

30 YEARS OF LEADERSHIP

Excellence Innovation Achievement
Transformation Growth





MHMD MISSION

Our mission is to lead the transformation of medical practice in collaboration with patients, payors and caregivers, through the use of evidence-based medicine. We establish a culture of physician accountability and create and deploy new methods of health care that will improve the quality, safety and cost efficiency of the care we provide for the populations we manage.

MHMD PHYSICIAN COMPACT

PHYSICIANS AGREE TO:

- Practice evidence-based medicine
- Uphold regulatory, quality and safety goals
- Report quality data
- Meet Clinical Integration criteria
- Attend meetings and feedback sessions
- Receive MHMD information
- Accept decisions of physician committees
- Be flexible and professional
- Collaborate with colleagues and hospitals
- Share ideas

MHMD AGREES TO:

- Be loyal to physicians
- Negotiate well to align incentives
- Include physicians in work decisions
- Provide clear and timely information
- Offer vital services and education
- Seek feedback from physicians
- Maintain confidentiality
- Communicate with physicians
- Host informative meetings
- Create leadership training





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EXECUTIVE SUMMARY

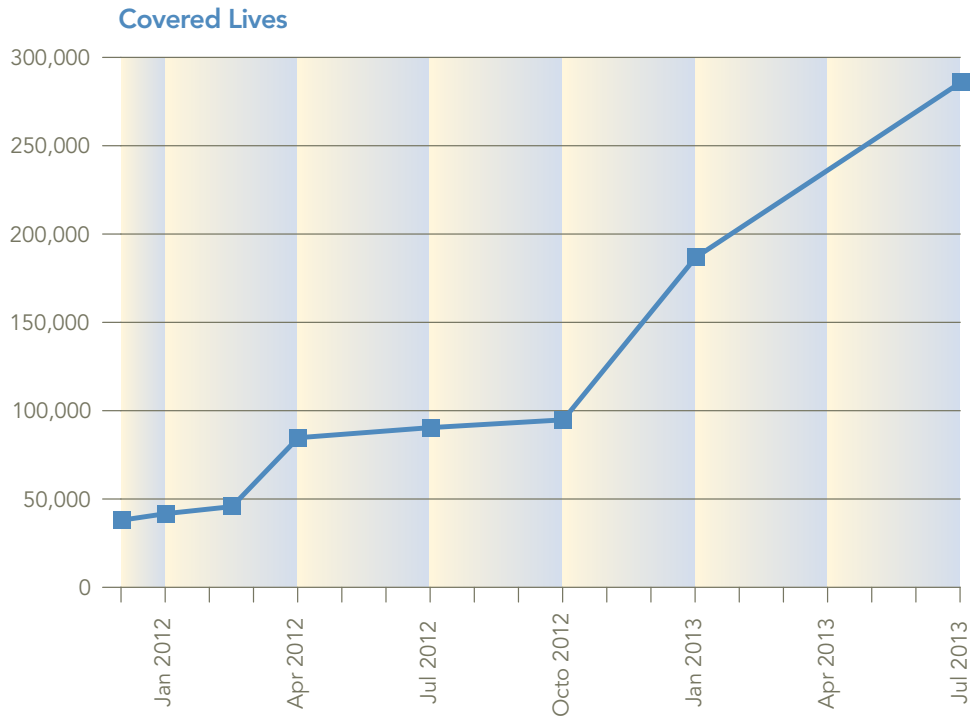
TRANSFORMING THE PRACTICE OF MEDICINE

2014 brought rapid, market-changing growth to MHMD, one of the largest physician organizations in the country, and to Memorial Hermann Health System, one of the most advanced fully integrated health systems in the nation. Together, the two organizations continued to operationalize the Memorial Hermann Accountable Care Organization (MHACO), which was accepted to participate in the Medicare Shared Savings Program on the first pass of review. Medicare attributed 24,000 of its covered beneficiaries to us in the beginning; that number has grown to more than approximately 30,000 persons age 65 and older.

We rapidly processed the underlying metrics to identify opportunities to reduce cost in this population and achieved 100 percent compliance with Year 1 quality requirements.

The MHACO allowed us to align our clinically integrated physicians under a single-signature contracting structure. We have continued to grow capabilities which resulted in our emergence as a top-performing ACO. With 2,000 physicians in the MHACO serving both commercial and Medicare contracts, we have become one of the largest ACOs in the country.

MHMD Leadership (left to right) Rachel Taylor, System executive; Nicole Clarke, CFO; Michael Davidson, M.D., CMO; Chris Lloyd, CEO; Keith Fernandez, M.D., MHMD president and physician-in-chief; Mary Folladori, director of care management; Shawn Griffin, M.D., chief quality & informatics officer; and Sandra Gomez, M.D., medical director of supportive medicine.



With our ACO and single-signature capability in place, we signed agreements with two major payors, adding over 250,000 lives to our population management efforts, including both commercial and Medicare Advantage contracts. These contracts are unique in our market in relation to cost, quality and growth opportunities. In addition to collaboration with insurance companies, we make our product available directly to employers, helping them better control employee benefit costs.

Recognizing that a new system of reimbursement will replace fee-for-service payment, MHMD has implemented a new model of care management delivery focused on population health management. The goal is to keep people healthy and productive, reducing emergency department visits, hospitalizations, and unnecessary or duplicative tests and procedures. We based our population health program on our growing network of Advanced Primary Care

Practices (APCPs), which grew our APCP to over 350 physicians in 2014, including more than 50 primary care providers on the faculty of UTHealth Medical School. By the end of 2014, we had become the largest primary care network in Houston. Our growth has been deliberate: We focused on attracting the highest-performing primary care physicians in the Greater Houston area. The growth of the APCP network will allow us to continue expanding our base of contracted payors and manage even larger populations within our community.

Moving from a focus on single patients to a focus on population health required us to embrace considerable new technology. Thus in 2014, we invested in tools for population management, claims processing, and care management. Using claims data from both commercial payors and Medicare, we identify groups of patients that pose higher risks for adverse health events and costs so that we can direct our care management efforts accordingly. Additionally, this data helps physicians to be more proactive in anticipating the health needs of their patients, preventing illnesses and complications of chronic diseases.

The patients are the heart of the matter. Their wellbeing is fundamentally what drives everything we do, and it motivates us to insist upon superior medical knowledge, diagnostic and procedural skill, and evidence-based practice.

It's been a journey. We hope you find the articles in our 30th anniversary annual report interesting and informative. We're proud of what we've accomplished, and we're not stopping here.



A handwritten signature in black ink that reads "Chris Lloyd".

Christopher Lloyd
MHMD Chief Executive Officer



A handwritten signature in black ink that reads "Dr Keith Fernandez MD".

Keith Fernandez, M.D.
MHMD President and Physician-in-Chief



Donald Molony, M.D., MHMD CPC
Hospital Medicine Committee co-chair,
discusses a new quality safety program
with two medical residents.

MHMD clinically
integrated doctors
collaborate with
Memorial Hermann,
payors and patients
to practice evidence-
based medicine
and hold each
other accountable
for the care they
deliver.



UNCHARACTERISTIC PARTNERSHIPS WITH UNCHARACTERISTIC PARTNERS

In 2014, MHMD forged and strengthened several key partnerships, each of which was in many ways uncharacteristic to the way we have historically functioned in health care. These partnerships fall into three categories: Partnerships with physicians, Expanded partnerships with the Memorial Hermann System and partnerships with payors and employees.

PARTNERSHIPS WITH PHYSICIANS

In the past four years, MHMD has pulled together a fragmented group of nearly 2,000 private, employed and academic physicians into its Clinical Integration (CI) Program. What integrates these physicians is their common and mutual commitment to practice evidence-based medicine and to hold one another accountable for doing so. The majority of the CI physicians comprise the physician component of the MHACO. As of 2014, these physicians contract with payors via a single signature through the ACO. This has greatly enhanced our ability to improve health care and control costs, with benefits to both physicians and patients.

Our partnership with physicians means that practicing physicians hold many key leadership



positions, including board membership, committee chairmanship, and leadership of our regionalized physician groups.

EXPANDED PARTNERSHIPS WITH THE MEMORIAL HERMANN SYSTEM

Our relationship with the Memorial Hermann Health System and its hospitals sets us apart from

other prominent physician organizations in the Houston area that have no such partnership. Nowhere is this more apparent than the formation and maturation of the MHACO. When MHMD and Memorial Hermann made the deliberate decision in 2012 to submit the application for participation as an ACO provider in the Medicare Shared Savings Program,

it cemented the partnership between the hospital and MHMD physicians. In 2013, the strategy of having an MHACO with a strong physician organization and a strong hospital system proved itself over and over, as we gained the attention and respect of the payor community. MHMD continues to make substantial investments in infrastructure and strategy around the ACO, resulting in reduced costs, improved quality and management of populations. The MHACO is now among the largest and most sophisticated ACOs in the country.

The governing board of the Memorial Hermann Health System has delegated the responsibility for establishing standards of quality and performance within all Memorial Hermann hospitals to the MHMD systemwide committee structure, the Clinical Programs Committee (CPC).

This partnership between MHMD and one of the largest not-for-profit health systems in the nation has built trust among our physicians, the hospital system and its executives. Together, we have put health insurance products on the market that employers are choosing for their cost effectiveness and close alignment with healthcare reform.

PARTNERSHIPS WITH PAYORS AND EMPLOYERS

MHMD has been successful in advancing its collaborative strategy with many payors. For example, MHMD and Aetna have now collaborated on a co-branded product, resulting in joint growth opportunities that provide lower cost and higher quality as well as lower premiums overall for employees in the Greater Houston area.

Advancing our relationships with payors around ACO principles has afforded us the opportunity to align our clinically integrated physicians under a single signature contracting structure, even though they continue to run independent practices. When Memorial Hermann Health Solutions engages the market with our health insurance product, we can offer employers and other payors access to a group of physicians who have agreed to one signature and a common incentive structure. This mechanism is unique in the country, and our success has positioned Memorial Hermann as one of the most advanced fully integrated health systems in Texas and one of the first in the country.

Fundamental to these innovative partnerships, insurance companies commit to supplying MHMD with transparent claims and outcomes data that truly enables us to evaluate our performance and manage population health. As a result, we are sophisticated in gathering and analyzing population health information data. In turn, our physicians are identifying the “gaps” in care and addressing these gaps so our patients receive the care needed to keep them well.

It provides a new level of knowledge for the management of cost and quality parameters. Employers have come to recognize this and are seeking to switch their employee health plans to our network. Through these sorts of uncharacteristic partnerships with businesses and employers in the community, we have achieved unprecedented success in controlling costs and improving the quality of care.

BETTER MEDICINE THROUGH CLINICAL INTEGRATION:

A PRESCRIPTION FOR INDEPENDENT PHYSICIANS

MHMD's CI program is the foundation upon which we have built all of our quality and efficiency initiatives and the MHACO. From its inception in 2008, when participation in CI was initiated primarily through a relatively rudimentary quality reporting system, Clinical Integration within MHMD has matured into something quite different and sophisticated.

Basic requirements for CI participation by our physicians in 2014 included:

- Connection between the physician's practice management system and the MHMD physician performance data base (Crimson)
- Electronic submission of all claims data to MHMD
- Electronic submission of quality performance data to MHMD
- Participation in all payor contracts with the CI network
- Participation in development of and compliance with MHMD-approved clinical protocols and guidelines



Peter Sabonghy, M.D., Orthopedic Surgeon.

- Attendance at CI meetings conducted at all Memorial Hermann hospitals
- Upholding and practicing the principles delineated in the MHMD Compact

Additionally, we are now asking our CI physicians to incorporate electronic health data into their practices and to conform to CMS Meaningful Use criteria in so doing. By the end of 2013, more than 80 percent of our advanced primary care integrated practices had done so. We see this as critical to our commitment to accountable care because EHRs provide improved documentation, quick access to medical records, claims-based risk stratification, unparalleled quality tracking and peer benchmarking. The results: safer practice, improved patient outcomes, cost efficiency and the potential for bonus earnings within the evolving pay-for-performance reimbursement system. EHRs allow MHMD member physicians and referring /consulting colleagues to access a patient's complete medical history in organized electronic files. Information gaps and unnecessary testing are eliminated, and the risk of medical errors is decreased.

At the very core of CI is the word "integration." CI interconnects our physicians, not by way

of being employed by a single entity as is the case with many large health systems in the country, but through their own commitment to practice evidence-based medicine, to participate in establishing best practice protocols and guidelines, to uphold the principles of the MHMD Compact, and to hold each other accountable for doing so.

Our CI program can be summarized as an agreement among nearly 2,000 independent physicians and our UTHealth Medical School faculty to work together to improve the healthcare services they provide. As a result, our CI physicians now participate in value-based contracts in recognition of the quality they are delivering.

From the independent physician's perspective, CI is a new way of practicing medicine that reduces fragmented care. It represents a new alignment of physicians, hospitals and other high-quality network providers. Information connectivity between patient care settings facilitates timely communication with treating providers. This leads to a better experience for patients as they navigate through a complex delivery model and produces better patient outcomes.





To improve safety and streamline care delivery, Memorial Hermann is currently utilizing eOrdering (computerized physician order entry) throughout all of its nine acute-care facilities, with deployment in all Memorial Hermann Emergency Centers.

INFORMATION TECHNOLOGY AND DATA ANALYTICS

Electronic connectivity between physicians and MHMD, and between MHMD and insurance companies, is a critical part of our success in the world of accountable care. MHMD has become recognized as a national leader in linking independent physicians, employed physicians, and hospitals to improve care delivery. In 2014, we bolstered our IT capabilities in a number of ways to support our efforts in improving the quality of care.

For example, when physicians send data to any payor for billing and tracking, they use MHMD's EHR software to send the same information to the MHMD Crimson data warehouse. Crimson Population Risk Management (CPRM) provides MHMD physicians with claims-based risk stratification, quality tracking and peer benchmarking. In 2014, our teams distributed quality and efficiency reports that we share openly with participating physicians during group meetings, which leads to the sharing of best practices among our physicians to raise the performance of the entire care team. These reports show overall performance, along with risk-adjusted metrics for MHMD's numerous

insurance plans, providing clinicians with individual "gap reports." This allows our Care Management teams to address any noted quality gaps through direct outreach to plan members. During the year, MHMD continued to work with Crimson in developing tools to track our physician documentation of chronic conditions and quality metrics. This in turn improves the yearly documentation required for Medicare insurance plans. Additionally, our partnership with Crimson also resulted in development of physician referral tracking tools that allow MHMD to engage our aligned specialty physicians and develop integrated networks of physicians caring for a population based on shared information.

Additionally, our current registry tool provides standard summary information, rules and reminders within the office workflow during the office visit to intervene in care gaps. We now use this tool to assist our physician practices in achieving National Committee for Quality Assurance (NCQA) Level 3 patient-centered medical home recognition by providing summary reporting of quality metrics and improvement. We are expanding our rules

to include more embedded care guidelines to promote evidence-based treatments, and will leverage our experience to develop new tools built into the care workflow across more practices.

2014 also marked the deployment of DocBookMD to our physicians. This Web and smartphone tool places an integrated directory of in-network providers at their fingertips. Further, it offers the ability to send HIPAA-compliant clinical information and images, thus improving communication and care coordination among our network of physicians.

Other IT tools that support our care management and accountable care initiatives include:

- Disease stratification tools which enable us to focus on illnesses and conditions with major improvement opportunities
- A performance tracking tool that enables our primary care physicians to track their performance against measures of quality and efficiency
- Teledoc, offering patients the opportunity to consult with physicians online

- ScheduleNow, which enables rapid online scheduling of physician visits and procedures
- PhysicianLink, our Web portal providing our physicians with access to CME programs, committee reports, news and updates

In each of these areas, MHMD is recognized as an innovative development partner that advances the technology on a national basis just as our successful physicians “raise the bar” for quality and efficiency. Future plans at MHMD include expansion of the Clinical Integration program’s capability to support physicians as they work on ICD-10 adoption and Meaningful Use 2.0 requirements. MHMD-created reports provide many of our members’ practices with the only consistent quality reporting data available to them on a regular basis.

Finally, while embracing advances in IT, we also remain focused on working with physicians to make sure that “chasing the information” does not interfere with caring for patients.



THE CLINICAL PROGRAMS COMMITTEES:

ENSURING BEST PRACTICES

Regardless of all the attributes of a robust IT infrastructure, it is ultimately our physician experts who provide the leadership for successful programs. Throughout 2014, the Clinical Programs Committees (CPCs) continued to expand in terms of committees, meetings, physician participation and, most significantly, their impact on the practice of medicine throughout our organization. During the past

year, the CPCs included 57 specialty-based subcommittees, joint operating councils and task forces which met a total of 173 times. Together, the members recommended over 530 process improvements that were adopted by hospitals in the Memorial Hermann Health System.

More than 450 physicians comprise the collective membership of these committees. In 2013

and 2014, we added nurses, pharmacists, care managers and executives from each Memorial Hermann hospital, substantially increasing collaboration and communication between the physician organization and the system.

The number of multidisciplinary committees has increased as well, and we are now seeing a high level of collaboration between specialties that didn't exist even a year ago. By working synergistically across hospitals, the physicians are streamlining processes and developing standards of care that improve safety, quality of care and cost efficiency. Some of these multidisciplinary groups include task forces to address:

- Ethics and Supportive Medicine
- Informatics
- Inpatient medicine
- Deep vein thrombosis prevention
- Timely assessment of admitted patients
- Perioperative management
- Pain management
- Physician documentation





Physicians Robert Montoya, M.D., and Christophe Salcedo, M.D., discuss new patient care measures.

The largest networked medical home in the region, Advanced Primary Care Practices (Advanced PCPs) forms the patient-centered medical home centerpiece of the Memorial Hermann Physician Network.

Some of the notable accomplishments of the Clinical Programs Committees in 2014 include:

- Development of a standardized peer review process and reporting form to be used in all Memorial Hermann hospitals
- Implementation of the Surgical Home model through the work of the Perioperative CPC and its Joint Operating Council
- Launching a multidisciplinary Blood Management Council to help standardize perioperative blood management and transfusion guidelines
- Adoption of numerous clinical management guidelines by many of the CPCs to ensure compliance with scientific evidence and best practices throughout the organization
- Launching an Informatics Committee entirely focused on informatics in the non-hospital (ambulatory) setting
- Adoption and standardization of credentialing and privileging criteria for robotic surgery
- Standardization of nomenclature related to orthopedic and sports-related injuries

Two things really stand out as remarkable about the work of the CPCs. The first is that they are made up of private practice physicians, employed physicians and faculty members of UTHealth Medical School, who are empowered through the CPC to make decisions related to patient care based on what they determine to be evidence-based and right for their patients. Not only do they address inpatient care, they also work on cost containment issues and best practices in the outpatient setting, with the goal of avoiding unnecessary hospital stays and visits to emergency departments.

Additionally, the CPCs have allowed physicians and clinical and administrative staff, with input from the hospital Medical Executive Committees, to jointly make process and supply-chain decisions, previously exclusively under the purview of hospital administrators. Mutual trust, synergy and engagement of physicians in unprecedented ways have been the result, helping us to improve quality, patient outcomes and cost efficiency. The lesson: Don't present physicians with a solution and expect them to engage. Instead, present them with the problem and they'll find a great solution and own it.



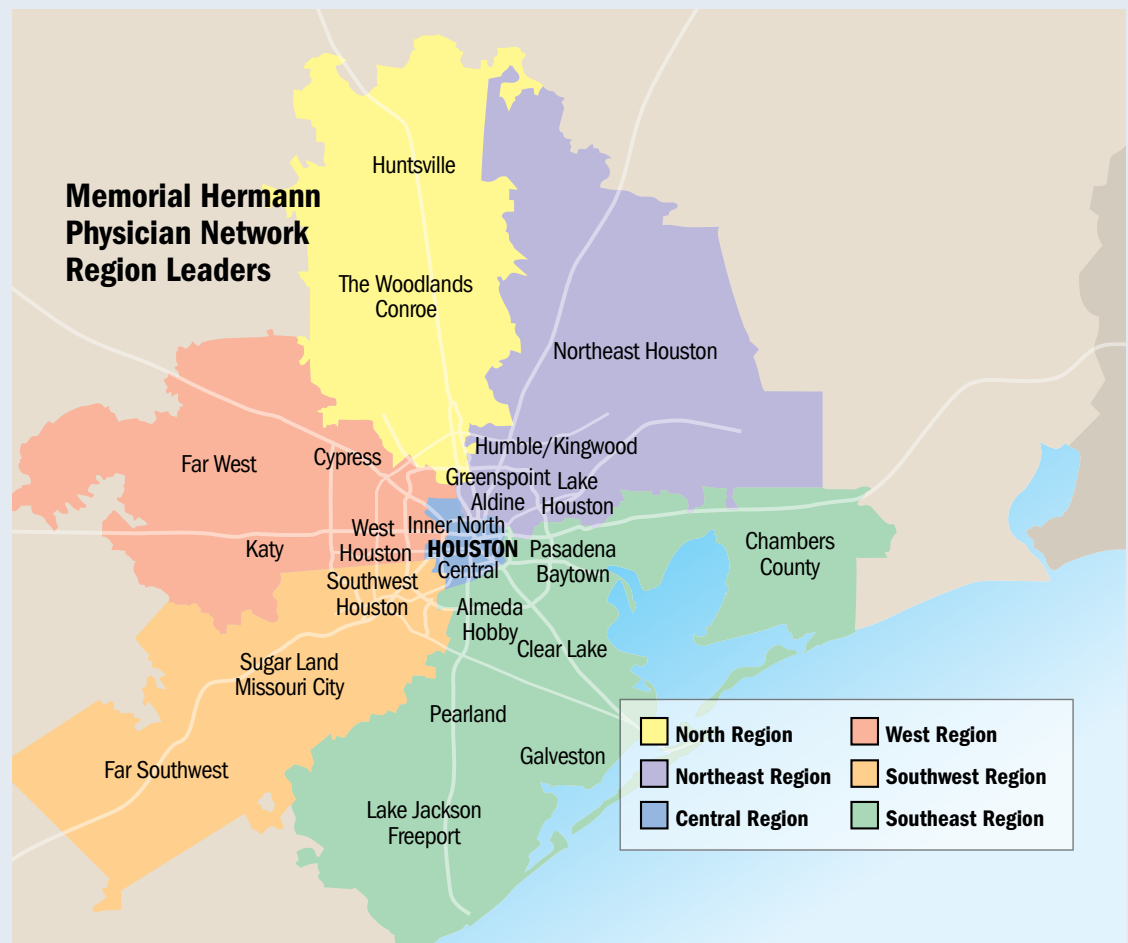
MEMORIAL HERMANN ACCOUNTABLE CARE ORGANIZATION

TOP-PERFORMING MEDICARE ACO IN THE COUNTRY FOR 2013

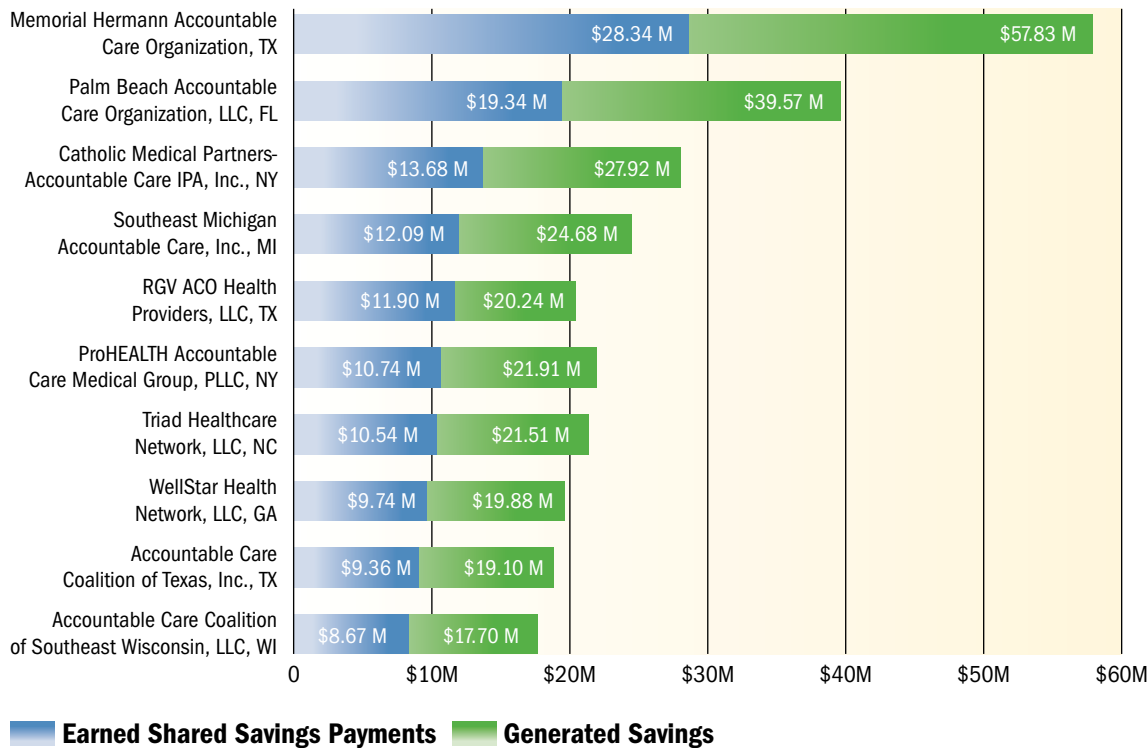
When Memorial Hermann joined the Medicare Shared Savings Program as an Accountable Care Organization in July 2012, it presented the opportunity to impact the care delivery in a Medicare Shared Savings model of attributed Medicare beneficiaries in Houston and surrounding areas. After starting with an attributed 24,000 Medicare lives, MHMD is now touching 250,000 lives.

This remarkable growth is the result of the unique network that MHMD brings to the Houston market. Through our collaboration with the Memorial Hermann system, we can offer current and future clients a full care delivery system - a 12-hospital health system, clinically integrated primary care physicians, easy access to specialists and subspecialists, a robust care management program to support physicians and their patients, and a growing supportive medicine program for patients with palliative care needs.

Our ACO rests in the CI infrastructure. In fact, MHMD's first 1,200 CI physician members



Savings: The Top 10 ACOs in the Country



produced dramatically better results than other physicians in hospital-tracked data. They had fewer complications, shorter hospitalizations and fewer readmissions. Private insurers began to take notice. MHMD physicians were significantly better than the market in terms of cost and quality. This performance and our proven success in collaboration with the

hospital system became the foundation upon which we constructed the ACO.

On that foundation, MHMD greatly expanded its Advanced Primary Care Practices (APCP) program. These practices adopt the principles of the patient-centered medical home, which is made of primary care providers and practices.

We made access to physicians easier through online scheduling and allowed patients to access their lab test results via online portals. These APCPs include advanced outcomes tracking technology and embedded nurse care managers to better support our patient population. MHMD added care management staff to our organization and linked them with physician offices, making medicine more personalized. Instead of someone from an insurance company calling a patient about a health issue, a nurse representing the patient's physician calls the patient. 2013 and 2014 saw a significant expansion of the Supportive Medicine program, a medical discipline which provides patients with relief from the symptoms, pain and stress of serious illness, no matter the diagnosis. The Supportive Medicine program now operates at seven Memorial Hermann hospitals. In addition, patients can now receive outpatient care from our Supportive Medicine specialists at four community clinics. As a result of these and other APCP initiatives, 39 of our APCP practices (210 physicians) have now achieved level 3 NCQA recognition, an accomplishment unprecedented in the Houston area.

In 2013, we organized our ACP practices into geographically determined regions. Physicians and practice administrative leaders within each region meet several times during the year to review individual practice performance compared to regional performance, and as a whole against quality and cost-efficiency metrics. By the end of 2013, we began assigning our high-performing specialist physicians to these regions to further enhance provider-to-provider communication and support our performance improvement efforts.

Clinical Integration and the Advanced Primary Care Practice prepared MHMD to complete the move into the future of health care: managing populations as an ACO. We are now able to make the next step to building an entire community of high-quality providers. In our ACO network, there are hospitals, urgent care clinics, a preferred skilled nursing facility network, clinical pharmacist support, rehabilitation services, durable medical equipment, home health, and supportive medicine – all the services that go into caring for patients for life. This positioned us to receive recognition from CMS as the top-performing Medicare ACO in the country for 2013. We produced the highest amount of

MEDICARE SHARED SAVINGS PROGRAM ACO PROGRAM OVERVIEW

- July 1, 2012 start date
- Three-year program commitment
- Shared savings model
- Based on PCP attribution
- Accepting and analyzing CMS claims
- Processing population analytics

MSSP ACO PRIORITY WORK EFFORTS

- Network development, including monthly TIN adds/terms submitted to CMS
- Network management, region reporting, scorecards and education
- Ongoing beneficiary notification mailings
- Bi-weekly CMS conference calls
- Year One quality data submission, April 15, 2013
- Care management infrastructure development and outreach
- Leverage population management tools, including monthly reviews of attributed lives

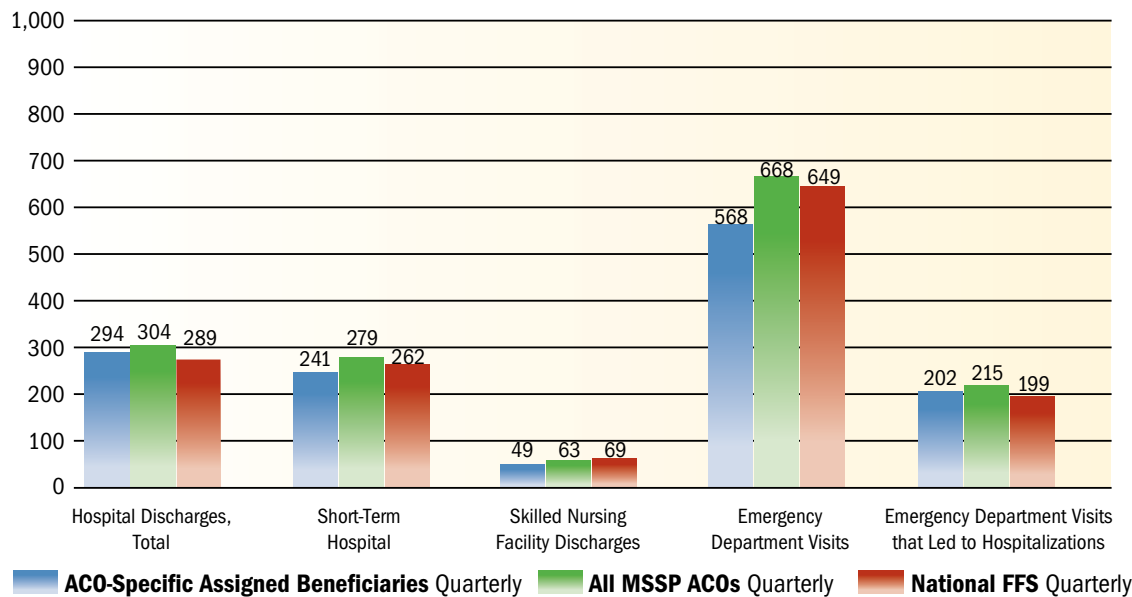
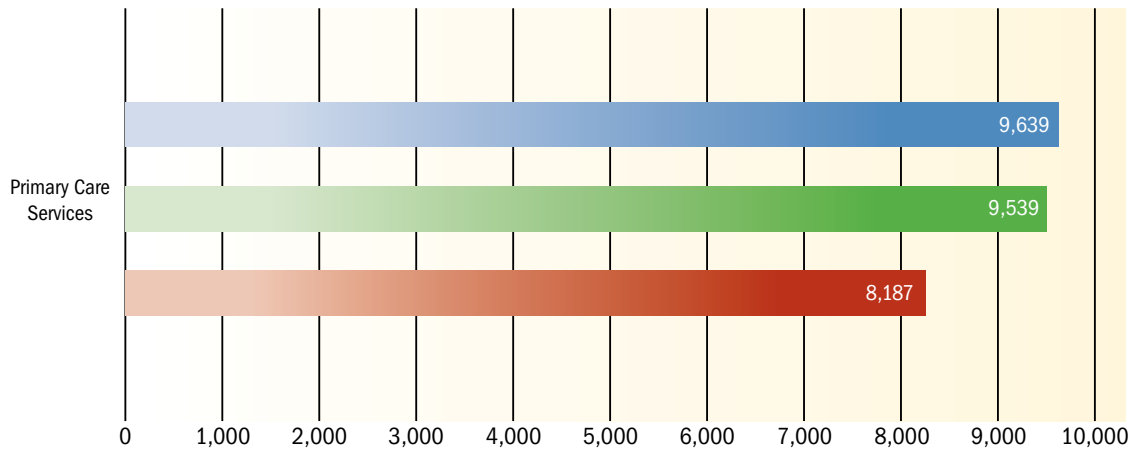
savings for this population while improving quality and patient experience.

The old model of healthcare delivery has evolved. Instead of managing chronic conditions like diabetes, we're driving toward and addressing the root cause of the problem – diet, exercise, and stress management. We're developing a program that targets at-risk patients with elevated blood sugar levels. We

provide face-to-face educational sessions with a licensed diabetic counselor, further supported by health coaches to reinforce the right behaviors. Our goal is to reduce the diabetes disease burden in our community, thereby reducing the costs of caring for this population.

Physicians, employees and employers all benefit from being part of an ACO. The ACO allows us to design benefit plans to discourage

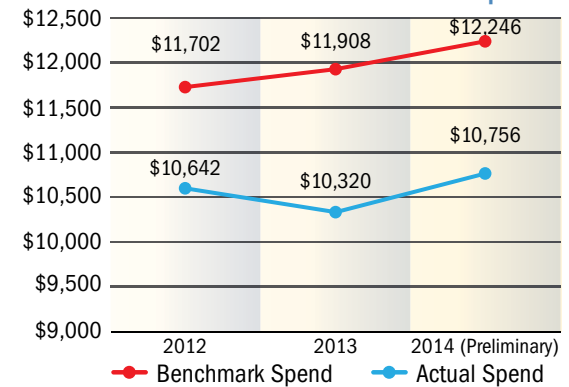
Additional Utilization Rates (per 1,000 Person-Years) Increased PCP Services has led to a decrease in high cost utilization



unhealthy behaviors and promote healthy ones. When employees can see a physician quickly, they can get back to work quickly. With the Memorial Hermann ACO's large base of specialists and subspecialists, we are able to get patients in to see a cardiologist or orthopedist within 72 hours. Getting people back to work faster benefits everyone by lowering overall healthcare costs, increasing a company's productivity, and helping people recover faster.

For MHMD, these ACO-related efforts resulted in care management engagement in the transition of care, a substantial improvement in medical costs within the Medicare Advantage plans, and significant savings within the Medicare Shared Savings Program.

MSSP Benchmark vs. Actual Spend





The ACO allows us to design benefit plans to discourage unhealthy behaviors and promote healthy behaviors. When employees can see a physician quickly, they can get back to work quickly.

Presidents Gold Circle Award



MHMD CARE MANAGEMENT

Memorial Hermann
2013 President's Gold Circle Award
Breakthrough of the Year - Patient Experience
"Care Management-Accountable Care Network"
MHMD

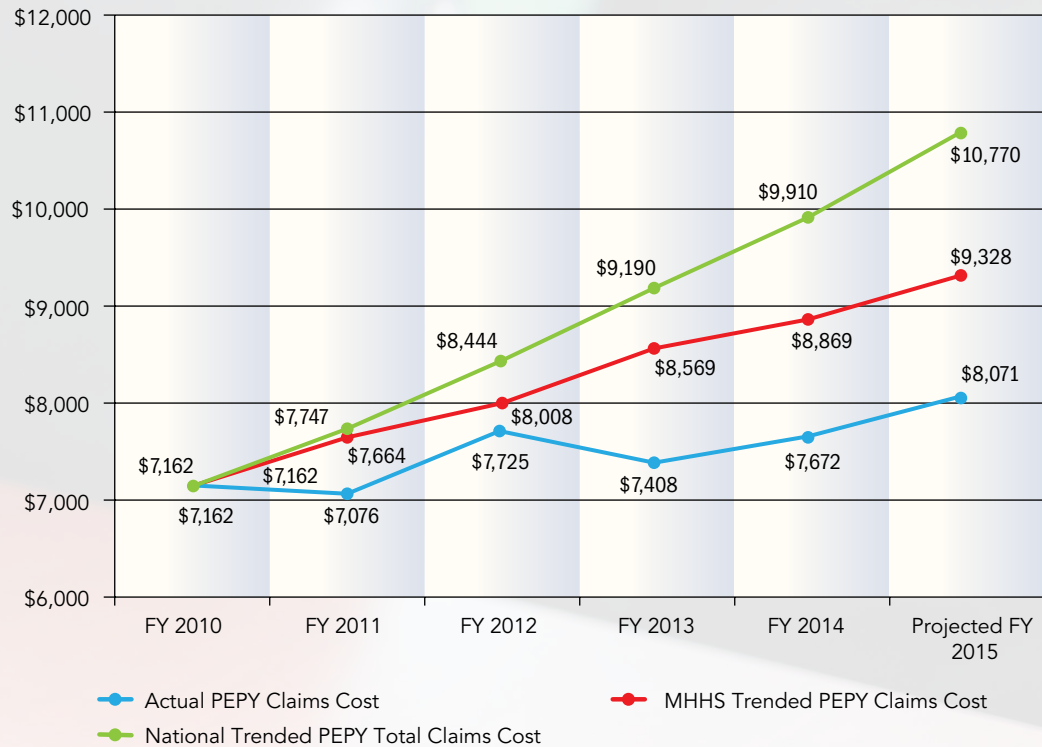
As our number of covered lives grows, we have continued to expand the care management team. By the end of 2014, the team was comprised of 40 care management nurses, social workers, health coaches and a clinical pharmacist, all providing support to the more than 350 primary care physicians participating in MHMD's Advanced Primary Care Practice program. Working with the patients of the APCP practices, the team reinforces the physician's treatment plans and provides additional support and education. The social work team helps patients address any family or social issues interfering with their ability to focus on medical needs.

These care management efforts have resulted in a substantial reduction in the rate of increase for employee health costs to approximately 10 percent annually over the five-year period, charted in the Cost Trend graphic to the right. Keys to this sort of success include embedding MHMD care coordinators in the physician practices, collaboration with affiliated physicians, partnering with payor-based Care Management departments, a strong information technology infrastructure that allows for clinical integration and data sharing with physician members, and robust programs for managing gaps in care, care transitions and complex illnesses.

In 2014, MHMD partnered with a prominent software development company to design and integrate a Care Management documentation system which uses data retrieved from sophisticated tracking software. Care managers identify health plan members who have gaps in care or are high utilizers of healthcare services. Once they identify these patients, they utilize a common platform to coordinate their care.

As these patients are engaged, our Care Management professionals use motivational interviewing techniques and specialized engagement tools and coaching materials to develop a relationship characterized by trust and accountability, which then aids in encouraging a strong provider relationship, attendance at appointments and access to resources patients need to obtain high-quality, coordinated,

Memorial Hermann Cost Trend

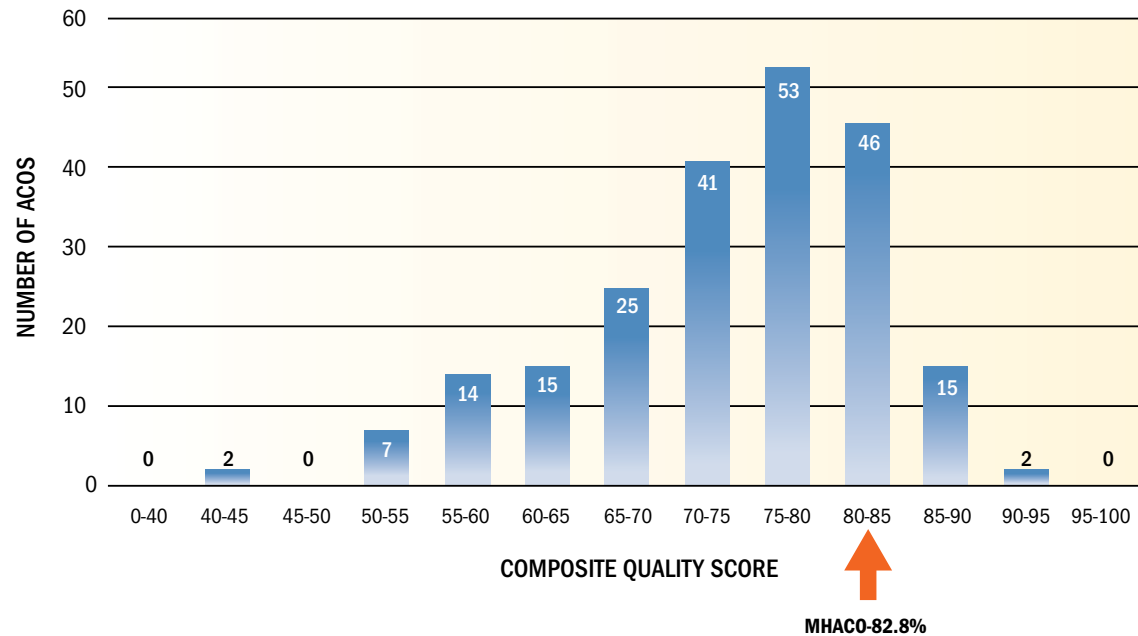


and cost-effective care. Through this sort of preventive outreach during 2014, the Care Management team identified more than 5,000 Memorial Hermann employees and family members with gaps in care.

Programs initiated by the Care Management team include:

- The MHMD Transitional Care Program, which engages with patients at the time of a care transition, such as discharge from the hospital. This program helps ensure that patients follow the discharge plan and get reconnected with their primary care physician. In 2014, the program achieved an engagement rate of over 40 percent, and a complex care management engagement rate of 41 percent, higher than the national average.
- The Complex Care Management Program guides the care management process for individuals with severe diagnoses, multiple chronic conditions, limited functional status and complex psychosocial needs, who account for a disproportionate share of healthcare costs and utilization.
- Pathways for Life Support serves patients and their families as they are dealing with the realities of life-ending diseases and the choices they are making.

2013 National MSSP Quality Performance



- My Health Advocate, MHMD’s disease management program, provides telephone support to patients, encouraging them to follow their physician’s instructions for medical compliance, exercise, diet and lab work, as well as office follow-ups.

Traditionally, case managers have provided this service within hospital walls, but care management outside the hospital has expanded

and is now providing strong support to our physician members as they increasingly provide more care for increasingly complex patients in the ambulatory arena. Our goal is to get patients engaged in the physician office environment so they will truly consider it their “medical home,” improving their satisfaction and that of their families, and avoiding unnecessary and costly trips to the Emergency department for care.



BRUCE FRENCH GRADUATES FROM THE COMPLEX CARE MANAGEMENT PROGRAM



Yetunde Adekunle, RN, CCM
and Bruce French

As a member of Memorial Hermann Health Solutions, the health system’s employee health plan, Bruce French came to the attention of Yetunde Adekunle, RN, CCM, after repeat visits to the Emergency department for a non-healing diabetic leg wound. In her role as a care manager for MHMD, Adekunle utilizes information retrieved from sophisticated tracking software to identify plan members who have gaps in care or are high utilizers of healthcare services. Once they’re identified, she reaches out to help them develop a provider relationship and find the resources they need to access quality, cost-effective care.

French, who lives in Clear Lake, presented at the Memorial Hermann Southeast Hospital Emergency Center twice in a period of months for re-infection of his leg wound, and was admitted for a weeklong administration of IV antibiotics. “After we connected, Yetunde checked up on me regularly and worked closely with my internist in Friendswood to arrange appointments with specialists,” says French, a 21-year employee of TIRR Memorial Hermann, where he works as an education resource coordinator. “She found out I was eligible for care at the outpatient wound clinic at Memorial Hermann-Texas Medical Center, which is close to my office and kept me out of

the ER for wound care. If we faced a hurdle, she helped me overcome it. Working with Yetunde is like having a personal healthcare coordinator. It's been a 100 percent positive experience.”

Adekunle also connected him with an MHMD social worker to provide access to other resources, and put him in touch with My Health Advocate, a Memorial Hermann disease management program that provides telephone support to patients, encouraging them to follow their physician's instructions for medical compliance, exercise, diet and lab work, as well as office follow-ups.

As an MHMD care manager, Adekunle provides patient services to several doctors in the independent physician network, including internist Deepti Mishra, M.D., a Memorial Hermann Medical Group physician who practices in Friendswood and is Bruce French's primary care provider. “The Care Management Program adds an extra level of service, and it's important that primary care providers know that it's available,” Dr. Mishra says. “As physicians, we may not see our patients for several months. We worked with Bruce to create a plan of care tailored to his needs, and Yetunde helped ensure that he stayed on track with follow-up visits.

MHMD's Complex Care Management Program is a jump ahead in terms of providing safe, high-quality care that is also cost effective.

She also connected him to resources he otherwise wouldn't have know about. MHMD's Complex Care Management Program is a jump ahead in terms of providing safe, high-quality care that is also cost effective.”

In addition to helping her grow her practice and offering support that improves patient care, membership in MHMD helps Dr. Mishra navigate the changes brought about by healthcare reform. “It offers an invaluable educational forum – a way to learn how to manage my practice more efficiently, among other things,” she says.

MHMD provides the same services to all its payors to ensure that the patients they cover don't fall through the cracks. “In addition to working with Memorial Hermann's employee health plan, we connect patients of MHMD physicians with their own insurance provider's care coordination department,” Adekunle says. “As care managers for MHMD, we're in a unique position to have a long-term, life-changing impact on our clients,” she adds. “As nurses, we want to see tangible, positive results. Watching them take control of their health is very rewarding.”

Thanks to his primary care physician and care manager, French has graduated from the Complex Care Management Program, which is designed to guide the care management process for individuals with severe diagnoses, multiple chronic conditions and other complex needs. “Bruce's situation is stable now, and he has access to resources that help him manage his care independently,” Adekunle says. “Care management is designed to empower patients to make informed healthcare decisions that keep them healthy and out of the hospital. If we can keep patients from going through the revolving door of the ER, we can reduce costs for patients, payors and society in general.”

MHMD SUPPORTIVE MEDICINE PROGRAM

After its launch in 2013, the MHMD Supportive Medicine Program grew rapidly in 2014. We now have 25 individuals dedicated to the program across the Memorial Hermann Health System, including 10 board-certified palliative medicine physicians. The program, which was initiated in 2013, focuses on helping patients with chronic or incurable illnesses. It is having a significant impact on the quality of care, with consultation provided to more than 3,500 patients throughout the system in 2014.



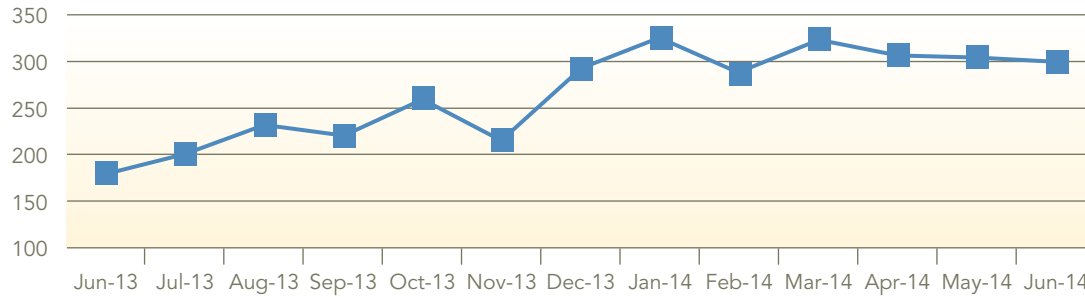
Supportive medicine is a specialized medical discipline which provides patients with relief from the symptoms, pain and stress of serious illness, no matter the diagnosis. This program also helps family members improve quality of life by reducing the physical, social, emotional and spiritual burdens of illness. The Supportive Medicine Program is an innovative outgrowth of traditional palliative medicine programs that focus primarily on end-of-life care. The goal is improvement in quality of life by early intervention as opposed to merely mitigating the burden and angst of dying.

The program addresses all the stages of illness and includes symptom management, supportive counseling and advance care planning. We are educating our physicians regarding our ability to enhance the care they deliver in a synergistic way. Rather than being an “end of the line” program where the PCP turns the care over to a



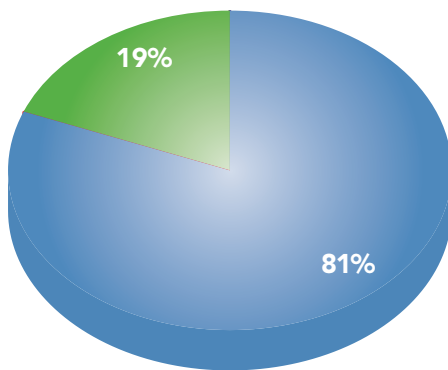
Sandra Gomez, M.D., MHMD System Director
of Supportive Medicine and Palliative Care

Supportive Medicine Consults



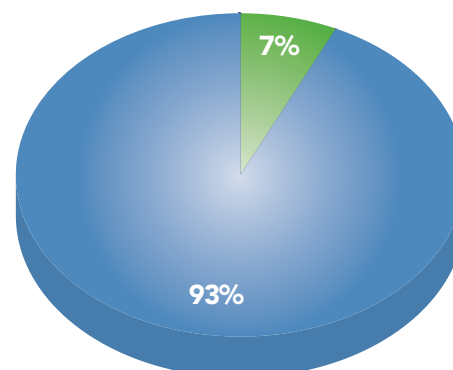
Would you have preferred an earlier intervention?

■ Yes ■ No



Would you recommend an earlier intervention?

■ Yes ■ No

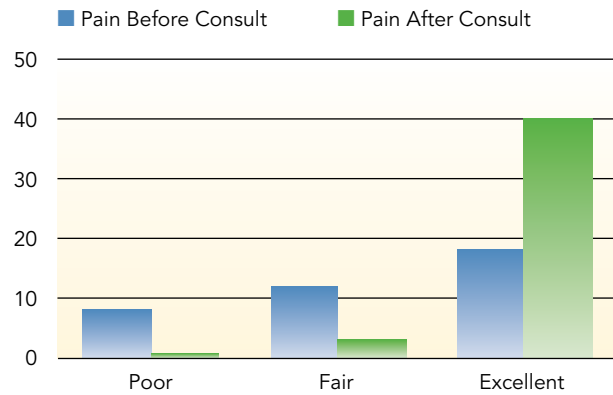


palliative care physician or program, supportive medicine works with treating physicians to ensure that their patients can optimize their life quality.

The MHMD Supportive Medicine Program now offers specialized supportive medicine teams at seven Memorial Hermann acute-care hospitals. In addition, patients can now receive outpatient care from our supportive medicine specialists at four community clinics as well as through home-based services. Each hospital team has a dedicated palliative medicine board-certified physician and a nurse coordinator who work closely with a chaplain and social worker. We are now adding nurse practitioners, counselors and social workers to augment our Supportive Medicine teams.

The Supportive Medicine Program recognizes that in the future, health care will be centered in the community, not in the hospital. We know that individuals would much prefer to have their health needs met while living at home rather than being confined to a hospital bed. This is what our patients want. Healthcare reform and our aging population have given us a great sense of urgency. Many patients and families have to make hard

Pain Management



choices. The Supportive Medicine Program offers our patients and their physicians choices and alternatives to hospitalization.

As the physician network for the Memorial Hermann Health System, MHMD is uniquely positioned to provide supportive medicine in the community. Sandra Gomez, M.D., the MHMD system director of supportive medicine and palliative care, points out that no other health system in Houston can offer this level of service. We have all the components in place - a city-wide system of hospitals, a clinically integrated medical group, home health services, a hospice, and the ability to follow patients in specialty clinics.



Sandra Gomez, M.D., and
Sanford Hughes



SUPPORTIVE MEDICINE HELPS KEEP SANFORD HUGHES OUT OF THE HOSPITAL

Before he became part of MHMD's Supportive Medicine program, Sanford Hughes logged three hospital stays ranging from a week to a month over a three-year period. Born with severe scoliosis that continues to worsen, the 53-year-old resident of The Woodlands has suffered a multitude of disorders as a result of his condition.

In 2010, a urinary tract infection led to pneumonia and sepsis that left him near death in the ICU at Memorial Hermann The Woodlands Hospital. Today, he's under the care of internist Julio Rivera, M.D., and has had no hospital admissions for more than a year.

"Dr. Rivera was on duty when I was in the ICU," says Hughes, whose scoliosis is so severe that MRI images can no longer visualize his entire spine. "He was so caring and concerned about my wellbeing that I wanted him as my doctor when I left the hospital."

The curvature of Hughes' spine has compressed his lungs and moved his left hip partially out of the socket. "It was becoming increasingly hard to walk," he says. "My left foot was at an angle that forced me to walk on the ball of my foot."

"I'm not just a number. They're kind, dedicated and supportive. Whatever I need, they tell me it will be easily done. Life is a gift."

In 2000, he broke his right femur. Physical therapy helped him return to function but in 2004, he broke his left leg, which caused him to rely on a scooter to move around his home." His parents, with whom he lives, provide help when needed and his brother, Alex Hughes, transports him for regular checkups with Dr. Rivera.

"My brother is a hell of a guy who never complains, regardless of what he's going through," Alex Hughes says. "Years ago, I lived in Canada where we had socialized medicine and you knew you'd be taken care of, regardless of what happened. The care Sanford is receiving now is every bit as good, and the people are fantastic."

Dr. Rivera sees Sanford Hughes at his office, where he collaborates with palliative medicine specialist Sandra Gomez, M.D., FAAHPM, MHMD system medical director for supportive medicine. Between regularly scheduled visits, the MHMD Supportive Medicine team sees him at home. "Our overall

aim is to improve quality of life for our patients and keep them out of the hospital through active surveillance and symptom management," Dr. Rivera says. "Ultimately, continued active care is better for the patient and it also reduces hospital utilization and overall healthcare costs. Programs like this help patients avoid the revolving door of the emergency room and hospital. Through regular home visits, the team identifies problems and resolves them before they become major issues that require a hospital stay. We refer back and forth to each other seamlessly to provide a strong continuum of care."

"By all means, it's keeping me out of the hospital," says Hughes, who is known by Dr. Rivera and the Supportive Medicine staff as a very grateful and polite gentleman. "I'm in awe of the program - it's why I'm here. It gives me reason to believe in a system that really takes care of people. I'm not just a number. They're kind, dedicated and supportive. Whatever I need, they tell me it will be easily done. Life is a gift."

PHYSICIAN EDUCATION INITIATIVES

In 2013-2014, MHMD produced five online educational programs for its physicians. Completion of them was a requirement for receiving a portion of the bonus payments to CI physicians. The topics included Recognition and Management of Sepsis, Prevention of Deep Vein Thrombosis, Compliance with Medicare Advantage Requirements, Value-based Purchasing and ICD-10, and 2013 rules for Observation Services. More than 1,300 of our physicians completed all five modules. The MHMD Physician Education Committee approved 264 programs for CME accreditation

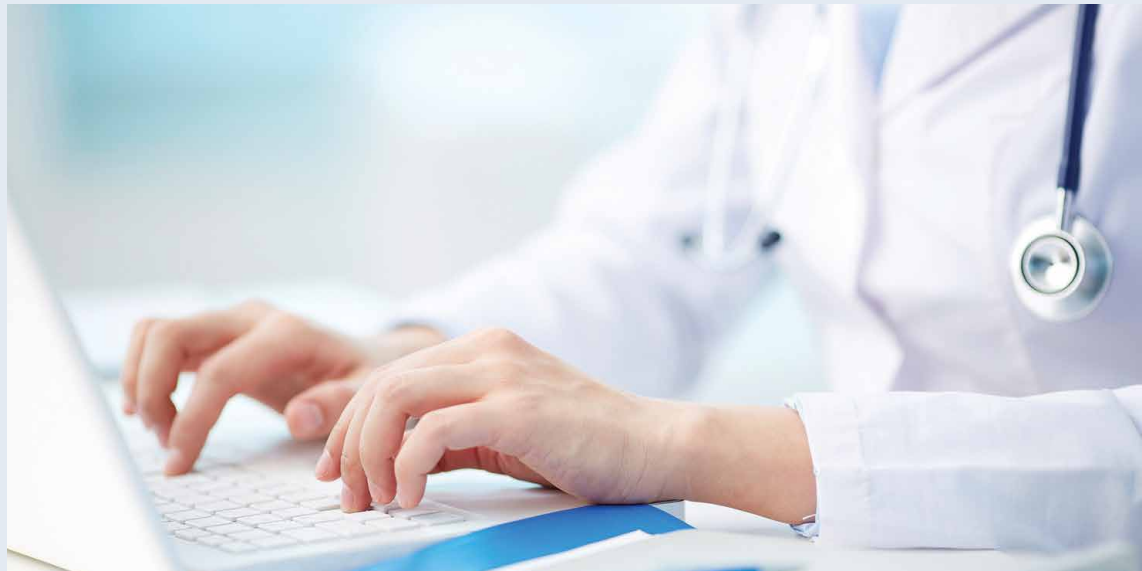
in 2014 and granted 782 hours of CME credit. In all, 9,045 programs were completed by our physicians in 2014.

In addition, MHMD conducted six retreats for our physician leaders in 2013-14. Invitees included all MHMD board members and committee chairs, all Memorial Hermann System chiefs of staff and MEC members, and all chief medical officers. Speakers included nationally acclaimed personalities Jonathan Burroughs, M.D., president and CEO of The Burroughs Healthcare Consulting Network,

Inc., Jean Chenoweth of Truven Health Analytics, Linda Haddad of the Harty Springer law firm, Nate Kaufman, managing director and founder of Kaufman Strategic Advisors, LLC, James E. Orlikoff, president of Orlikoff & Associates, Inc., and Victor F. Trastek, M.D., former vice president for Mayo Clinic and former CEO for Mayo Clinic in Arizona. They spoke on the future of health care, accountable care, the economics of health care, physician leadership, peer review and credentialing.

MHMD continues to develop online educational offerings for our physicians. Within the CPCs, physician members look to the educational needs of physicians of their own specialty. Additionally, they consider topics related to their specialty that physicians in other specialties need to know to improve quality, patient safety and efficiency of care.

In 2015, “MHMD University” was launched to deliver formal leadership education to physicians in an academic setting and provide us with talented and capable physician leaders as we advance into healthcare reform, population health management and risk-based contracting.





Richard Blakely, M.D., MHMD physician advisor, has played a large role in initiating physician education and launching the MHMD University.

One way in which we connect the primary care physicians with in-patient hospital stays is to notify PCPs electronically via an email, text message and/or their clinical computer system upon an emergency visit.



MHMD: 30 YEARS OF GROWTH AND EVOLUTION

In 2014, MHMD began its fourth decade in existence. From our humble beginnings in 1983 as the physician network for the Memorial Hospital System, MHMD has grown into one of the largest clinically integrated physician organizations in Texas, comprised of approximately 3,900 physicians throughout the Greater Houston area.

In its first 20 years, the physician network functioned purely as a messenger model independent physician association (IPA) bringing managed care contracts to its member physicians and a large physician network to contracting payors. There was no real partnership or collaborative effort between it and the hospital system.

During the first decade of the 21st century and extending through 2014, MHMD changed dramatically, adopting an entirely new function and role. MHMD began the effort to ensure that consistency and standardization of best practices throughout the Memorial Hermann system became our goals. That led us to develop a committee structure to enable our doctors to address physician-related issues throughout the health system. The structure that began as a systemwide Pharmacy and Therapeutics Committee grew and matured over the next decade into the MHMD Clinical

MHMD recognized that its long-term success would be based on a committed and close collaborative relationship with the Memorial Hermann Health System.

Programs Committee (CPC). Today, the CPC, comprised of more than 50 subcommittees with 600 member physicians, sets standards and protocols of evidence-based care for physicians of all specialties.

Further, the CI Program and the CPC structure strengthened the relationship between MHMD and the hospital system. MHMD recognized that its long-term success would be based on a committed and close collaborative relationship with the Memorial Hermann Health System. That, in turn, set the stage for MHMD joining with the System in establishing the Memorial Hermann Accountable Care Organization, which is now leading the nation in terms of achieving healthcare savings and quality improvements.

By 2014, we were focused on bolstering our primary care physician network through the development of the Advanced Primary Care Practice program, with its capabilities in care management, disease management, wellness, population health management, supportive medicine and a substantial IT infrastructure to help tie everything together. We are proud of our physicians. They are all board certified, and are all committed to working together to practice the best possible medicine and to hold each other accountable for doing so.

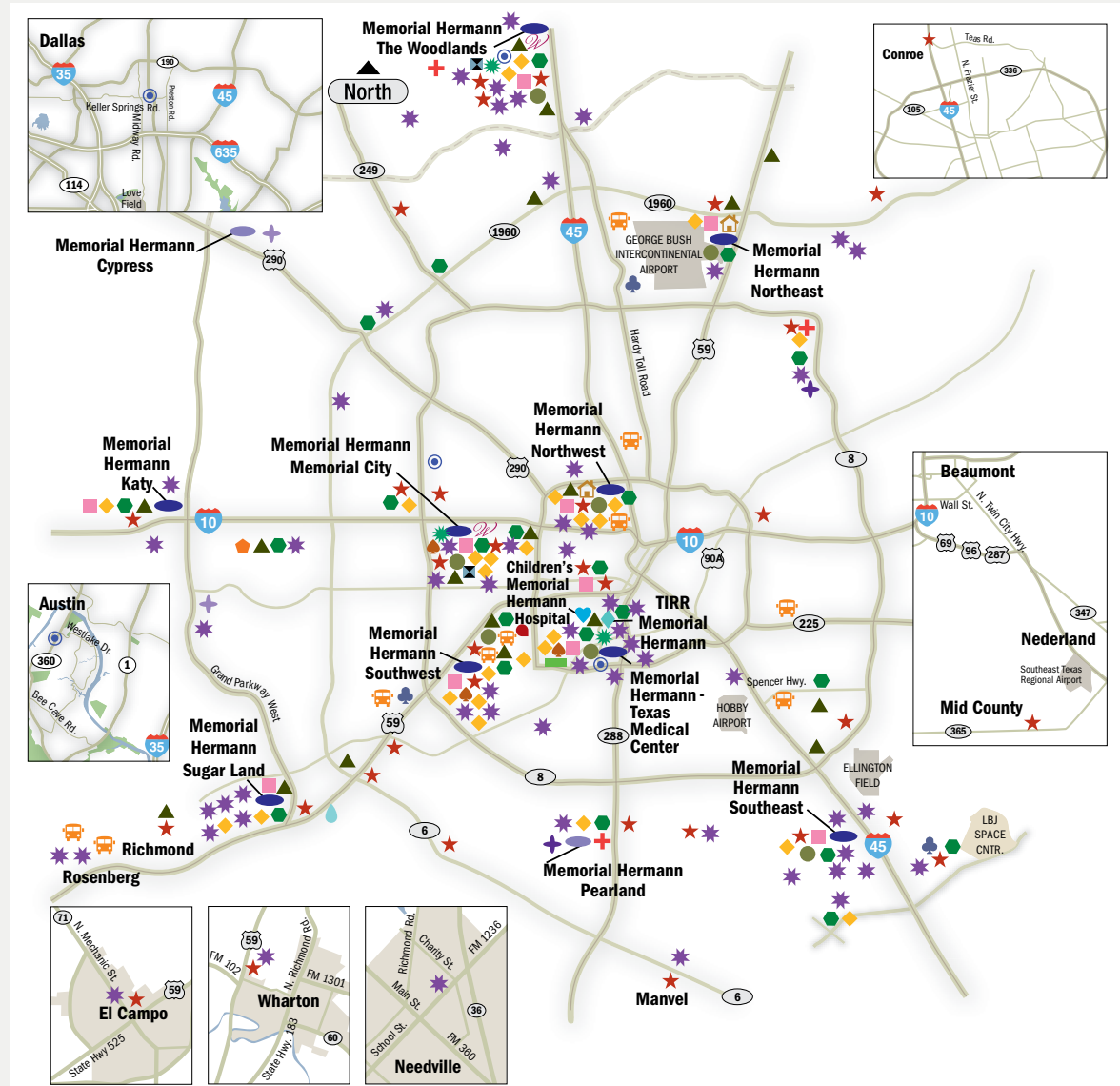
Because of our unique program in successfully engaging independent physicians into a single organization that has truly improved the healthcare experience and outcomes, MHMD has garnered much attention across the country. MHMD senior executives have given speaking presentations and participated in seminars on nearly 50 occasions in 23 states since 2010. We have hosted visits from 12 large health systems and large employers wanting to learn from our success.

We've come a long way in our first 30 years!

MEMORIAL HERMANN HEALTH SYSTEM

One of the largest not-for-profit health systems in the nation, Memorial Hermann is an integrated system with an exceptional medical staff and more than 21,000 employees.

The system serves Southeast Texas and the Greater Houston community with 12 hospitals, including three in the Texas Medical Center – an academic medical center with Level I adult and pediatric trauma centers, a hospital for children and one of the top three rehabilitation hospitals in the United States – as well as eight suburban hospitals. The system also operates three Heart & Vascular Institutes; the Memorial Hermann Mischer Neuroscience Institute at the Texas Medical Center; the IRONMAN Sports Medicine Institute at three locations; Women’s Memorial Hermann; Memorial Hermann Life Flight®, the largest and busiest air ambulance service in the United States; the Prevention and Recovery Center, an award-winning chemical dependency treatment center; and a comprehensive array of home health services, rehabilitation centers, outpatient imaging and laboratory services. Patients enjoy unique access to the expertise of multiple subspecialties and clinical research trials through MHMD’s community physicians and UTHealth Medical School.



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|---------------------------------------|---------------------------------|--|-------------------------------------|--|---------------------------------|
| ● 22 Imaging Centers | ✚ 3 24 Hr Emergency Center | 🚗 10 School-Based Health Centers | 🟢 1 Mischer Neuroscience Institute | 🏥 9 Acute-Care Hospitals | 🔴 1 Orthopedic & Spine Hospital |
| 🏠 10 Breast Care Centers | 🏠 3 Home Health | 🏠 2 Neighborhood Health Centers | 🟡 5 Prevention and Recovery Centers | 👶 1 Children’s Memorial Hermann Hospital | |
| ★ 34 Sports Medicine & Rehabilitation | 🏠 7 Cancer Centers | 🏠 2 Convenient Care Centers | 🌟 60 Memorial Hermann Medical Group | 🏠 1 TIRR Memorial Hermann | |
| 🔬 22 Diagnostic Laboratories | 🏠 3 Heart & Vascular Institutes | 🌟 3 IRONMAN Sports Medicine Institutes | 🏠 2 Executive Health Centers | 🏠 2 Acute-Care Hospitals Under Construction | 227 Memorial Hermann Facilities |
| 🏠 18 Surgery Centers | 🌊 1 Physicians at Sugar Creek | 👩 2 Women’s Memorial Hermann Hospitals | 🏠 1 Rehabilitation Katy | 🏠 2 Convenient Care Centers Under Construction | |

NATIONAL RECOGNITIONS FOR MEMORIAL HERMANN

15 Top Health Systems; Top 5 Large Health Systems (2012 & 2013)

John M. Eisenberg National Patient Safety & Quality Award (2012)

National Quality Forum National Quality Healthcare Award (2009)

TIRR Memorial Hermann -- No. 3 in rehabilitation hospitals

Texas Hospital Association Bill Aston Quality Award (2011)

Healthcare's "100 Most Wired" 8th consecutive year

America's #1 Quality Hospital for Overall Care (2011 & 2012)

America's 50 Best Hospitals (2010-2014)

The Joint Commission Top Performer (2012), Heart Attack, Heart Failure, Pneumonia, Surgical Care

2011 Texas Healthcare Foundation Quality Improvement Awards (9 Memorial Hermann Campuses)

2013 Houston Business Journal (HBJ) No. 4 Best Places to Work

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GLOSSARY OF TERMS

Accountable Care Organization (ACO)

A group of healthcare providers working voluntarily with Medicare to provide high-quality care at the right time, in the right setting.

Advanced Primary Care Practice (APCP)

A model of care that builds a long-term healing relationship between the patient and a physician-led care team and uses advanced IT tools, patient care reminders and biometric screenings to optimize patient health.

Clinical Integration (CI)

An agreement by independent physicians from every specialty to come together in a common commitment to quality and accountability.

Clinical Programs Committees (CPCs)

Physician committees serving as the primary source of evidence-based practices intended to improve quality and efficiency of care.

CPOE or eOrdering

A computerized physician order entry system for medical orders integrated with adverse event data to streamline delivery of safer patient care.

Continuity-of-Care Document

The accepted electronic format for the exchange of clinical information, including patient demographics, medications and allergies.

Diagnosis-Related Group (DRG)

A coding system used in determining reimbursement that classifies hospital cases into groups to identify the products/procedures that a hospital provides.

Electronic Health Record (EHR)

An electronic healthcare tool that can be used to facilitate, inform, measure and sustain improvements in the quality, efficiency and safety of health care.

Evidence-based Medicine

A collaborative effort between scientific researchers and physicians to deliver better patient outcomes based on patient observation and scientific data.

Medical Home

A model of care that builds a long-term healing relationship between the patient and a physician-led care team and uses advanced IT tools, patient care reminders and biometric screenings to optimize patient health.

Meaningful Use

The incentivized use of certified electronic medical records technology to achieve health and efficiency goals through data capture and information sharing.

National Care Quality Association (NCQA)

Organization that provides accreditation and certification of patient-centered Medical Homes and provider organizations.

Order Sets

Standard collection of predetermined medications and interventions appropriate to a particular disease, condition or procedure and proven to lead to better clinical outcomes.

Population Health Management

A model for providing care for large populations of people based on establishing ongoing primary care and specialty care relationships for individuals, and assisting physicians in analyzing data across entire patient populations.

Medicare Shared Savings Program (MSSP)

An initiative established by the Centers for Medicare & Medicaid Services (CMS) to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs by sharing monetary savings with participating ACOs.



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