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Emerging Community Hospital Networks: Forging Alliances to Remain Independent

July 24, 2014

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Role of Alliances In the Evolving Health Care Market

Presented by:
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Discussion Agenda

- Rationale for the Formation of Alliances
- Benefits of Alliances
- Business Opportunities Alliances are Pursuing

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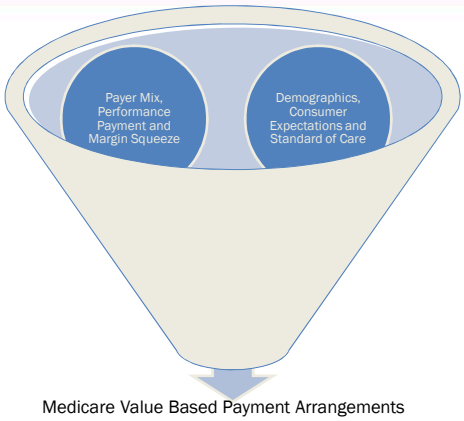
Forces Driving Change to the Current Business Model



Medicare Value Based Payment Arrangements
Hospital Competitors Consolidating the Market
Independent Physician Organizing
Commercial Payer Value Based Payment Strategies
Challenges and Costs of Transforming to a Value Based System of Care

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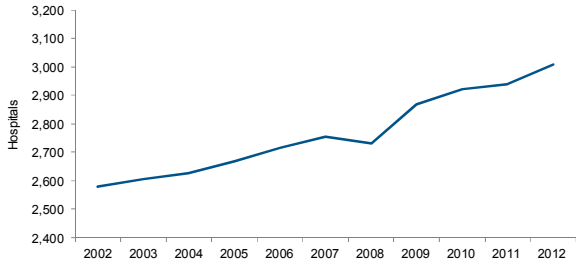
Market Opportunities | Hospital Consolidation

Hospital Consolidation is leading to a Limited Choice of Integrated Delivery Systems

- Hospital markets are rapidly consolidating (statewide, regional and national)
- System-affiliated hospitals outnumber those that remain independent

Number of Hospitals in Health Systems,(1) 2002 – 2012



OPPORTUNITY FOR ALLIANCES:

- Working collectively, Alliances provide a counterweight to existing large systems: assets, geographic distribution, physician alignment, cost/quality profile

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2012, for community hospitals.
(1) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.

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A New Set of Core Competencies is Required For Provider Success Going Forward

Integration Attributes	Key Characteristics of the Best Prepared
Physician/ Hospital Integration	A highly aligned medical staff characterized by shared goals, outcomes-based contractual arrangements, significant planning input, and adequately represented in organizational governance
Care Coordination/ Management Capability	Use of care coordination tools and processes by an empowered and integrated workforce to meet performance goals that are regularly measured and reported
Information Systems Sophistication	An IT platform that supports clinical decision making, information management, facile communications, and access by all stakeholders (physicians, patients, administration) to proper treatment and strategic decision making
Service Distribution System Effectiveness	A rational service distribution system that has accessible primary care and easy access (both physically and through referrals) across the care continuum, delivered in contemporary facilities with contemporary equipment
Cost Structure Management	A right-sized organization-wide cost structure, highlighted by appropriate levels of staffing, capital spending, overhead support, and supply chain costs; constantly reviewed based on comparative peer group studies and benchmarks
Scale and Market Essentiality	Sufficient scale to attract competitive clinical and administrative talent, realize economies, drive marketplace innovation, and be an essential provider to health plans and patients
Brand Identification	Well recognized and respected, associated with high-quality and service excellence.
Payer Relationships/ Contracts	Maintaining strong relationships with payers and the ability to negotiate support for "new era" business practices
Financial Strength/ Capital Capacity	Strong appeal to capital markets through sustained operations, revenue growth, and balance sheet strength

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Market Opportunities | Physician Organization

Organized Physician Entities have spearheaded efforts to reduce costs and have been gaining experience and capabilities in managing the health of defined populations.

- Gaining experience and developing resources and tools to manage populations is leading these organized MD entities to strategize additional ways to lower the total cost of care, including looking at ways to partner with selected providers (hospitals, physicians, home health companies and nursing homes) to continue to reduce the total cost of care.
- The end game for the more well organized and capitalized of these Physician Organizations is to build the capability to take on risk arrangements, particularly Medicare Advantage risk arrangements.

OPPORTUNITY FOR ALLIANCES:

- Alliance hospitals must have a lower cost position relative to larger existing systems, demonstrated results from efficient management of patients pre, during and post discharge (through hospitalist programs, patient navigators, disease management programs and nursing home collaboratives), geographic distribution and comprehensive service coverage. With these advantages, Alliances can be positioned as a preferred partner to certain independent organized MD entities.
- To be attractive to organized physician entities, Alliances must direct resources and investments in data and analytics, clinical integration and care management resources to support population health management.

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Market Opportunities | Payer Strategies

Payer Contracting Strategies Continue to Evolve as Experience is Gained with Provider/Payer Collaborations

- The trend: restructure payment toward one that pays for the quality of care delivered (as measured through outcomes) and performance on reducing total cost of care versus paying for the units of service provided.

Current State

- Most Payers have embarked on market strategies which incorporate this philosophy.
- Many have in place similar PCP shared savings arrangements with organized MD groups with a few PHOs/ACOs that incentivize physicians to reduce inpatient and ED utilization and to utilize lower cost settings for ambulatory and diagnostic procedures.
- In the short term most savings have come from managing hospital readmissions and reducing ED utilization. The more difficult strategy of moving patients to alternative lower cost facilities has proven difficult as consumer incentives are not aligned with this approach and this may require physicians to change practice patterns, including hospital affiliations.
- Payers continue to evolve their approaches, alternatives being pursued: Offering integrated Physician/Hospital Networks that can provide a significant premium differential from current PPO and HMO offerings.

OPPORTUNITY FOR ALLIANCES:

- With expanded geographic presence and lower cost profiles, Alliances can provide a competitive alternative to Payers who are interested in expanding their markets by challenging incumbent health insurers.
- Working collaboratively with selected Payers, an Alliance could bring new models of care delivery and payment reform to market with a co-branded health plan and/or custom tailored networks for Employers and other targeted market segments.

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Strategic Questions Healthcare Organizations Are Posing

- What is a sustainable Vision that maintains our organization as a valuable asset?
- Can we achieve this vision on our own?
- What options should be considered?
  - » Full asset merger
  - » Joint operating agreement
  - » Partnership or Alignment with other like-minded organizations

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Benefits of Alliances

- Preserves independence and local control while collaborating with other like- minded organizations
- Serves as a ready format for providers to collaborate, as permitted by law, to share best practices to improve quality and lower costs and to take advantage of scale opportunities
- Allows participants to begin in a modest way and work together more closely over time as it makes sense

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Benefits of Alliances (cont.)

- Serves as an alternative to change of ownership, sale or consolidation
- Can be a counterweight to larger health systems
- Essential partner to payers and physicians for value-based products (e.g., narrow/tiered networks, risk)
- Market capture and growth

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Recent Alliance Activity

Formation of Non-Ownership Hospital Affiliations

- Across the country, independent hospitals are forming collaborations to gain the advantages of mergers without the expense, downside risks and loss of local control
- To date efforts have been largely focused on
  - Boosting purchasing power and reducing operating costs
  - Sharing the costs of acquiring skills and resources in population health management
  - Sharing best practices in quality improvement and creating clinically integrated networks of physicians and hospitals
  - Organizing to partner with Payers and employers for innovative solutions to manage the total cost of care

Granite Healthcare Network	Granite Healthcare Network - New Hampshire
BJC	The BJC Collaborative - Missouri & Illinois
Value Health Alliance	Value Health Alliance - Connecticut
AllSpire	AllSpire - Pennsylvania, New Jersey, NY and Maryland
Noble	Noble Health Alliance - Philadelphia Pennsylvania
Trivergent Health Alliance	Trivergent Health Alliance - Maryland
The University of Iowa Health Alliance	The University of Iowa Health Alliance - Iowa
INITIANT	Initiant Health Collaborative - South Carolina
Georgia Health Collaborative	Georgia Health Collaborative - Georgia
Stratus Healthcare	Stratus Healthcare - Central and South Georgia

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Alliance Profiles | Commonalities

Structure / Leadership	Staffing	Capitalization Ranges	Payer Strategies	PHM Tools and Resources	Shared Services/ Scale Opportunities	Clinical Integration Initiatives
• LLC • Executive Board comprised mainly of CEOs • CEOs meet in person regularly and phone calls in between • Assigned leadership e.g. Chair, Vice Chair, etc. • Various sub committees with executive leadership	• Staff on loan or hired (or consulting) • Staff may be on payroll of one hospital and billed to Alliance monthly • Staff typically includes: Executive Director, Pop Health Mgr, Analyst, Project Coordinator, Assistant	• Ranges from $400k to $1M per member per year (or pro-rata share based on % of NPSR) • Board review and approval for capital expenditures • Requires vote for capital needs	• Initial focus on employees (e.g. eACO) • Tiered networks • Some considering joint ventures with payers • Co-branded products	• Initial focus on employees for population health management • Developing single ASO/TPA for employees • Focus on improving regional health status: Obesity and Depression • Evaluating vendor relationships	• HR back office functions and standardization • Standardize billing processes • Collections • Pharmacy • Reference lab • Core lab • Supply Chain • Consolidate non-strategic operations • GPO	• Development of CI committees • Identification of starter set of metrics, in conjunction with IT • CMOs meet to establish evidenced based guidelines for Asthma, ED use, Readmissions, Advanced radiology, low back pain, etc.

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Challenges

- Real vs. perceived "value" in terms of price position
- Clash between what the market wants to buy and an Alliance is offering/ready and capable to offer
- Variable strengths and weaknesses of Alliance members
- Addressing needs of potential members
- Required investment in building out the strategy
- Ability to adapt and move quickly as the market evolves

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Value Care Alliance

Presented by:

Pat Charmel

ValueCare ALLIANCE

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Discussion Agenda

- Overview of the Value Care Alliance
  - » Market Dynamics in Place
  - » Current Alliance Participants and Alliance's Relative Market Position vis a vis Competitors
  - » Member Commitments
  - » Areas of Focus
  - » Development Schedule

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Discussion Agenda (cont.)

- Lessons Learned
  - » Getting Started
  - » Data and Data Sources
  - » Managing the Process
  - » Staying the Course

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Overview | Market Dynamics at the Time of Formation

- Existing Health Systems in the process of solidifying their market power by increasing scale and level of physician integration.
- All major payers in the market using Shared Savings Arrangements with PCP organizations to lower total medical costs (TME).
- Organized MD entities enjoying payer support for PHM infrastructure build and shared savings arrangements. To keep PMPM payments and achieve shared savings payouts, there is increasing pressure to produce results.

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Overview | Market Dynamics at the Time of Formation (cont.)

- Expected next moves:
  - » Payers offer integrated Physician/Hospital Networks that can provide a significant premium differential from current PPO and HMO offerings
  - » Expectations are for a 10%+ reduction in costs
  - » This requires Hospital/MD collaboration on Total Medical Spend
  - » Tiered Networks align stakeholder incentives (MD, Member, Hospital, Payer and Employer)

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Value Care Alliance | Business Imperatives for Members

- Maintain Independence
- Grow Market Share (reduce leakage)
- Enhance Low Cost, High Quality Position
  - » Share Best Practices (i.e. Clinical Integration) to Reduce Medical Costs, Enhance Clinical Quality and Improve Patient Experience
  - » Take Advantage of Scale Opportunities to Reduce Operating Costs
- Get Care and Risk Ready
  - » Build the foundation for Population Health Management which will lead to improved quality, enhanced access and lower costs

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Value Care Alliance | Organizational Philosophy

- The underlying foundation of VCA is that care that can be delivered in the community needs to stay in the community
- Physicians "have a seat at the table"
- VCA is a collaborative organization with each integrated delivery system and aligned MD organizations having equal standing
- VCA is committed to working with payers in a transparent way and on a collaborative basis

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Value Care Alliance | Organizational Philosophy (cont.)

- VCA has no interest in forming a competing health plan but would have interest in working with payers on "private label products"
- VCA recognizes that it is critically important to effectively manage the cost of care
- VCA also realizes that it needs time to acquire and excel with the core competencies of PHM

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Value Care Alliance | Organizational Philosophy (cont.)

- The organization is committed to managing patient care in a way that
  - Measurably improve clinical quality and patient safety
  - Provides an improved patient experience
  - Has strong physician support and oversight of all patient care
  - Provides for the best value for the consumer, payer and employer

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Value Care Alliance | Membership Selection Criteria

- Cost and Quality
- Geographic Essentiality
- Physician Alignment
- Desire to remain Independent
- Willingness to make required commitments

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Member Commitments

- ☑ Participate in the governance and leadership of the VCA, through appointed representatives to the Board of Managers and the Committees.
- ☑ Provide the VCA with a limited right of first opportunity for designated Payers and product offerings.
- ☑ Meet prescribed cost, quality, efficiency and patient satisfaction metrics agreed to by the Board of Managers.

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Member Commitments (cont.)

- ☑ Assist the VCA to enable local physicians and /or physician organizations ("POs") to clinically integrate and share financial risk with the Hospital and VCA in connection with Payer contracts.
- ☑ Facilitate the development of locally integrated delivery systems which include the continuum of providers necessary to manage designated populations' health.
- ☑ Establish local capabilities as prescribed by the Alliance to effectively manage designated populations' health.

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Member Commitments (cont.)

- ☑ Participate in Alliance Shared services and information technology architecture to reduce costs and to support the clinically integrated delivery model.
- ☑ Pay to Alliance periodic dues, assessments and/or service fees as established by Alliance from time to time.

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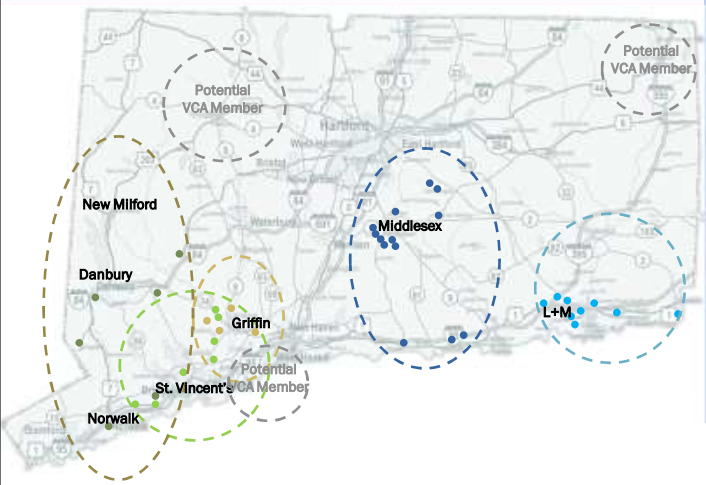
Value Care Alliance | Profile



* Locations are approximate

VCA Impact throughout Connecticut:

- 90,000+ inpatient admissions
- 34,000+ Medicare admissions
- 17,000+ Medicaid admissions
- Almost $64 million in charity care
- Over $2 billion in revenue
- 7,000+ live births
- Hundreds of access points for inpatient and outpatient care
- 4 Level II Trauma Centers, 3 Level III NICUs and 2 Level II NICUs
- Numerous Joint Commission Accreditations, Center of Excellence Designations and HealthGrades accolades

Economic impact:

- VCA employs over 11,000 FTEs and approx. 2,000 physicians
- Spans 85+ communities
- Reaches more than 1,800,000 Connecticut residents in combined service area

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Value Care Alliance | Share in Key Markets

- Opportunity to stem leakage and reduce costs

Hospital	% Share of Commercial Discharges in PSA	% to System A	% to System B
Griffin	30%	48%	0%
Lawrence & Memorial	59%	19%	15%
Middlesex	43%	28%	17%
St. Vincent's	34%	52%	0%
Danbury	79%	11%	1%
Norwalk	30%	26%	0%

Source: Inpatient Discharges in Primary Market of Member Hospitals by Payer, CHIME data, FY2012

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Comparison of Networks

	VCA (existing and members under consideration)	System A	System B
Composite HCAHPS Score	70.5	70.0	69.6
Composite Core Measure Score	95.3	95.5	93.4

Sources:
- FY 2013_OHCA 12 Month Reports
- HCAHPS (July 2012-June 2013)
- Core Measures (July 2012-June 2013)

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Awards and Designations | Core Members

Danbury

- Wound Care Accreditation by the Undersea and Hyperbaric Medical Society (UHMS)

Griffin

- Joint Commission Top Performer on Key Quality Measures 2011 and 2013
- Leapfrog "A" Hospital (Fall 2013)
- Planetree Designated Patient-Centered Hospital with Distinction
- HealthGrades Top Performer Award
- NAPBC Accreditation w/ Commendation by Commission on Cancer
- ACR Breast Imaging Center of Excellence
- CareChex Quality Recipient
- Gold Award – Stroke (AHA)
- Baby Friendly Designation

L+M

- Joint Commission Accreditation
- American Academy of Sleep Medicine Accreditation
- Breast Imaging COE
- Stroke Certification
- Commission for Accreditation - Rehabilitation
- Gold Award – Stroke (AHA)

Middlesex

- 100 Top Hospitals in US
- ANCC Magnet Hospital
- Press Ganey Summit Award
- HealthGrades: Safest Hospitals in America, Clinical Excellence, Emergency Care, Best 100 Hospitals
- JC Gold Seal of Approval
- Consumer Reports Safest
- "Most Wired" Hospital
- Beckers "100 Great" Community Hospitals

Norwalk

- Center of Excellence for lung and colorectal cancer from the Joint Commission
- HealthGrades Distinguished Hospital Award for Clinical Excellence™
- Teaching facility for the Yale School of Medicine
- The Joint Commission's Gold Seal of Approval® - lung cancer program

St. Vincent's

- Leapfrog "A" Hospital
- Nursing Magnet Recognition
- 5-Star by HealthGrades for Interventional Cardiology and Valve Surgery
- Winner of Connecticut Hospital Association John D. Thompson Safety Award for high reliability safety program
- Named Best Hospital in Fairfield County and Western Connecticut by U.S. News and World Report in 2013-2014
- Commendation by Commission on Cancer
- Joint Commission Accredited
- Gold Plus Stroke Quality Achievement Award
- Breast Center of Excellence
- First in CT to Go Green and SmokeFree

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VCA's Competitive Position is Clear

- VCA offers a competitive alternative to the 2 existing systems
  - » Market Share: Significant market share in key geographic markets
  - » Cost/Quality Profile: Favorable cost and quality profile
  - » Assets: Integrated physician entities in all hospitals; comprehensive ambulatory, inpatient and post acute capabilities
  - » PHM Tools and resources: Significant and ongoing investments in care management and data and analytics to become "care and risk ready"

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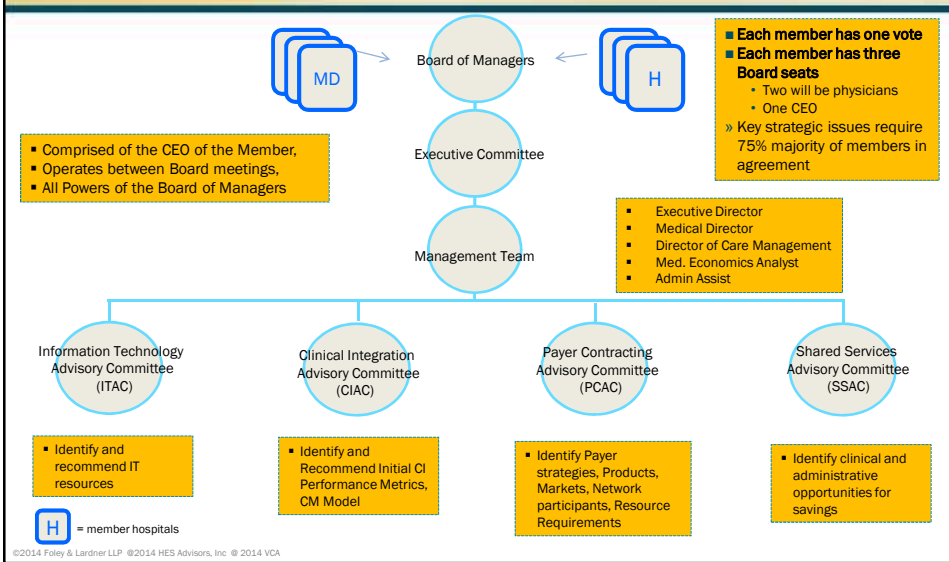
Governance & Operating Structure | Org Chart



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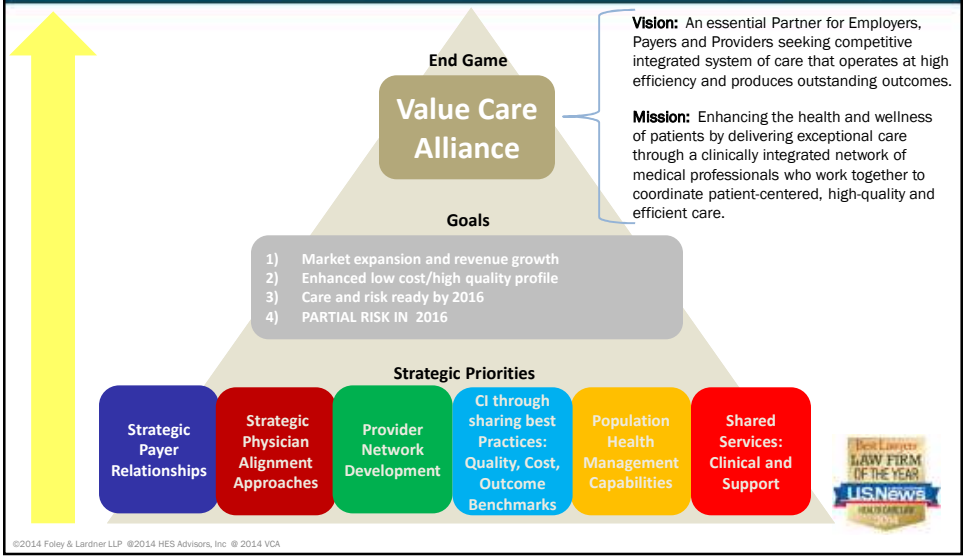
VCA | Vision, Mission, Goals and Strategic Priorities



Vision: An essential Partner for Employers, Payers and Providers seeking competitive integrated system of care that operates at high efficiency and produces outstanding outcomes.

Mission: Enhancing the health and wellness of patients by delivering exceptional care through a clinically integrated network of medical professionals who work together to coordinate patient-centered, high-quality and efficient care.

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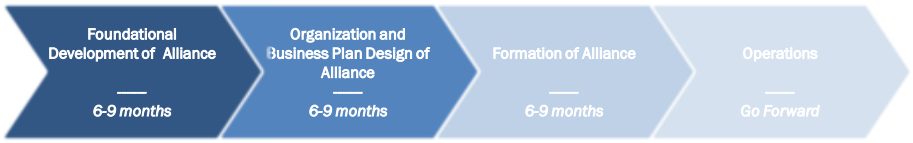
Development Timeline

As potential Alliance member hospitals begin discussions, it may be useful to consider an 18 to 27 month timeframe



Foundational Development
- Agreement to form Alliance by initial member hospitals
- Initial cost and quality analysis
- Engage advisors and attorney
- Perform in-depth pop health mgt capabilities assessment

Organization and Business Plan Development
- Finalize MOU
- Approve Advisory Committee Charters and Leadership
- Sign Operating Agreement and Participating Provider Agreements
- Begin meetings with multiple payers to discuss potential products

Foundational Development
- Approve Business Plan
- Continue Payer meetings
- Initiative Advisory Committees
- Form Board
- Define Physician Alignment Models
- Build out Network
- Develop marketing and communication strategy
- ID PHM Platform
- Develop Care Model

Organization and Business Plan Development
- Begin Alliance operations
- Capital Resource Plan

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Lessons Learned

Getting Started	Managing the Build	Staying the Course

• CEO Leadership is a pre-requisite
• Commitment to a Common Vision and Mission
• Composition of the Network
• Physician Alignment and Engagement
	• Markets continue to evolve
	• Not all Payers will play
	• Tertiary Providers may retaliate
	• Gaining consensus requires flexibility on certain issues
	• Data and Data Sources:
	  • Capabilities Assessment
	  • Cost Reports
	  • Leakage Reports
	  • Claims Analysis
		• Timeframe
		• Decision making
		• Infrastructure costs

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Legal and Structural Considerations

Presented by:

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Guiding Business Principles

- Attractive to payers
- Phased approach to risk assumption
  - » Narrow network products
  - » Shared savings (upside only)
  - » Shared savings (downside risk)
  - » Move to full risk (with or without bundled payments/episodes of care)
- Consensus driven
- No domination by larger hospitals/systems over smaller hospitals (or vice versa)

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Guiding Business Principles (cont.)

- Attractive to physicians/IPAs/PHOs
- No domination of hospital/health system interests over physician interests (or vice versa)
- Open to other care components
- Participate by ownership or contract
- Feasible business plan within financial means of Members
  - » Capital contributions tied to business plan
- Equitable participation in rewards
- Flexible, adaptive

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Design Phase

- Confidentiality/Standstill Agreement among Founders
- Letter of Intent for Founder commitments
  - » Governance
  - » Participation
  - » Business plan
  - » Financial commitment
- Due diligence/strategic assessment/member profile
- Definitive documents

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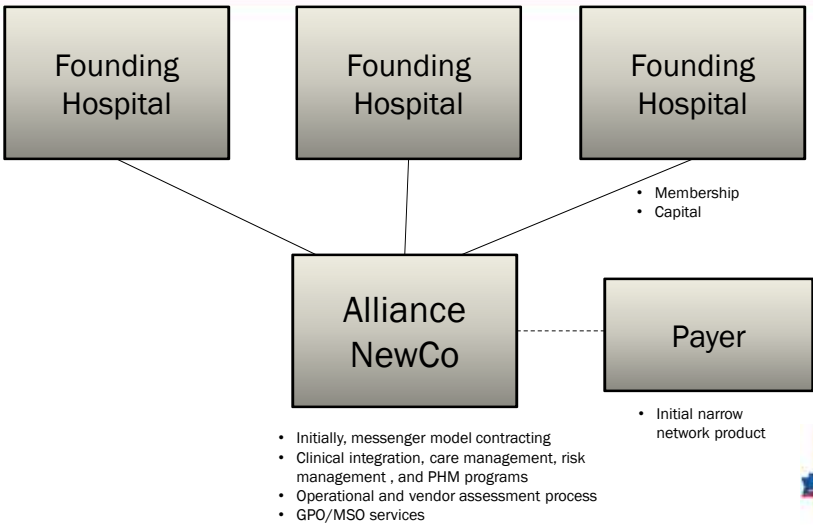
Alliance Entity



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Structural Options

- Choice of entity
  - Limited Liability Company
  - Non-profit taxable
  - Non-profit tax-exempt
  - For-profit corporation (C or S corp)
  - Hospital cooperative service organization

VCA has been organized as a Connecticut LLC

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Structural Options (cont.)

- Choice of entity: Limited Liability Company
  - Flexible, and can accommodate investment by for-profits
  - Pass-through entity (no tax at corporate level)
  - Distributions are not taxable to hospital members that are exempt organizations (except for any UBIT)
    - Activities of Alliance should generally be sufficiently related to the exempt purposes of member hospitals to avoid or mitigate UBIT risk
  - No form 990 reporting

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Structural Options (cont.)

- Other Choice of Entity Options
  - » Non-profit, tax exempt organization—cannot accommodate for-profit investment
  - » Hospital cooperative service organization—not clear that payer contracting and insurance risk management services would qualify; cannot accommodate for-profit investment
  - » Non-profit, taxable organization or for-profit business corporation—earnings and profits taxable at federal and state corporate income tax rates (40+%), including any retained earnings to fund surplus/reserves for insurance products
  - » Can't be S corp with corporate shareholders

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Antitrust Considerations

- Formation/size
- Joint pricing/contracting
- Market allocation
- Concerted refusal to deal
- Joint purchasing
- Information sharing

Guidance: DOJ/FTC Statements of Antitrust Enforcement Policy In Health Care (1996)

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Antitrust Considerations (cont.)

- Multi-provider networks
  - » Evaluated under the rule of reason if provider integration through network is likely to produce significant efficiencies that benefit consumers, and any price related agreements by network providers are reasonably necessary to realize those efficiencies
    - Substantial financial risk and/or clinical integration is pro-competitive
  - » Selection/Exclusion: If other networks offer the same types of services or could be formed, no significant competitive concern with excluding a particular provider from network

Generally no problem if participating providers don't compete

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Antitrust Considerations (cont.)

- » Pro-competitive benefits outweigh anticompetitive risks
- » Assess impact on competition in relevant geographic and product markets
  - Market share and concentration, e.g., inpatient hospital services (as measured by such indicia as number of institutions, number of hospital beds, patient census, and revenues), physician services (in physician specialty or other service market), other services provided by competing participating providers
  - Geographic and product markets (PSA vs 75%/90% patient draw markets)
  - Dominant (50% or more) v. non-dominant hospitals
  - Sole community providers
  - Exclusive v. non-exclusive network participation/payer contracting
  - Cost savings and efficiencies
  - Collateral constraints/spillover effects

Less risk for non-exclusive networks; networks reserving limited ROFO for specified payers/products

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Antitrust Considerations (cont.)

- Payer contracting/No price fixing
  - » Non-Risk contracts (e.g., FFS, narrow network contracts, shared savings upside only)
    - Not sufficient shared financial risk for integration to support single signature contracting
    - Until sufficiently clinically integrated can't use single signature contracting
    - Could use existing provider contracts/rates, with no re-contracting

Use black-box, messenger or modified messenger model approach, as necessary

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Antitrust Considerations (cont.)

- » What constitutes sufficient clinical integration to support joint contracting for non-risk or limited risk (e.g., shared savings (downside risk) contracts?
  - Significant joint investment of capital and human resources to develop infrastructure to support CI programs
  - Capability to track, measure and report compliance with CI standards, and CI program outcomes though a common information system or IS interfaces
  - Standard protocols and pathways for a significant number of clinical conditions (e.g., diabetes, asthma, COPD, MI, etc.) so that all network members have a consistent approach and "product" for diagnosing and treating diseases
    - Single hospital vs. across multiple hospitals/PHOs is particularly difficult (See FTC Adv. Op. re: Suburban Healthcare Organization)
  - Policies and procedures to identify non-compliant providers and enforce compliance
  - Corrective actions against non-compliant members that involves escalating education, warnings, censure, probation and discipline, including termination for persistent non-compliance

Sufficient CI unlikely to be achieved by geographically dispersed and diverse multi-provider networks

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Antitrust Considerations (cont.)

- Risk contracts: if sufficient financial risk (e.g., 10-20% of revenues on a shared risk basis), then contract may be negotiated on a single signature basis
  - » Do not "gun jump"—should not prematurely contract on single signature basis absent substantial financial and/or CI integration (without approval from FTC/DoJ/AG)
  - » CI plans are generally not enough (e.g., Partners Healthcare)
  - » Different providers may become financially/clinically integrated at different times
  - » If contract does not involve sufficient financial risk-sharing, then use black-box messenger/modified messenger model arrangements

Combination of shared financial risk and network-wide CI may support single signature contracting for multi-provider networks

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Antitrust Considerations (cont.)

- Ready for single signature contracting when determined by network governing board
  - » In consultation with health care antitrust counsel
  - » FTC/DOJ Business Review Letter or Staff Advisory Opinion?

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Antitrust Considerations (cont.)

- Information Exchange: Without appropriate safeguards, information exchanges among competing providers may facilitate collusion
  - » Safety Zone: (1) the survey is managed by a third-party; (2) the information provided is based on data more than 3 months old; (3) there are at least five providers reporting data upon which each disseminated statistic is based, no provider's data represents more than 25 percent on a weighted basis of the statistic, and (4) data is de-identified

Per Safety Zone, comparative pricing information can be compiled and disseminated by a consultant to aid in pricing decisions by network participants

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Antitrust Considerations (cont.)

- Monopsony power and group purchasing
  - » Group purchasing viewed as allowing participants to achieve efficiencies that benefit consumers, unless
    - Accounts for too large a portion of the purchases of the product/service in the relevant market, or
    - The products/services account for too large a proportion of the total cost of the services being sold by the participants so that the joint purchasing may facilitate price fixing or reduce competition
  - » Safety Zone: absent extraordinary circumstances, joint purchasing will not be challenged if
    - The purchases account for **less than 35 percent** of the total sales of the purchased product/service in the relevant market
    - The cost of the products/services purchased accounts for **less than 20 percent** of the total revenues from all products/services sold by each competing participant in the joint purchasing arrangement

To mitigate risk, can maintain some supply from local vendors that may otherwise be harmed by exclusion

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HIPAA Considerations

- Network as business associate (or sub-business associate) of participating organizations
- HITECH Act direct liability for BAs
- Need adequate privacy/security infrastructure
  - » Policies, procedures
  - » Administrative, physical and technological security measures
  - » Privacy officer, security official?
  - » HIPAA training

Handling high volume of PHI as a BA makes HIPAA compliance a significant area of risk, particularly for "young" networks

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Governance

- One or multiple classes of Members?
  - » Small vs large hospitals; community vs tertiary hospitals
  - » PHOs
  - » Physician organizations
- Ownership Interests based on relative capital contributions
  - » VCA capital contributions tied to business plan
  - » Ownership interests and voting weight may differ
- Supermajority voting to build consensus and assure no oppression of minority interests
  - » Protect against small hospitals being dominated by large (and vice versa)
  - » Protect against physicians being dominated by hospitals (and vice versa)
  - » Special Class veto rights on issues of vital interest?

VCA started with single Health System Class with 75% voting and is evolving toward creating a Physician Class

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Governance (cont.)

- What happens if Members merge with one another?
- How should Member hospital-affiliated PHOs be structured in?
  - » Participating contract only?
  - » Hospital Class? Physician Class? PHO Class?
  - » Lack of capital for Membership?
    - Health regulatory hurdles in financially assisting PHO with buy-in
    - MSSP limited waivers

VCA currently includes Member affiliated PHOs in Health System Class, and permits membership to be assigned to PHO

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Governance (cont.)

- Board of Managers serves as the governing body, with overall responsibility for policies, programs and operations
- Management Board comprised of representatives of each Member
  - » VCA Board comprised of three (3) representatives of each Member
  - » Managers serve at pleasure of appointing Member; no term/term limits
- Board acts by similar supermajority as Members to assure relative consensus
  - » Class voting?
  - » Subject to any special Class veto rights?
  - » Subject to any Member reserve powers on major corporate actions?
- Flexibility: Management Board may be expanded or restructured to accommodate and represent new hospitals/ IPAs /Pos / PHOs/ medical groups or investors

VCA Board acts by 75% vote with reserved powers to Members on major corporate matters; considering certain special Physician Class veto rights

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Governance (cont.)

- Committees—VCA committees include:
  - Executive Committee comprised of CEOs of all Members
  - Clinical Integration Program Committee
  - Finance and Payer Contracting Committee
  - Operations and Information Technology Committee
  - Shared Services Committee
- Each Member is entitled to be represented on all Committees

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Buy-Sell Provisions

- Substantial capital contribution
- No Member may transfer, assign or encumber ownership interest without Member approval
  - Assignment to local PHO is permitted
- Upon occurrence of a Terminating Event with respect to a Member, option of remaining Members to (i) redeem Membership interest of Terminating Member, or (ii) liquidate Alliance

Designed to provide sufficient "glue" to give VCA opportunity to succeed, while permitting Members to exit for other strategic options, if necessary

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Buy-Sell Provisions

- Differentiates "adverse" and "non-adverse" termination events
  - » On a non-adverse Terminating Event, Terminating Member's interest is redeemed for full FMV
  - » On an adverse Termination Event, Terminating Member's interest is redeemed for partial FMV
- Voluntary withdrawal and termination of PPA are adverse Termination Events, but change of control is not

Disincentive to terminate, except in a change of control circumstance, which was important to preserve strategic options of Member hospitals

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VCA Participation Agreement

- Non-exclusive
- Limited right of first opportunity only for "designated payers/products"
- Coordinated with existing contracts; roll-in to VCA contracts on expiration/renewal
- Messenger model/Modified messenger model contracting for non-risk contracts (until Alliance is sufficiently clinically/financially integrated)
- Single signature contracting for risk contracts that involve sufficient financial risk
- Single signature contracting for all payer contracts/ products once Alliance is sufficiently clinically/ financially integrated

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Miscellaneous

- Orderly transition out of VCA/payer contracts on termination
- Escalating dispute resolution process
  - » CEO/Chair meeting
  - » Voluntary mediation at request of any party
  - » Binding arbitration
  - » Continued performance during dispute resolution process

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Conclusion

- Presenters will answer questions as time permits. Please submit your question via the Q&A box on your screen.
- A recording of today's web conference will be available on www.foley.com in 2-3 business days
- Thank you for attending