OPTUM

Monarch Pioneer ACO

Patient Engagement Strategy

March 3rd, 2015

Monarch HealthCare Facts and Figures

Expertise in Population Health Management

- Founded January, 1994
- Acquired Knox Keene in 2008
- 100% of PCPs capitated
- 100% of specialists in performance based contracts

Optum Affiliate

- Joined Optum in November 2011
- Part of largest physician group in region and in US
- Largest IPA in Orange County
- Over 2,300 physicians and 19 hospitals

Employed Practitioners & Mid-Level Extenders

- 150 Physicians, NPs, and PAs
  - Mostly primary care
  - 27 Hospitalists
- 102 MA's and Mid-Levels

Contract with Nearly Every Major Health Plan with a California Presence

Global Capitation contracts with nearly every payer

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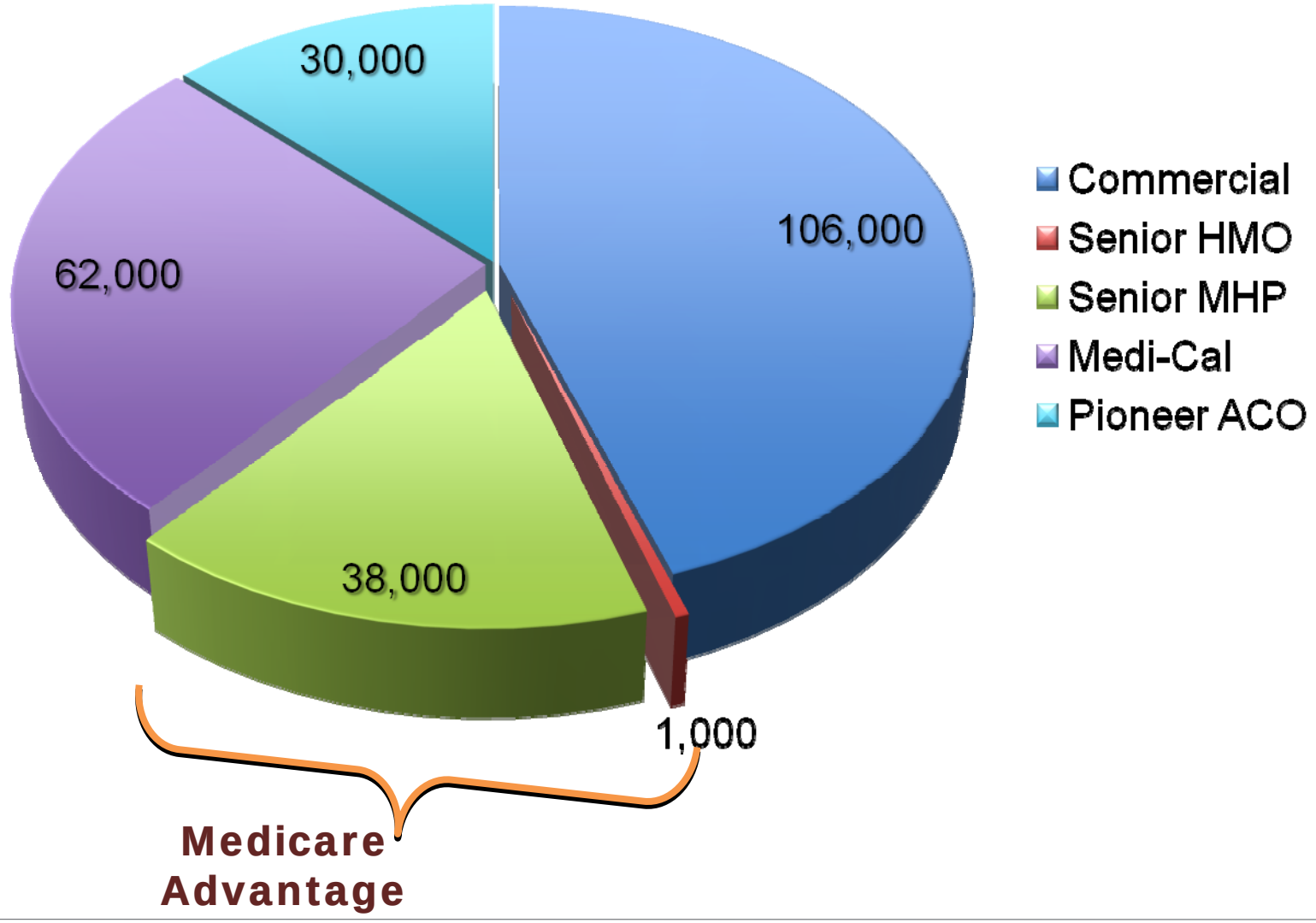
January 2015 Monarch Population: 237K Total



Monarch Pioneer ACO Was the 2nd Highest Performer in the Program in the First Two Years

Performance Summary	2012	2013
Patients	17,365	19,530
Shared Savings %	6.2%	5.4%
Total Shared Savings	$12,143.409	$14,608,113
Quality Performance %	NA	84%
Monarch Shared Savings %	50%	70%
Total Monarch Shared Savings	$6,071,705	$8,544,577
Shared Savings PMPM	$29.16	$36.50

- 2013 shared savings drivers:
  - Lower utilization - admits, ALOS and readmits
  - Lower skilled nursing facility costs (~18% of shared savings)
  - Increased par-PCP utilization and lower non-par leakage
    - PCP visits/yr increased from 3.2 in 2011, to 4.3 in 2013
  - Increased hospice utilization

Patient Outcomes and Resource Use are Improving but Medicare Advantage Still Significantly Better Product

Key Operating Indicators	PY0/FFS (2011)	PY1 (2012)	PY2 (2013)	MA (2013)
Acute Admits/K	282	283	239	170-180
Acute Days/K	1,408	1,414	1,131	750-850
Acute Readmit Rate	18%	15%	14%	10-12%
SNF Admits/K	136	136	104	60-70
SNF Days/K	4,225	4,249	2,908	800-900
SNF Readmit Rate	17%	12%	10%	11%

- Monarch's ACO performance relative to MA performance illustrates remaining opportunity
- MA-like inpatient results would more than double shared savings for the Pioneer ACO

Monarch Pioneer ACO

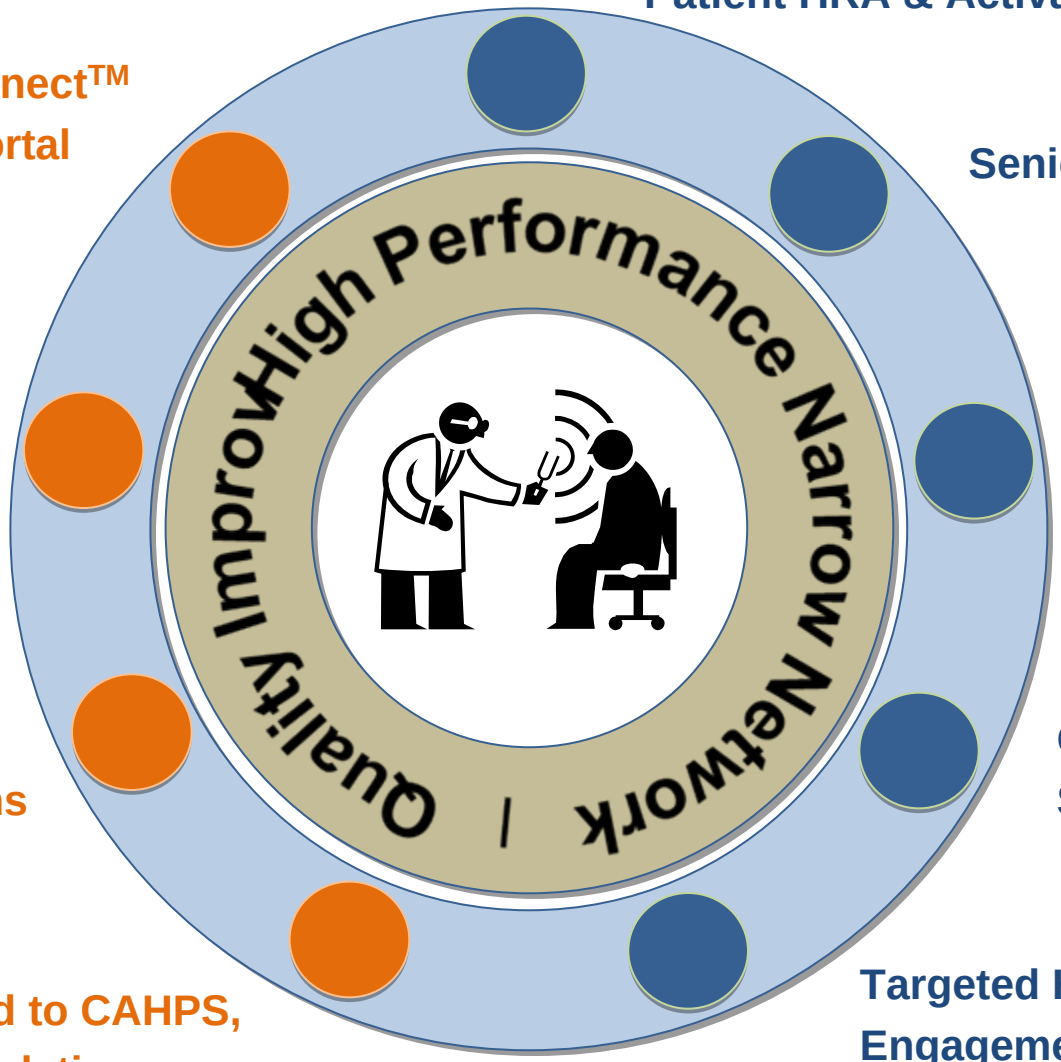
BUILDING A PATIENT ENGAGEMENT STRATEGY ON AN HMO FOUNDATION

Early Analysis Identified Familiar Opportunities and New Challenges

- Risk Stratification
- Predictive Modelling
- Practice Pattern Variation
- Episodic Analysis
- Transition of Care Pathways
- Leakage Analysis

- 4% of patients account for 47% of cost
- High prevalence of ESRD and CHF
- Identification of high cost facilities
- Distribution of provider performance by type
- Limited tangible benefit to offer patients
- Limited experience changing patient behavior

Building a Patient Engagement Strategy on an HMO Foundation



Patient HRA & Activation Survey

Practice Connect™ Physician Portal

Senior Advisory Board

Patient Communication Training

Patient Newsletter

Quarterly CAHPS Survey Simulations

Community-Based Services

Incentives Tied to CAHPS, and HRA Completion

Targeted High-Risk Patient Engagement

Provider-focused strategies

Patient-focused strategies

HMO strategy

Future ACO Models

GROWING IMPORTANCE OF PATIENT ENGAGEMENT

HHS Is Setting An Aggressive Pace For That Transition, With Significant Public- and Private-Sector Support

"In 2017, 100% of Medicare physicians will be in outcomes-based payment arrangements"

-**Patrick Conway, Chief Medical Officer, CMS, 4/10/14**

"HHS has set a goal of tying 90% of all traditional Medicare payments to quality or value by 2018"

- Sylvia M. Burwell, Secretary, HHS 1/26/15

"Today's announcement by Secretary Burwell is a major step forward in achieving [the goal of] advancing a patient-centered health system "

- Karen Ignani, President & CEO, America's Health Insurance Plans, 1/26/15

"There is considerable bipartisan support for moving away from fee for service toward alternative payment models that reward value, improve outcomes, and reduce costs"

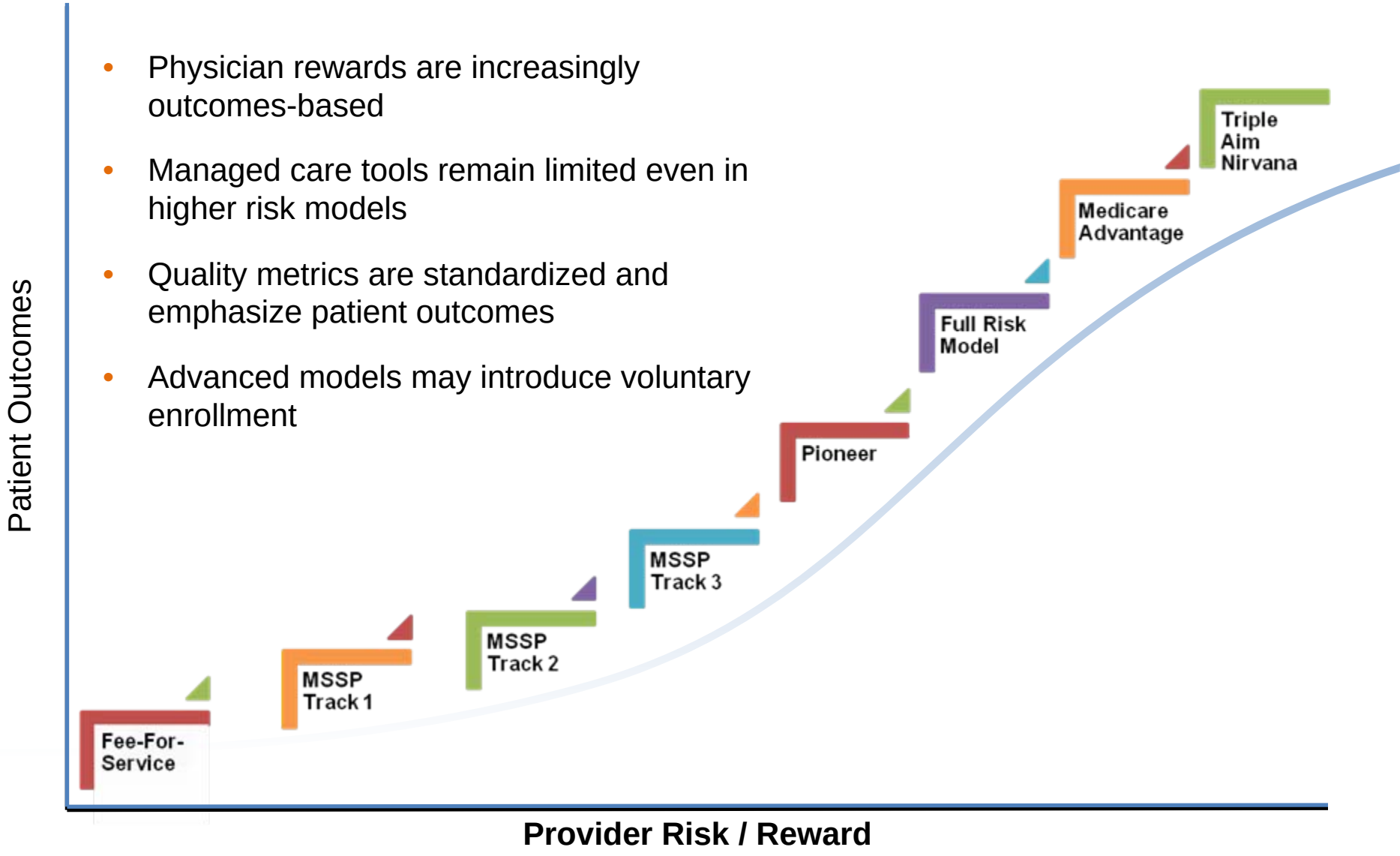
-**Janet Marchibroda, Bipartisan Policy Center**

ACO Program Options in 2016

			New in 2016		*New in 2016*
	MSSP Track 1: One-Sided Risk	**MSSP Track 2: Two-Sided Risk**	**MSSP Track 3: Two-Sided Risk**	**Pioneer ACO Model 2.0: Two-Sided Risk**	**Full-Risk ACO Model: Capitation**
Size Requirements	- At least 5,000	- At least 5,000	- At least 5,000	- At least 15,000	- At least 15,000
Payment Model	- Up to 50% shared savings	- Up to 60% shared savings	- Up to 75% shared savings	- Up to 70% shared savings	- Capitation
Min. Savings Rate	- 2.0-3.9%	- 1.0-2.0%	- 1.0-2.0%	- 0.0-2.0%	- No hurdle rate
Payment Limit	- 10%	- 15%	- 20%	- 15%	- No payment limit
Waivers	- No waivers	- Limited waivers	- All waivers	- All waivers	- All waivers
Advantages / Disadvantages	- Low risk, low reward - Program slow to evolve - CMS not ideal administrator	+ Improved risk/reward - Program slow to evolve - CMS not ideal administrator	+ Significantly improved risk/reward - Program slow to evolve - CMS not ideal administrator	+ CMMI leadership + Waivers - Quality still anchored to MSSP	+ CMMI leadership + Waivers + Improved patient engagement + Waivers - Additional compliance - Administrative complexity

The Glide Path to Accountability

- Physician rewards are increasingly outcomes-based
- Managed care tools remain limited even in higher risk models
- Quality metrics are standardized and emphasize patient outcomes
- Advanced models may introduce voluntary enrollment



Patient Engagement Trends to Watch

- Price and quality transparency
- Physician performance transparency
- “Tailored” networks
- Strategic use of telemedicine/telehealth, wearables, patient portals, text communication