge instructions.	97.0%	100.00%	3	7.0%	$ 55,860
	2	Creatinine assessed pre and post PCI procedure	88.4%	94.6%	2	7.0%	$ 37,240
	3	Beta Blocker at discharge for all AMI	89.5%	100.0%	3	7.0%	$ 55,860
B	**Complications and Patient Safety Metrics**					**35%**	
	1	30-day readmission rate for recurrent CHF (All adult, includes planned readmits).	8.5%	7.7%	1	7.0%	$ 18,620
	2	30-day CHF readmission rate for any reason (CMS Payor, includes planned readmits)	22.0%	17.0%	2	7.0%	$ 37,240
	3	Overall AMI -unadjusted risk mortality (STEMI and non-STEMI)	6.2%	3.62%	3	7.0%	$ 55,860
C	**Process and Efficiency Metrics**					**22.5%**	
	1	Inpatient echo reports read and documented in Camtronics within 24 hours of procedure performance	94.3%	98.0%	2	5.0%	$ 26,600
	2	Early diagnostic catheterization for AMI patients (within 24 hours)	65.4%	70%	3	6.5%	$ 51,870
D	**Satisfaction Metrics**					**7.5%**	
	1	Invasive Lab Satisfaction	66.1%	70.8%	1	2.5%	$ 9,975
Total Compensation Earned							***$ 349,125***

Level 1 Compensation Level 2 Compensation Level 3 Compensation

*Metrics not achieved are not included in this example, weighting has not been altered

Performance Metrics - Scorecard

Cardiology Co-Management Scorecard	Weight	July 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	YTD Result	YTD Score	% Earned	1	2	3
Clinical Outcomes	**25%**												
Core Measures - Overall Mean Percent	1.7%	98.6%	99.4%					99.00%	1	0.45%	99.0% - 99.4%	99.4-99.7%	> 99.7%
Surgical Site Infections Index (Act/Pred) -CABG(chest/l	1.7%	0.05	0.01					0.03	3	1.8%	1.05 - 1.1	0.96 - 1.05	< 0.96
Severity Adj Avg LOS Index (Act/Exp)-AMI	1.8%	1.13	1.25					1.19			0.93 - 1.03	0.83 - 0.93	< 0.83
Severity Adj Avg LOS Index (Act/Exp)-HF	1.8%	1.22	1.22					1.22			0.94 - 1.04	0.84 - 0.94	< 0.84
Severity Adj Avg LOS Index (Act/Exp)-CAGB	1.8%	1.22	1.04					1.13			0.91-1.01	0.81 - 0.91	< 0.81
Severity Adj Avg LOS Index (Act/Exp)-PCI	1.8%	1.37	1.27					1.32			0.91-1.01	0.81 - 0.91	< 0.81
Risk Adjustment Mortality Index (Act/Exp) -AMI	1.8%	1.02	0.68					0.85			0.68 - 0.83	0.53 - 0.68	< 0.53
Risk Adjustment Mortality Index (Act/Exp) -HF	1.8%	0.84	0.98					0.91			0.44 - 0.59	0.29 -0.44	< 0.29
Risk Adjustment Mortality Index (Act/Exp) -CABG	1.8%	0.3	0.1					0.2	1	0.45%	0.15 - 0.30	0.0 - 0.15	< 0
Risk Adjustment Mortality Index (Act/Exp) -PCI	1.8%	0.75	1.21					0.98			0.15 - 0.30	0.0 - 0.15	< 0
30D Readmission Rate - AMI	1.8%	15.0%	12.1%					13.57%	1	0.45%	13.5% - 14.0%	12.99% - 13.5%	< 12.99%
30D Readmission Rate - HF	1.8%	24.1%	17.6%					20.85%			18.0% - 18.5%	17.49% - 18.0%	< 17.49%
30D Readmission Rate - CABG	1.8%	8.6%	13.2%					10.89%	3	1.8%	11.7% - 12.3%	11.25% - 11.7%	< 11.25%
30D Readmission Rate - PCI	1.8%	8.5%	7.4%					7.96%	2	0.9%	8.0% - 8.5%	7.76% - 8.0%	< 7.76%
Safety	**25%**												
Patient Safety Indicators - AMI	6.25%	0	0					0	3	6.25%	0.40-0.55	0.25-0.40	< 0.25
Patient Safety Indicators - HF	6.25%	0	0					0	3	6.25%	0.42-0.57	0.27-0.42	< 0.27
Patient Safety Indicators - CABG	6.25%	1.92	0					0.96			0.39-0.56	0.24-0.39	< 0.24
Patient Safety Indicators - PCI	6.25%	1.55	0.41					0.98			0.45-0.60	0.29-0.45	< 0.29
Satisfaction	**15%**												
Patient Satisfaction - Physician Domain	7.5%	76%	75%					76%			85%	90%	95%
Patient Satisfaction - Discharge Domain	7.5%	91%	92%					91%	3	7.5%	85%	90%	95%
Cost	**35%**												
Estimated Costs - AMI	8.75%	1.42	1.6					1.51	1	2.2%	1.27 - 1.52	0.77 - 1.02	< 0.77
Estimated Costs - HF	8.75%	1.58	1.52					1.55			1.03 - 1.28	0.78 - 1.03	< 0.78
Estimated Costs - CABG	8.75%	1.61	1.49					1.55			1.0 - 1.25	0.75 - 1.0	< 0.75
Estimated Costs - PCI	8.75%	1.45	1.38					1.41			1.0 - 1.25	0.75 - 1.0	< 0.75
TOTAL	**100%**									**28.1%**			

Level 1 Compensation Level 2 Compensation Level 3 Compensation

Valuation Overview

- FMV analysis required to determine appropriate compensation for PME
- Breadth and depth of fixed duties assumed by PME physicians drives compensation
- Inclusion of performance metrics with stretch goals is factored into valuation
- Valuation methodology typically consists of:
  - Market approach (more aggressive, “Top Down”)
  - Cost approach (very conservative, “Bottom Up”)
- Critical to select valuation firm experienced with co-management agreements to ensure physician buy-in

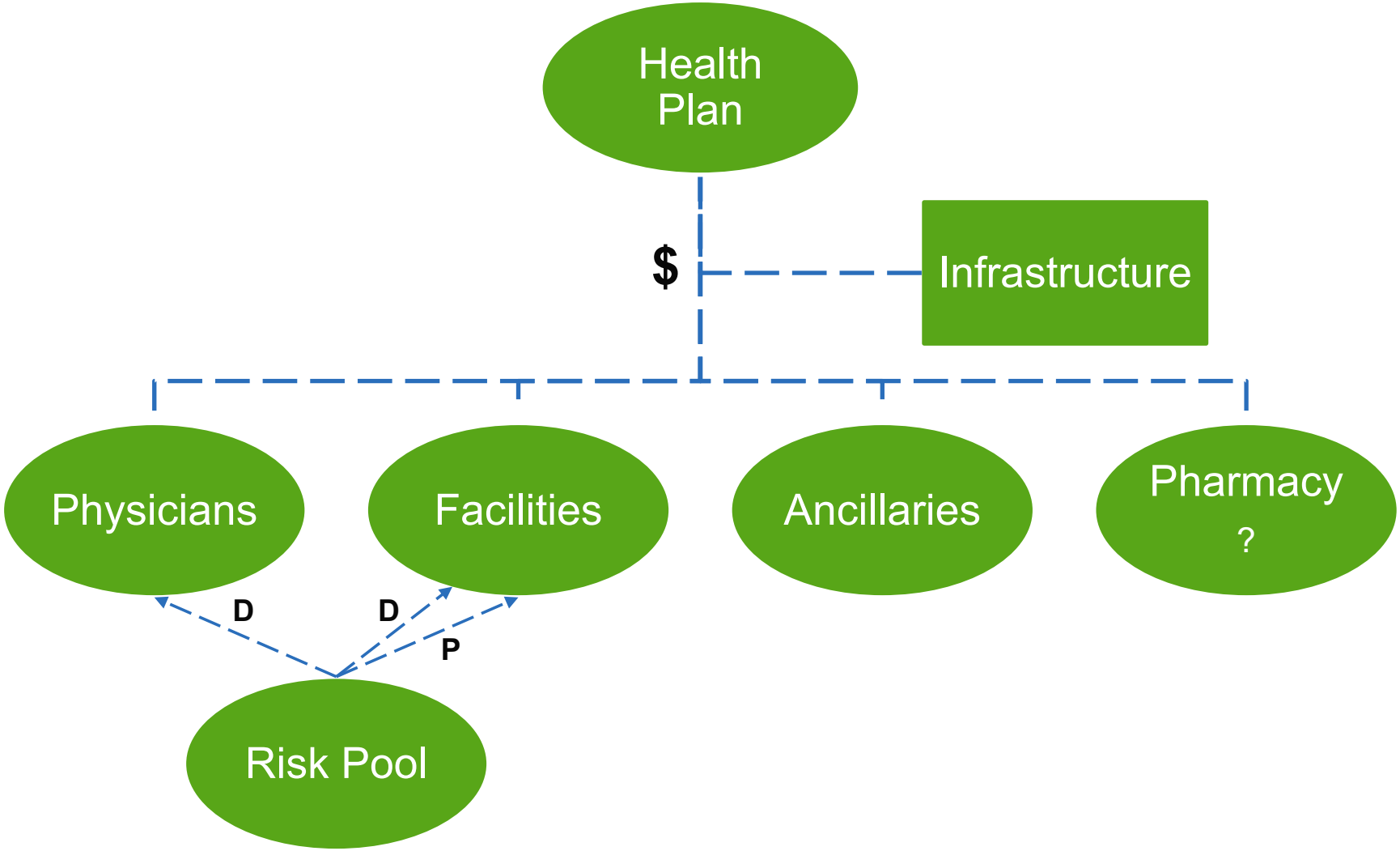
Direct Between Employer and Provider

- Wellness programs (Rand defines two components):
  - Lifestyle management (health risk: smoking, obesity, etc.)
  - Disease management (chronic conditions)
  - Trendy: self monitoring of activity, sleep, calorie consumption, etc.
- Centers of Excellence
  - Criteria: Ranked providers who provide treatment for a particular disease, procedure or condition
    - Organ transplants
    - Cancer
    - Cardiac surgery
    - Bariatric surgery
    - Joint replacement
    - Spinal surgery
  - Incentivize the employee by waiving co-pay, deductible and co-insurance and pay for travel and accommodations for the patient and their designee/caregiver

Payment Options and Behavior

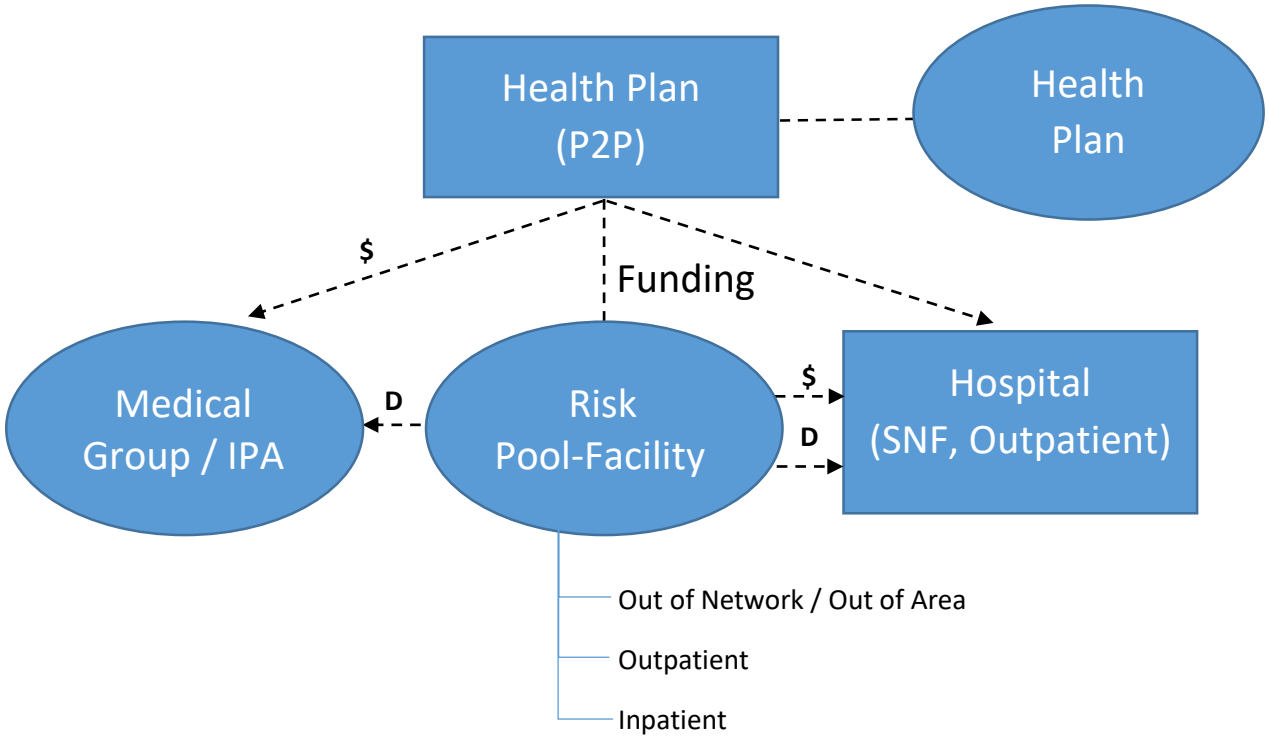
Primary Care	Specialists	Hospital	Risk Pool
CAP	CAP	Case Rate/Per Diem	✓
CAP	FFS	Case Rate/Per Diem	✓
FFS	CAP	Case Rate/Per Diem	✓
FFS	FFS	Case Rate/Per Diem	✓

Where Does the Premium Go?



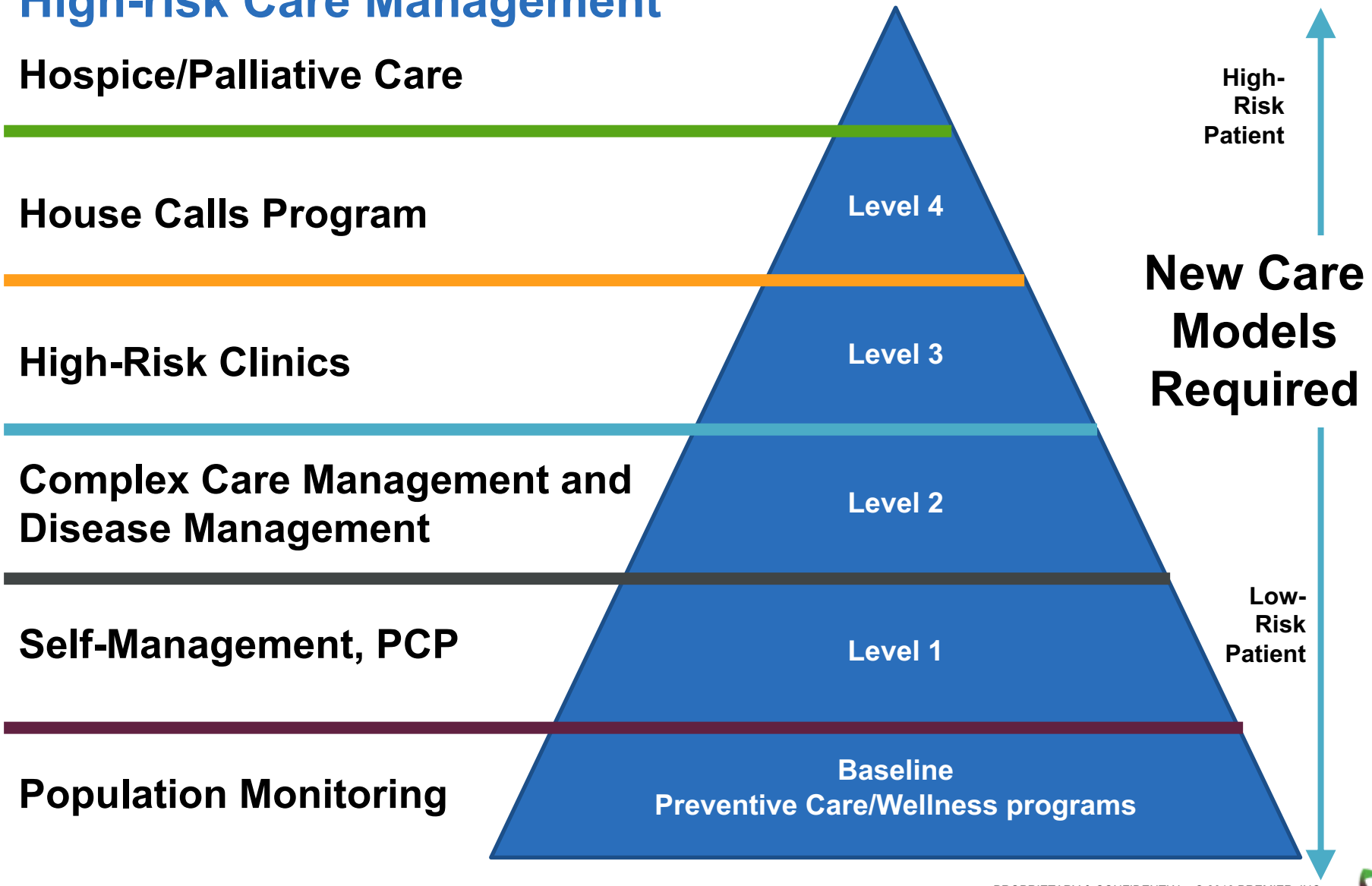
D – Distributions
P – Payments

P2P: Shared Risk Pool



D = Distribution Payments

High-risk Care Management



IDS Collaboration Opportunities

- Target markets:
  - Medicare Advantage
  - MSSP/ ACO
  - Commercial ACO
  - Medicaid managed care
  - Dual eligible managed care
  - Direct to employer
- Models/Options (IDS)
  - Health plan (own or partner)
  - ACO
  - CIN/RCIN
  - Shared risk pool
  - Bundle payment/co-management agreement

Collaboration Opportunities

- Payment methodologies
  - Shared risk pools (facility payments)
  - Health plan ownership-distribute net earnings
  - Standardize a Division of Financial Responsibility (DoFR)
  - Guidelines:
    - » Change payment model before care model
    - » Use aligned economic incentives to reward:
      - Quality outcomes (predetermined metrics)
      - Spend targets (predetermined metrics)
      - Economic incentives that target specific areas (problems)
      - Per diems, case rates
  - Those that benefit from infrastructure and resource consumption should pay for those resources

How are Shared Savings being Distributed?
Data from PHMC Members who generated shared savings

POPULATION HEALTH
MANAGEMENT COLLABORATIVE

Infrastructure/Reinvestment			
	PY2013	PY2014	PY2015
Average	38.4%	45.6%	40.3%
Range	12-73%	14-83%	9-73%

ACO Participants			
	PY2013	PY2014	PY2015
Average	64.8%	58.5%	66%
Range	33-88%	33-89%	33-90%

On average, PHMC ACOs are distributing the majority of their actual shared savings to PCPs, specialists, hospitals, and other providers while the remainder is distributed towards infrastructure and re-designed care processes/resources.

Example Models: Common Frameworks

	System A	System B	System C	System D	System E	System F
ACO Type	Commercial	Commercial	Medicare	Medicare	Medicare	Medicare, Commercial
Distribution metrics	Quality, Efficiency	Quality, Efficiency	Utilization, Quality	Utilization, Quality, Patient satisfaction	Utilization, Quality Y2- add Membership, Service	Utilization, Quality, Patient satisfaction, Efficiency
Hospital: Physician split	15% Hospital / 85% Physician		25% Hospital / 75% Physician after ACO costs	20% Hospital / 80% Physician	50 Hospital /50 Physician after 15% for ACO costs	66.6% Hospital / 33.3% Physician 50% of Hospital goes to Network infrastructure / 50% to continuum of service
Specialist: PCP split	56% SCP / 44% PCP	30% SCP / 70% PCP	25% SCP / 75% PCP	50 SCP / 50 PCP	0% SCP/ 100% PCP (Only PCP are eligible at this time)	30% SCP / 70% PCP
Provider Measure split	Quality 50% / Efficiency 50%	Specialist: Quality 65% / Efficiency 35% PCP: Quality 35% / Efficiency 65%	Process, Pat Sat & Outcomes 60% / Utilization-40%	Quality 40% / Pt Sat 40% / Utiliz 20%	Y1 Quality 50% / Utilization 50%	
Physician or Group Payment	Individual provider payments	Individual provider payments	Provider group payments	Individual provider payments	Individual provider payments	Varied

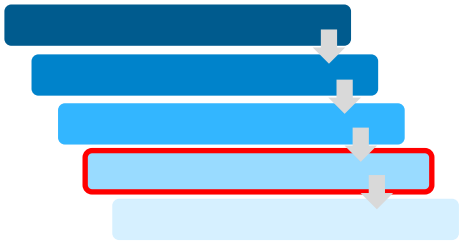
First savings are divided among provider categories

Secondly savings are divided from provider categories to the individual or group physician level

Metrics for the individual providers loosely tie to the organizational metrics

The specifics within the framework differ, including the division of payments between the hospital & physicians, between the physicians and if payments are made at the IPA or individual physician level

Define Shared Savings Measures



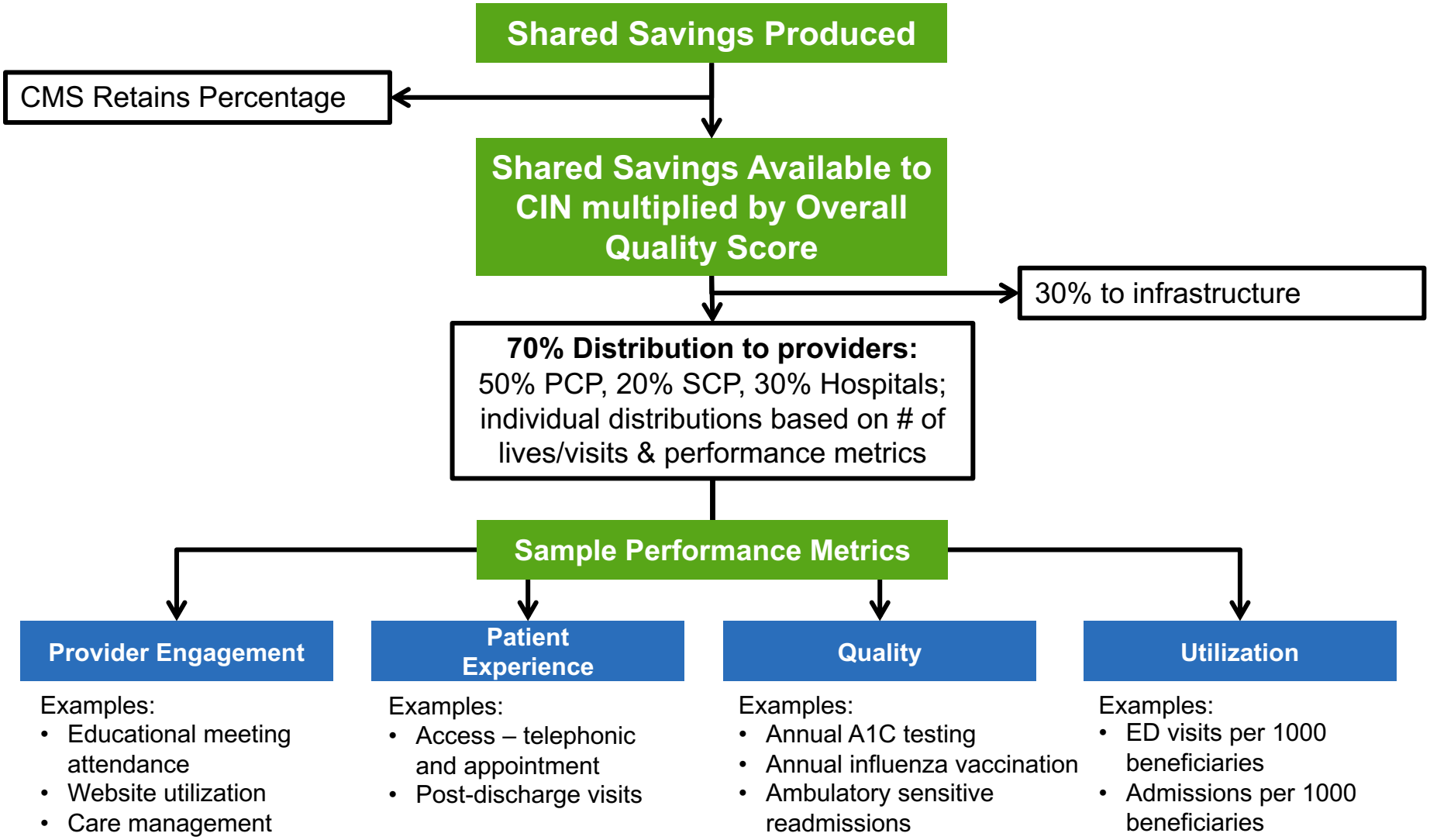
Overview:

- Metrics should promote the triple aim, and are expected to evolve with increasing data sophistication
- Consider what metrics are already being monitored that can be leveraged (physician groups, managed care, state reporting, etc.)
- Provider shared savings will be scaled based upon an overall performance score

Example Measures, Weighting, Scoring

Metrics	Level of reporting	Data source	Scoring	Definition of meeting measure	Weighting
Physician Engagement					**25%**
Attendance at meetings	Physician	Sign-in sheets	0,1	Attendance at 50% of town hall meetings	50%
Completion of education modules	Physician	Learning management system; log-in	0,1	Completion of 50% of education modules	25%
Completion of practice surveys	Practice	Data collection; survey monkey	0,1	Completion of 50% of practice surveys	25%
Quality					**25%**
Annual A1C testing for patients with diabetes	Population	Claims	0,1	75% of patients with Diabetes complete A1C testing in 2015	50%
Annual influenza vaccination	Population	Claims	0,1	55% of patients have influenza vaccination completed in 2015	50%
Utilization					**25%**
ED visits per 1000 beneficiaries	Population	4Q15 E&U report	0,1	5% reduction from benchmark report	50%
Admissions per 1000 beneficiaries	Population	4Q15 E&U report	0,1	5% reduction from benchmark report	50%
Patient experience					**25%**
Access	Practice	Secret shopper; survey	0,1	Same day access for urgent visit/consult as measures in 4th quarter 2015	100%

Example of Distribution and Performance Metrics



Areas of Opportunity

In Premier's experience, the greatest opportunities for improving utilization and cost per beneficiary are in these areas:

- Implementing **care management** for high-risk and rising risk populations
- Optimizing **post-acute care optimization** through high-value networks
- Implementing processes to reduce **readmissions**
- Reducing **avoidable admissions**

Summary of Lessons Learned

- There is no one right model
- Incentive distribution should not be confused with physician compensation
- Take strategic goals and savings opportunities into consideration in developing the plan; focus is very important
- PCPs, in most instances, have more impact on generating savings, and, the dollars available to specialists in most models are not significant enough to generate behavioral change
- Clearly communicate the distribution model early to incentivize participants
- Ensure distribution of “hard dollars”; avoid the temptation to immediately cover the ACO network’s costs at the expense of distributing funds to physicians
- Balance developing internal measures and systems that crosswalk the CMS attribution by TIN to correctly assign it to the NPI with not letting the perfect get in the way of the good
- Less is more – keep the model simple and modify over time, if necessary

Strategy: Guiding Principles

- Move to population health (continuum of care)
- Move to deliver value (payment systems pushing you there)
- Broad Access points (expand population served)
  - PCP, UCC, Retail, APPs, Health Plan, TeleHealth
- Move to risk payment/global payment (control spend)
- Improve quality (track Core Measure Quality Collaborative)
- Competitive cost structure
- Prepare physicians for MACRA
- Aligned payment systems:
  - Narrow networks
  - Alternative Payment Methodologies (ACO, PCMH, BP)
  - Shared risk pools to link with physician organizations

Guiding Principles for Value Based Payment

- Care models designed in response to payment models and incentives
- Those that hold the risk, should be responsible for the cost and delivery model
- Medicare Advantage, the better your performance (infrastructure, care model, metric results, less variation, etc.) you want a sicker patient (get paid more: coding)
- Medicaid, Commercial, Medicare and Dual eligibles are distinct populations and have different needs/access issues
- Quality outcomes and spend matter
- Clearly identify what you are at risk for (DoFR)
- Providers will optimize their economics

What Should I Pay Attention To?

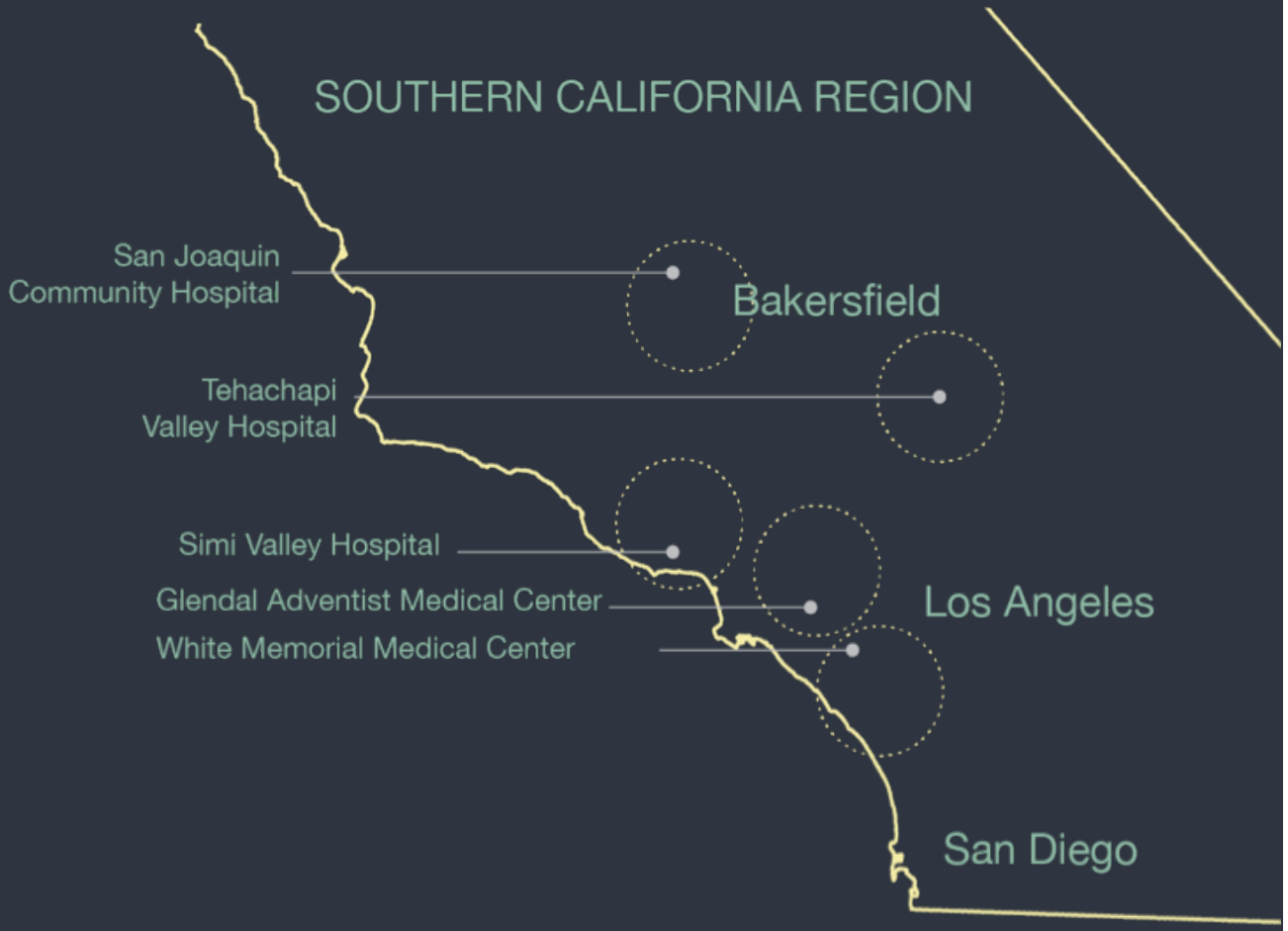
- Quality indicators:
  - HEDIS
  - MSSP Measures
  - MACRA metrics
  - CMS Star Ratings (target 4-5 Stars)
  - Anything specific to the contract
  - Patient satisfaction surveys
- Utilization indicators:
  - AD/1,000 and PD/1,000
  - LOS
  - ED visits/1,000
  - SNF days/1,000
  - Out of Network use (who and for what?)
  - Pre-authorization rate (target 95%, designate doctors)
  - Other areas where you have a spend problem
- Primary care referrals to specialists (rate)


Adventist Health
Southern California Region
This Is Who We Are

Who is the Region?

The Southern California Region is:

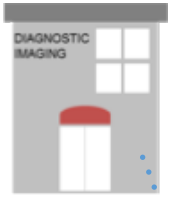
- 50% of the employee workforce
- 50% of the system volunteers
- 49% of the physician workforce
- 47% of patients admitted
- 56% of babies delivered
- 38% of emergency room visits
- 40% of the net revenue
- 40% of EBIDA



Adventist Health
Southern California Region

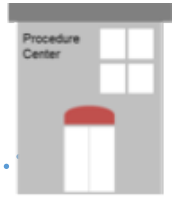
What Do We Bring to the Care in Southern California?

Health & Prevention
- Two Wellness & Therapy Centers



Ambulatory Network
- 10 Primary Care Sites: 56 providers
- 2 Multispecialty Sites: 26 Providers
- 14 Specialty Care Sites: 31 Providers
- 4 Urgent Care Sites: 35 Providers
- 4 Clinics/YMCA Partnerships
- 1 Federally-Qualified Health Center
- 1 LA Market IPA: 209 Physicians & 25,000 lives
- 1 Simi Valley CIN: 90+ Physicians
- 1 Kern County CIN: 100+ Physicians

Post-Acute
- Home Health & Hospice Care



Outpatient Centers
- 4 Outpatient Surgery Centers
- 6 Imaging Centers
- 3 Cancer Centers

Acute Care
- 5 Acute Care Hospitals

Large Employers Still Want To Provide Health Benefits, But What Are They Looking For?

More Predictable Price & Increased Transparency

"Value" Networks

Have Input on Network Participants

Wellness & Disease Management

Closer Relationships with Providers

What Are Their Options?

Employer Option	Trend	Important News
Traditional Model "Status Quo"		• Large employers costs continue to rise at an unsustainable pace • Some employers looking to either reduce their role in the process or gain more control of it
Private Exchange "We Give Up" (Walgreens, Hallmark)		• Mercer grew from 975,000 members to 1.4 million • Aon Hewitt grew from 750,000 members to 1.0 million • Accenture estimates exchanges grew 35 percent to approximately 8.0 million in 2016
Direct Contracting "We Want More Control" (Boeing, Intel, SHCA)		• Aon Hewitt survey reports that nearly 30 percent of employers are interested in some form of direct relationship with providers within the next three to five years. • Boeing direct-to-employer in Orange County

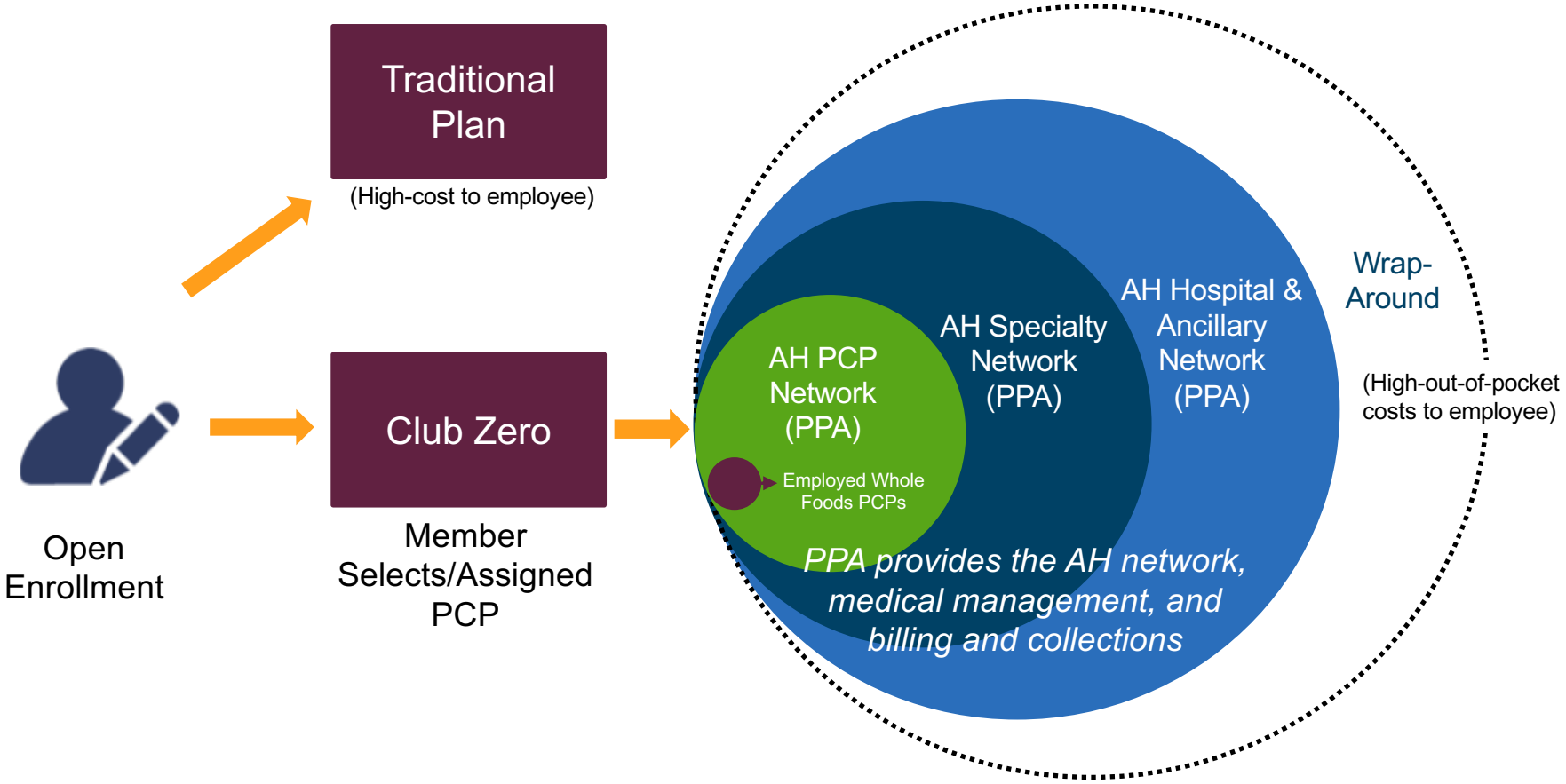
Sources:
https://www.accenture.com/us-en/insight-new-private-enrollment
http://www.forbes.com/sites/brucejapsen/2015/10/19/employers-shift-more-workers-to-private-exchanges/#6fd758d41db0
http://www.forbes.com/sites/brucejapsen/2014/10/08/more-employers-shifting-health-to-private-exchanges/#3d59d7c47abd
http://www.bdcadvisors.com/next-generation-health-care/
https://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2015/04/2015-emerging-trends-in-health-care-survey

Our Current Relationship

Highlights of Club Zero

- Population of 5,000, targeting 14,500
- Member must choose a PCP
- $0 monthly contribution from employee
- $0 cost sharing in-network
- 45% cost sharing for out-of-network
- Access to care coordination
- Greater discount on WF groceries
- Potentially extend program to other organizations (41,000 lives)-GPO

Club Zero Network Design



Early Success

- Club Zero is attracting higher-risk members (HUI Score of 1.21) which is giving AH the opportunity to make a significant impact on Whole Foods' health benefit costs
- Although still early, the population's utilization rates appear to be headed lower than expected
- If Club Zero continues to show positive results, there is potential for significant growth in the population at the upcoming Whole Foods open enrollment
- This arrangement is allowing us to further fund and develop greater capabilities around care coordination

Immediate Local Opportunities

Select Large Prospective Employers in Our Market

Private Sector

Nestlé

Avery Dennison

Western Growers

Disney

Public Sector

Seal of the Pasadena United School District — California

Metro

Simi Valley Schools — Simi Valley Unified School District

Burbank Unified School District — Equity and Excellence

Glendale Unified School District — Glendale Unified School District — California

Note: Additional large employers can be found in the appendix

Top Employers in Los Angeles County, Identified to Date

Employer	Number of Employees	Employer	Number of Employees
County of Los Angeles	97,500	Walt Disney	10,500
Los Angeles School District	73,300	Home Depot	10,200
Federal Government	48,100	Nestle	10,000
City of Los Angeles	47,700	Wells Fargo	9,500
State of California	30,400	MTA	9,200
Northrop Grumman	18,000	AT&T	8,900
Target	14,200	Cal Tech	8,900
Kroger	13,200	Edison International	8,300
Securitas Security Services	13,000	ABM Industries	8,300
Bank of America	12,000	Raytheon	8,200
Boeing	11,200	Warner Brothers	8,000

Note: Excludes healthcare providers
Sources: LA Almanac and Hoovers

The Market Opportunity: Focus on Large Employers (Over 1,000 employees)

By engaging employers with 1,000 or more employees, AH could capture a significant number of commercial members within the market and focus their resources

	Los Angeles County	Ventura County	Total
Number of businesses with 1,000+ employees (large)	253	16	269
Number of employees in the 1,000+ cohort	656,000	29,000	685,000
Estimated commercial beneficiaries in the market	3,900,000	436,000	4,336,000
Employees in large businesses as a percent of total commercial population	17%	7%	16%

Sources: http://www.labormarketinfo.edd.ca.gov/LMID/Size_of_Business_Data.html and InterStudy Data 2015

685,000 members make up an estimated 30,000 to 40,000 in acute commercial admissions

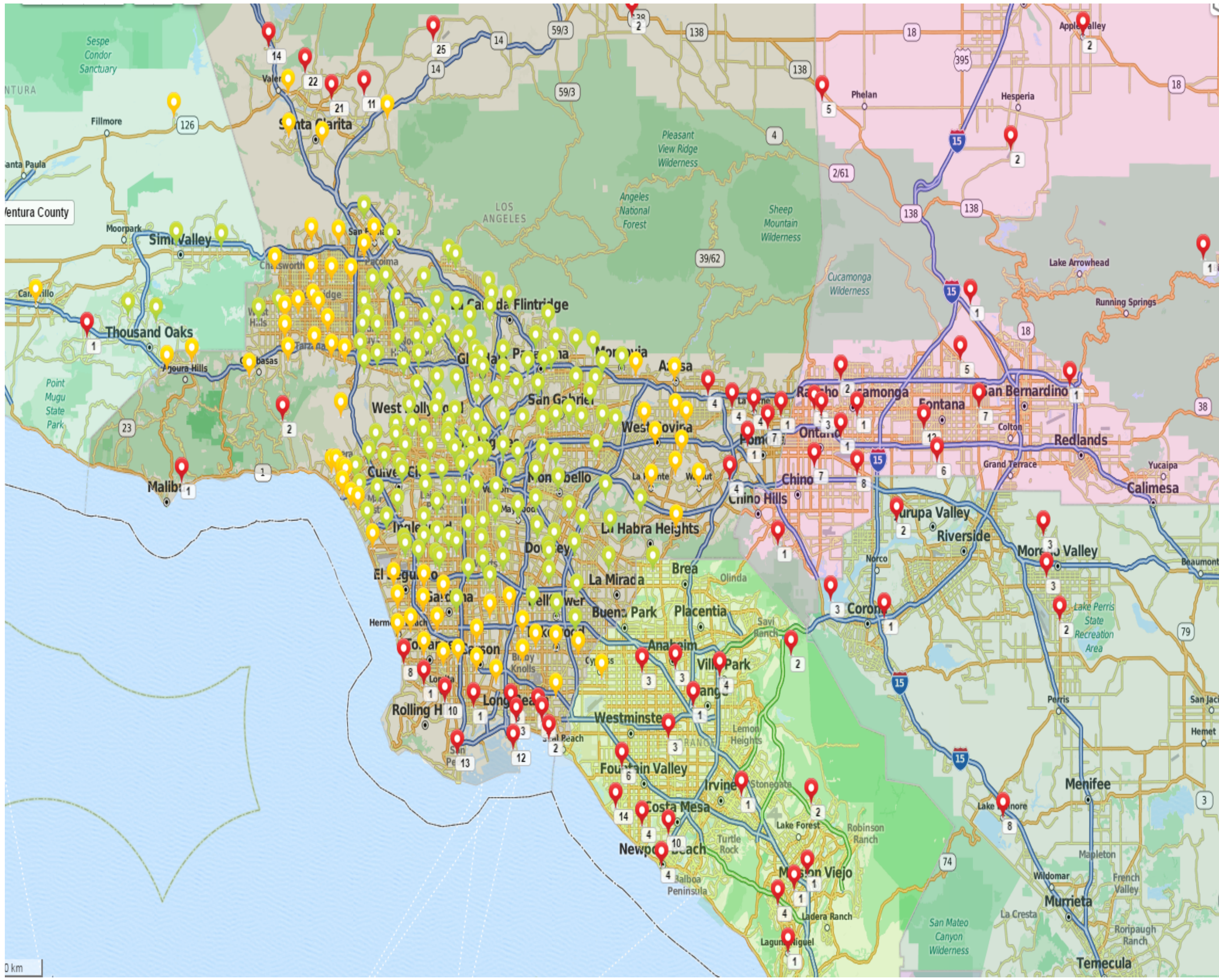
We Are Positioned for Success

Critical Success Factors

Price	• We are price competitive
Network	• We have a regional network, but will need strategic partners in select markets
Care Coordination Infrastructure	• We have care coordination through PPA. Will continue to build as we add more contracts
Relationships	• Employers are already reaching out to Southern California regional management directly

Where Might We Have Gaps in Our Network

Whole Foods Employees and Covered Lives – Glendale Area

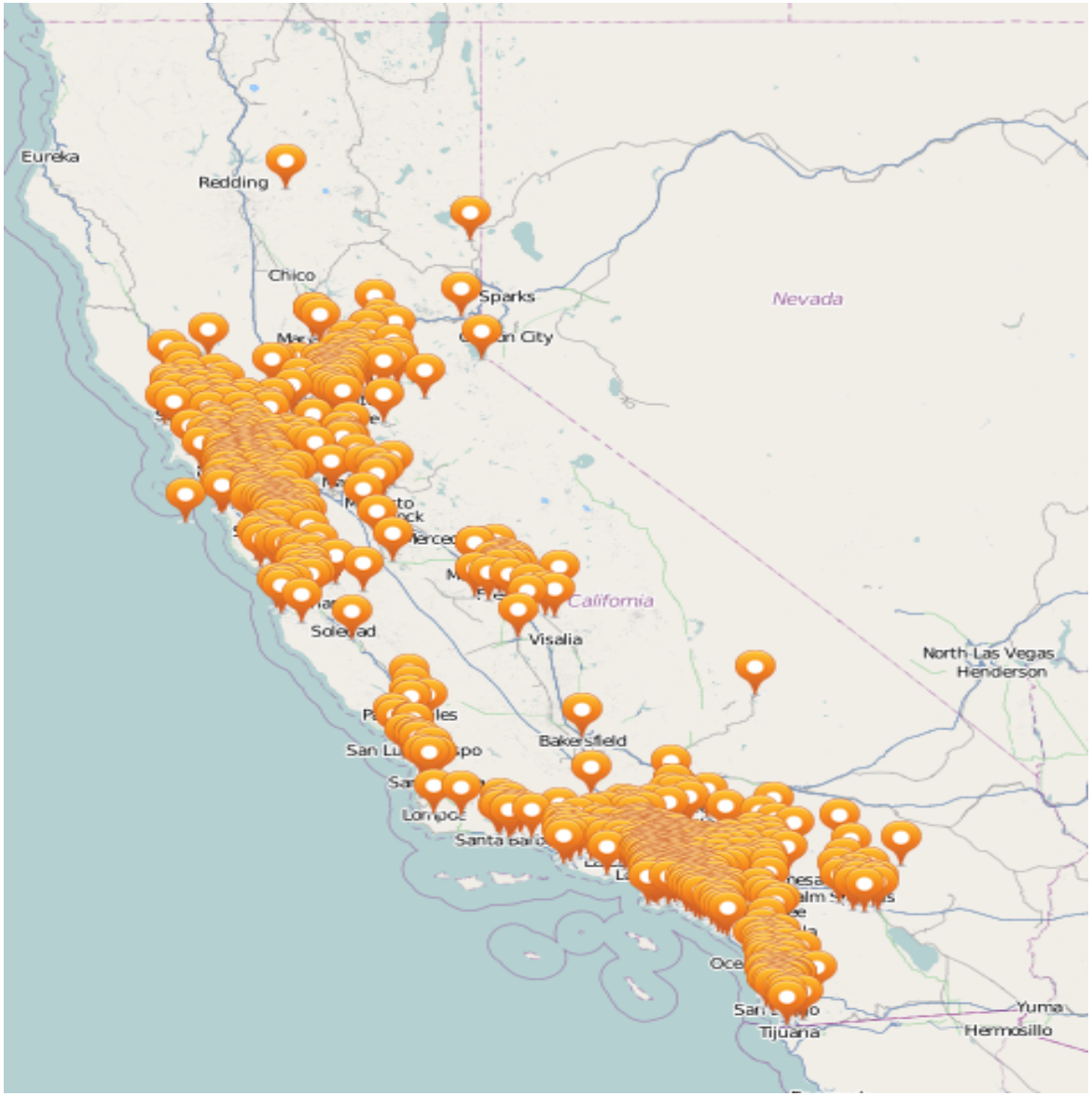


Map shows employee zip codes. Green represents employees within 10 miles of PCP, yellow within 15 miles, and red farther than 15.

Whole Foods California

Whole Foods California Employees

City	# of Mbrs	% of Total CA Mbrs
LOS ANGELES	1992	12%
SAN FRANCISCO	830	5%
SAN JOSE	800	5%
SAN DIEGO	444	3%
OAKLAND	390	2%
SANTA ROSA	358	2%
SACRAMENTO	249	2%
All Others	11107	69%
Grand Total	**16170**	**100%**



Pearls….

1. The Network is your value-build it intentionally
2. Care Navigation/Care Management is the secret sauce that differentiates from traditional Health Plan Network
3. The price point for Hospital Based services sells the network
4. Quality above Quantity