Collaborative Health Systems

a Universal American company

CHS and ACO Overview

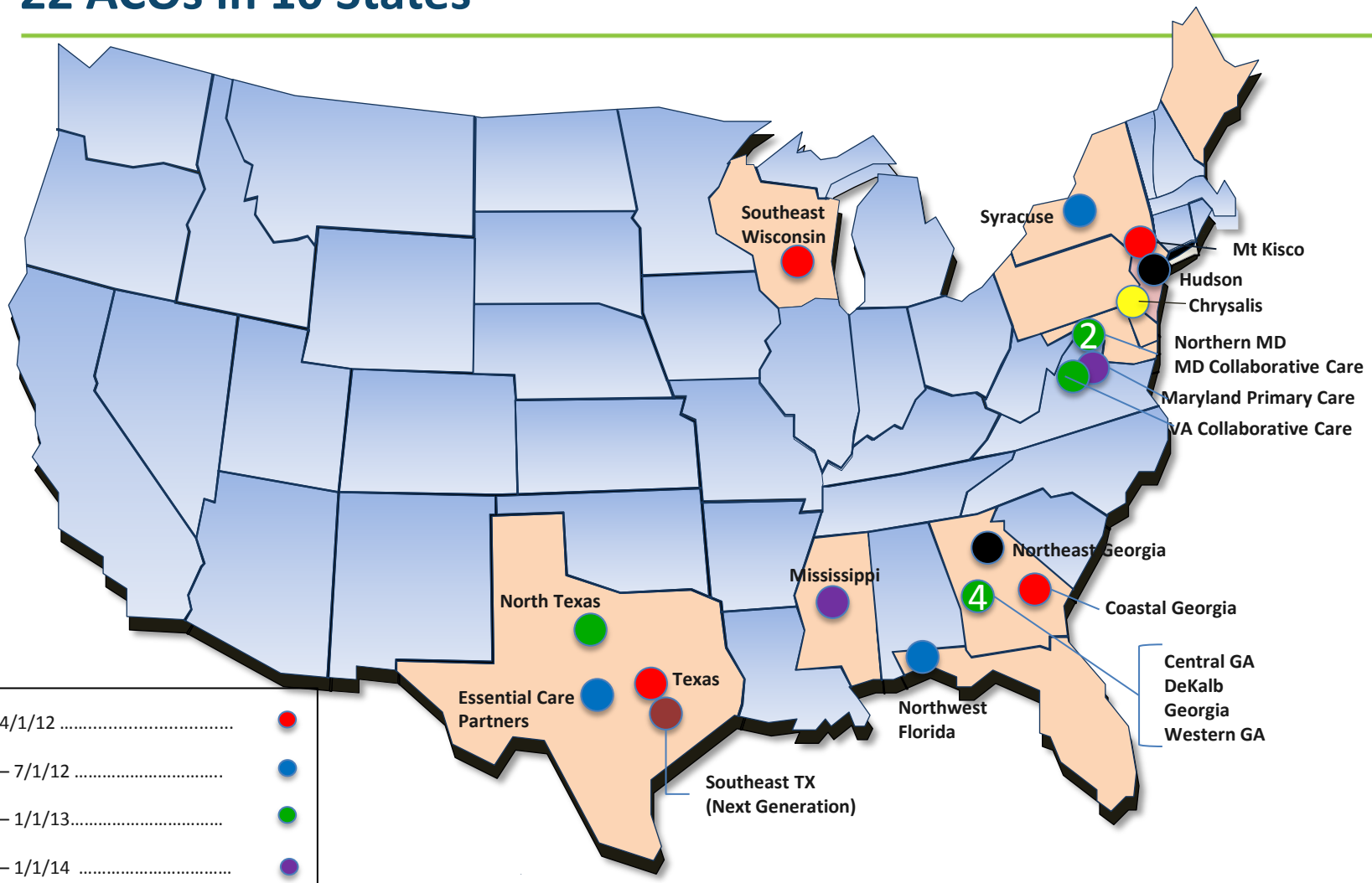
May 2016

COLLABORATIVE HEALTH SYSTEMS

CHS Is the Largest Sponsor of MSSP ACOs

- Collaborative Health Systems (CHS) is a wholly-owned subsidiary of Universal American Corp. (NYSE: UAM), which, through its health maintenance organizations and health insurance companies, offers and administers MA plans in Texas, New York, and Maine.
- CHS currently manages 22 MSSP ACOs, with more than 4,000 ACO providers, covering approximately 337,000 assignable Medicare beneficiaries in 13 states.
- We are champions of the independent, primary care physician (PCP)
- Universal American is the largest sponsor of MSSP ACOs in the country and has invested over $100 million in MSSP ACOs since the program's inception in April 2012. Investments include:
  - Innovative population health information technology tools and analytics
  - Clinical care coordination and care management programs to help community-based physicians deliver high-value care.
- Our ACOs have generated savings to CMS of over $137 million for PY2012, PY2013, and PY2014 combined.

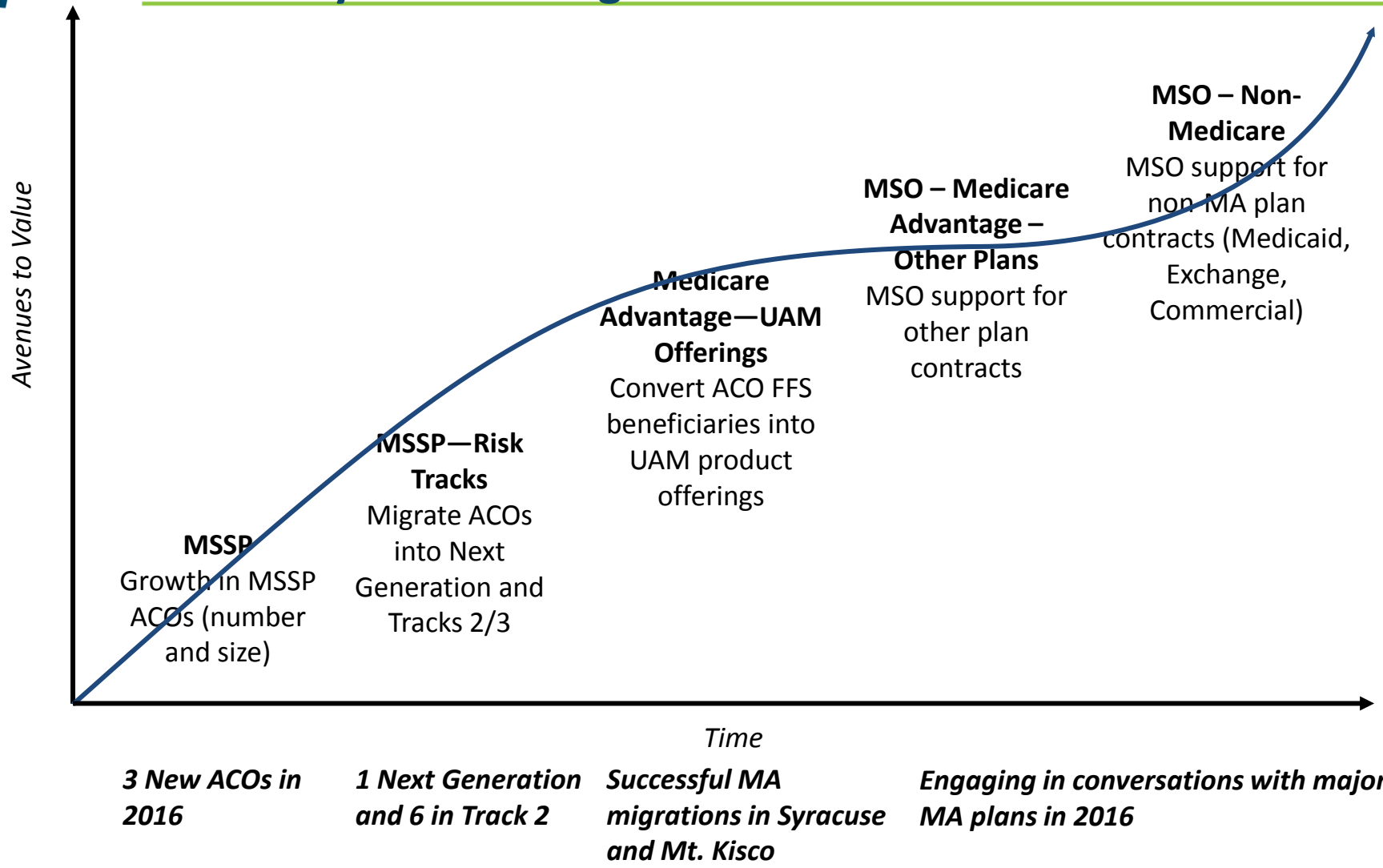
22 ACOs in 10 States



- 4 Approved ACOs 4/1/12 .....
- 4 Approved ACOs – 7/1/12 .....
- 8 Approved ACOs – 1/1/13.....
- 2 Approved ACOs – 1/1/14 .....
- 1 Approved ACO – 1/1/15 .....
- 2 Approved ACOs – 1/1/16 .....
- 1 Approved Next Generation ACO – 1/1/16 ..

COLLABORATIVE HEALTH SYSTEMS

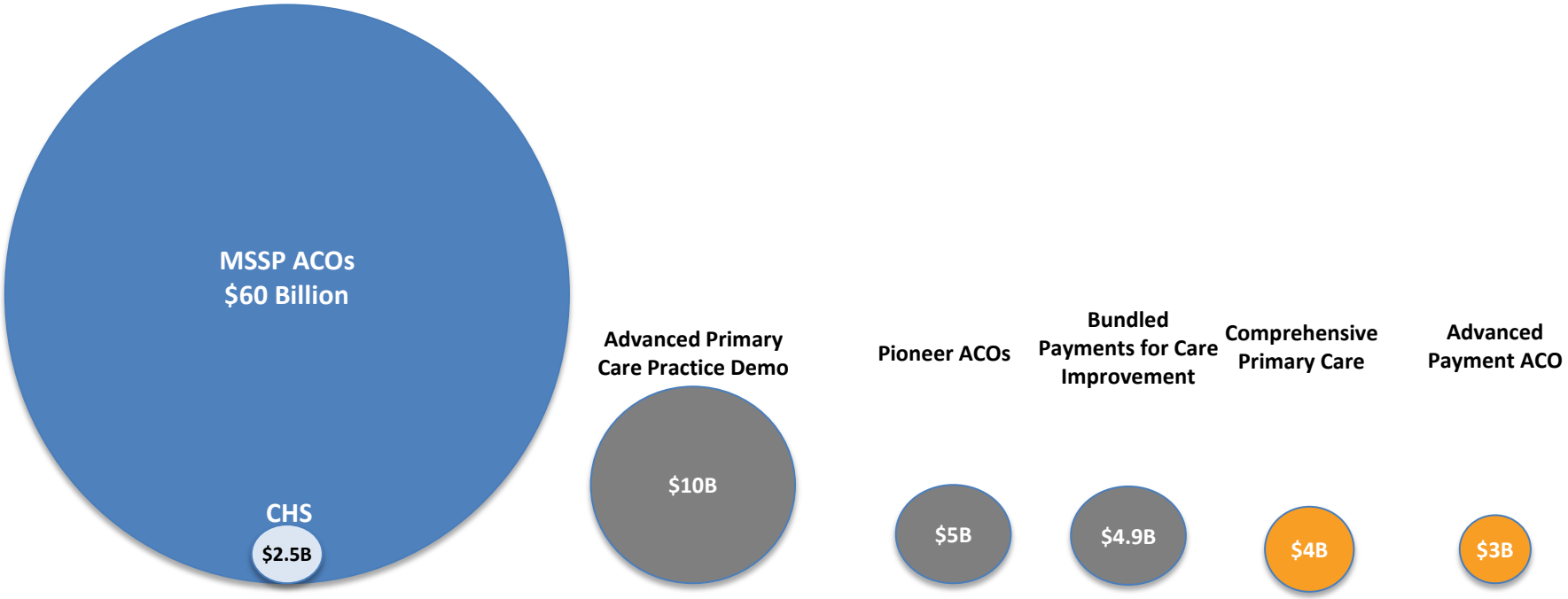
Our ACOs Are Transitioning Up the Curve to Greater Risk-Based Payment Arrangements



COLLABORATIVE HEALTH SYSTEMS

While CMS is Testing Many Models, MSSP is, by far, the Largest Initiative to Reduce the Rising Cost of Health Care

Estimated Total Medicare FFS Spend Managed*, 2016



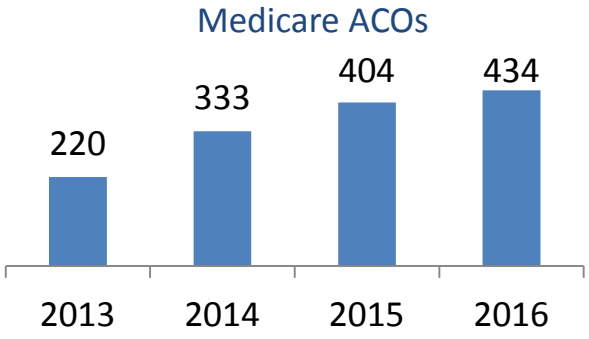
# of Beneficiaries	7.7M	900K	600k	150k	400k	300k

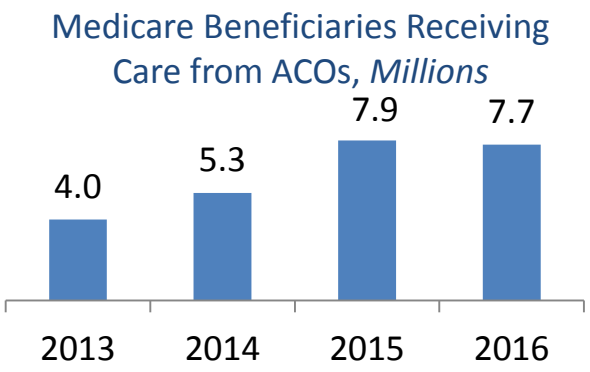
*Estimates based on total Medicare FFS expenditures of $445 Billion and number of Medicare beneficiaries enrolled in each model.
Source: CMS, Lewin Group BPCI Analysis, CMMI, "Two Year Cost and Quality in the Comprehensive Primary Care Initiative," NEJM.

COLLABORATIVE HEALTH SYSTEMS

To Date, the MSSP Has Had Mixed Success

Significant Growth in ACOs and Attributed Lives

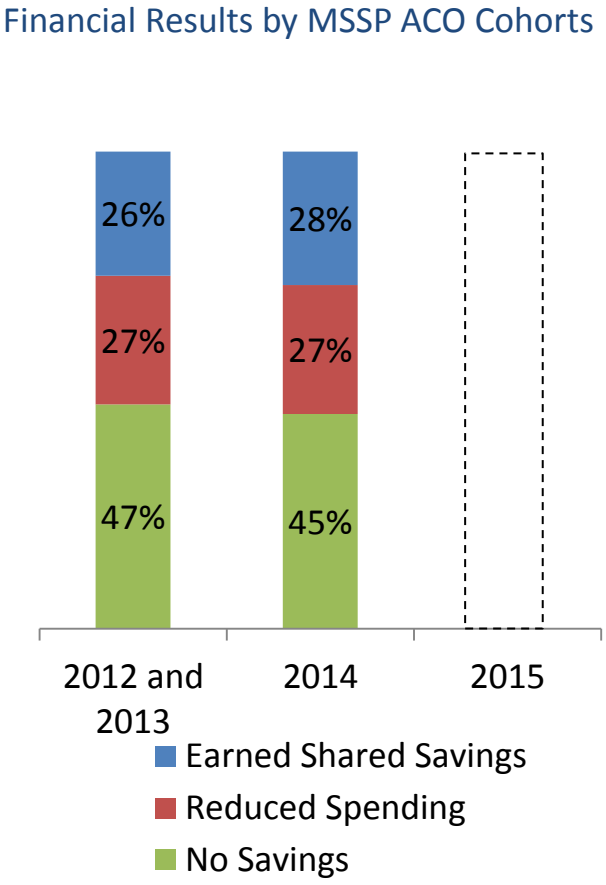




Positive Quality Results and CMS Realized Savings

- The first three years of the program can best be described as a valuable learning experience for all participants
- In PY 2013, MSSP ACOs improved on 30 of 33 quality measures
- ACOs that reported in both performance year two and three showed improvement in 27 out of the 33 quality measures
- $315 million in shared savings earned by 2012/13 MSSP ACOs and $341 million earned in 2014

…However, Less Than 1/3 of Participants Earn Shared Savings*



Source: CMS.gov; http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
*Results based on 220 MSSP ACOs in 2012/2013 and 333 in 2014.

COLLABORATIVE HEALTH SYSTEMS

CMS Proposed Several Changes to Improve MSSP in 2017

In January, CMS released a proposed benchmarking rule for MSSP that would improve the benchmarking methodology by incorporating regional spending. We anticipate the rule will be released in June 2016.

Proposed Change	Detailed Description
Incorporate regional FFS expenditures into the benchmarking methodology ***Note:** *Only applies to second or subsequent agreement period beginning on or after 1/1/17*	• **Replace the national trend factor with a regional trend factor** to rebase and update the benchmark annually. • **Gradually incorporate regional spending** into the ACO's benchmark. • **Remove the shared savings adjustment** when rebasing the benchmark. • **Define region according to counties,** weighted by the proportion of the ACO's beneficiaries in the county for all but ESRD beneficiaries. • **Use all beneficiaries eligible for ACO assignment** (as opposed to all FFS) when determining regional expenditures • **Account for regional differences in risk-adjustment** when adjusting the rebased benchmark.
Facilitate transition to risk	• **Add an option** for Track One ACOs **to extend for one year and defer moving** to Track Two or Three
Streamline the methodology for adjusting an ACO's benchmark when its composition changes	• **Adjust an ACO's historical benchmark for changes in participant composition using an expenditure ratio calculated for a single year** (as opposed to the current methodology that recalculates based on three years)
Refine criteria for reopening financial reconciliation decisions	• **Set a four-year limit** on reopening shared savings or losses determinations (contingent on good cause, such as new material evidence).
Provide enhanced access to ACO data	• **Publish new data files**, including per capita county-level FFS spending an risk scores for 3 historical years .

Source: Proposed Changes to the Medicare Shared Savings Program Regulations.

In Addition, Next Generation ACO Model Offers Stronger Financial Incentives and Tools to Create Systems of Care

Higher Levels of Risk and Reward

- Option of choosing between two risk arrangements—shared risk or full risk
- Shared risk option:
  - First three years, ACOs savings/losses will be 80%
  - During PYs 4 and 5, increases to 85%
- Full risk option:
  - ACO's share of savings/losses will be 100%
- ACO's share of savings and losses under both options is capped at 15% of benchmark

Broader Range of Payment Options

- *Normal Fee-For-Service*
- *Fee-For-Service With ACO Support Payment:* FFS rates plus an additional PBPM payment of up to $6 PBPM which is repaid at the end of the PY
- *Population Based Payments:* CMS will reimburse all claims submitted by ACO contracted providers/suppliers at a discounted rate
- *Capitation:* PBPM capitation payment

Improved Benchmarking Methodology

- Prospectively set benchmark and beneficiary attribution
- Annual benchmark risk adjustments (+/- 3% corridor) using all components of CMS's HCC risk scores to adjust the benchmark
- An additional "discount" adjustment to the benchmark to reflect the ACO's quality and efficiency

Tools to Create Informal Systems of Care

- Ability for ACOs to select preferred providers who may offer benefit enhancements to attributed beneficiaries
- Enhanced access to home visits, telehealth, and SNFs
- Reward payment to beneficiaries for receiving care from the ACO
- Process that gives beneficiaries a decision in their alignment with ACOs

Source: CMS, Next Generation ACO Fact Sheet.

COLLABORATIVE HEALTH SYSTEMS

Factors Determining the Future of ACOs and Alternative Payment Models (APMs)

- **2015 MSSP ACO results** will provide more data on the success of ACOs in terms of cost and quality. CMS is anticipated to release final 2015 reconciliation reports in July/August 2016.
- **MSSP final benchmarking rule** will determine how many ACOs have a viable path to success under the structure of the program. As proposed, we are concerned that the rule puts ACOs that are higher cost relative to their region at a perhaps insurmountable disadvantage.
- **MACRA implementation** will incent more physicians to move to two-sided risk models; ACOs represent the most widespread vehicle to accomplish this.
- **CMMI alignment of value-based models:** New APMs spun out of CMMI (e.g. Comprehensive Primary Care Plus) need be structured such that they ensure fair participation, rather than establishing competing models of care.
- **New administration in the White House:** Pending the results of the Presidential election, CMMI funding could be in jeopardy, undermining the Next Generation ACO model and other APMs.