WELLPOINT

Patient Centered, Value Based Provider Arrangements: WellPoint's New Normal

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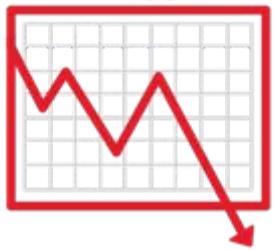
Anthem Blue Cross and Blue Shield in Connecticut - March 18, 2014

State of the Nation – We are at a Fork in the Road

Key environmental and market factors further drive need to transform the system

Consumer demand for information & convenience

Unsustainable costs elevate need for managed risk models



Medical cost pressure and new payer taxes

Delivery system appetite for prepayment & taking on risk

ACA market expansion & promotion of risk models

Increased competition, new entrants & disruptors

Holistic solution required to drive the change to a proactive, coordinated and efficient health system focused on the health and well-being of each patient

Proven Approach Based on Results from Our Pilots

Patient centered care pilots nationwide demonstrate improved health and lower costs

Colorado PCMH

18% fewer
hospital admissions

15% fewer
ER visits,
improvement in all diabetes measures

New Hampshire PCMH

3.6% fewer
hospital admissions

6.1% fewer
ER visits,
improvement in all diabetes measures

New York PCMH

12-23% fewer
hospital admissions

11-17% fewer
ER visits

Connecticut PCMH

8% fewer
hospital admissions

4% fewer
avoidable ER visits

9% lower
readmission rate

Dartmouth-Hitchcock ACO

6% fewer
hospital admissions

Up to 18% fewer
ER visits

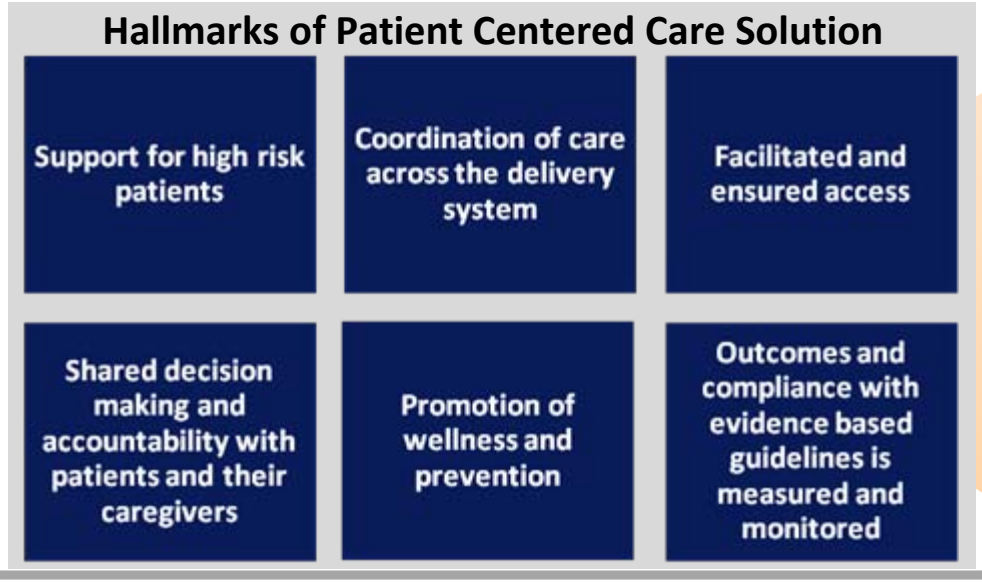
Enhanced Personal Health Care: Solution to Transform the System by Collaborating with Providers

Goal: Drive the transformation to a model of care that:

- Promotes **access, coordination** across the continuum and **wellness** and **prevention** to improve population health and reduce costs

How: Collaborate with providers **starting with provider organizations with a foundation of primary care**, in ways that:

- Facilitates a **shift** from a transaction based relationship to **an inter-dependent, collaborative relationship**
- Allows them to **successfully manage the health of their patients** and **thrive in a value based reimbursement** environment



- **Engages providers in synergistic, inter dependent relationships that allow them to successfully manage population health**
- **Rewards providers when they successfully manage population health**

Inclusive, Flexible and Extensible Framework

Differentiated approach to engage all willing providers in a patient centered care model, starting with those with a foundation of primary care

Inclusive, because any provider organization with a primary care foundation willing to follow the program terms can participate

- Whether small, independent PCP organizations or larger, integrated organizations (IPAs, ACOs, hospital systems)
- The broader our reach, the greater the opportunity to influence positive change

Flexible, because it is not a one-size-fits-all approach

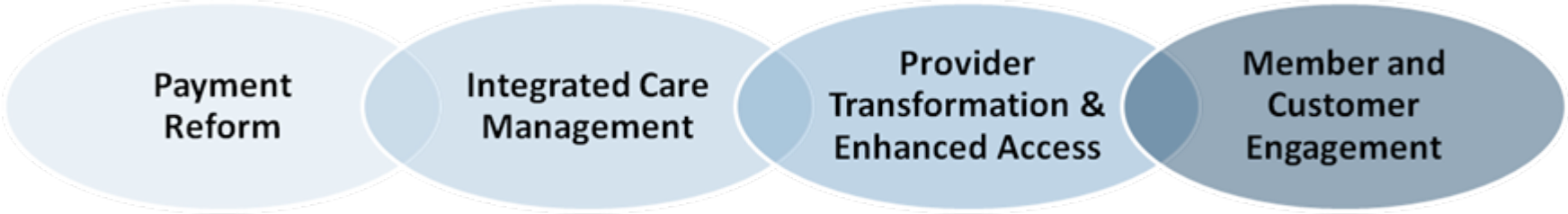
- We're moving past acronyms like PCMHs or ACO and creating a set of solutions that allow us to support and work with providers based on where they are today
- We will offer that support regardless of their current capabilities or how they are organized – and help them improve the quality and cost of care they deliver

Extensible, because it is designed to adapt and change with our physician partners

- Our model will continue to evolve with practices to support them as they take on increasing accountability for the cost and quality of care delivered to their patients

Key Solution Components of Our Model

We believe that payment reform is not enough. We couple payment reform with information, tools and resources to enable provider transformation and enhance member engagement, resulting in improved health and reduce costs



- Moving from volume to value based payment models
- Implementing a shared savings framework aligning provider payment with improved patient outcomes and reduced costs

- Providing physicians access to meaningful and actionable information (*e.g.,* reports, registry function)
- Promoting proactive care, care planning and coordination built around patient needs

- Giving providers the information, tools and resources needed to move towards a proactive, coordinated, population health model
- Promoting ensured access through a range of health care access options

- Encouraging a relationship with a trusted PCP even PPO environment
- Engaging members as active participants in their health
- Providing information to customers on the impact of the program

New, Innovative Processes Implemented to Support a Patient Centered Model

To drive provider participation, uptake and satisfaction, we re-engineered our processes to support our new normal

- **Developed new capabilities, processes and algorithms that support a patient centered model including:**
  - **Attribution and patient flagging** in our systems (*e.g.,* care management system) to track and support member engagement
  - **Shared Savings model** with program scorecard to determine threshold and absolute performance as well as participation and share of any achieved savings
  - Mechanisms to **calculate and distribute value based payments** we implemented (*e.g.,* care coordination and shared savings payments)
  - **Internal workflow and resource alignment** to ensure care coordination as well as support provider transformation and engagement
  - **Resources supporting provider transformation and population health management**, including, according to participants, best-in-class provider reports (*e.g.*, hot spotter, ER usage and inpatient authorization)
  - Members can **search for participating providers** on our provider finder
- **Executed** a provider communication strategy to support and drive program understanding and participation
  - **Included all of our fully insured business and nearly all of our self insured business (95%)**

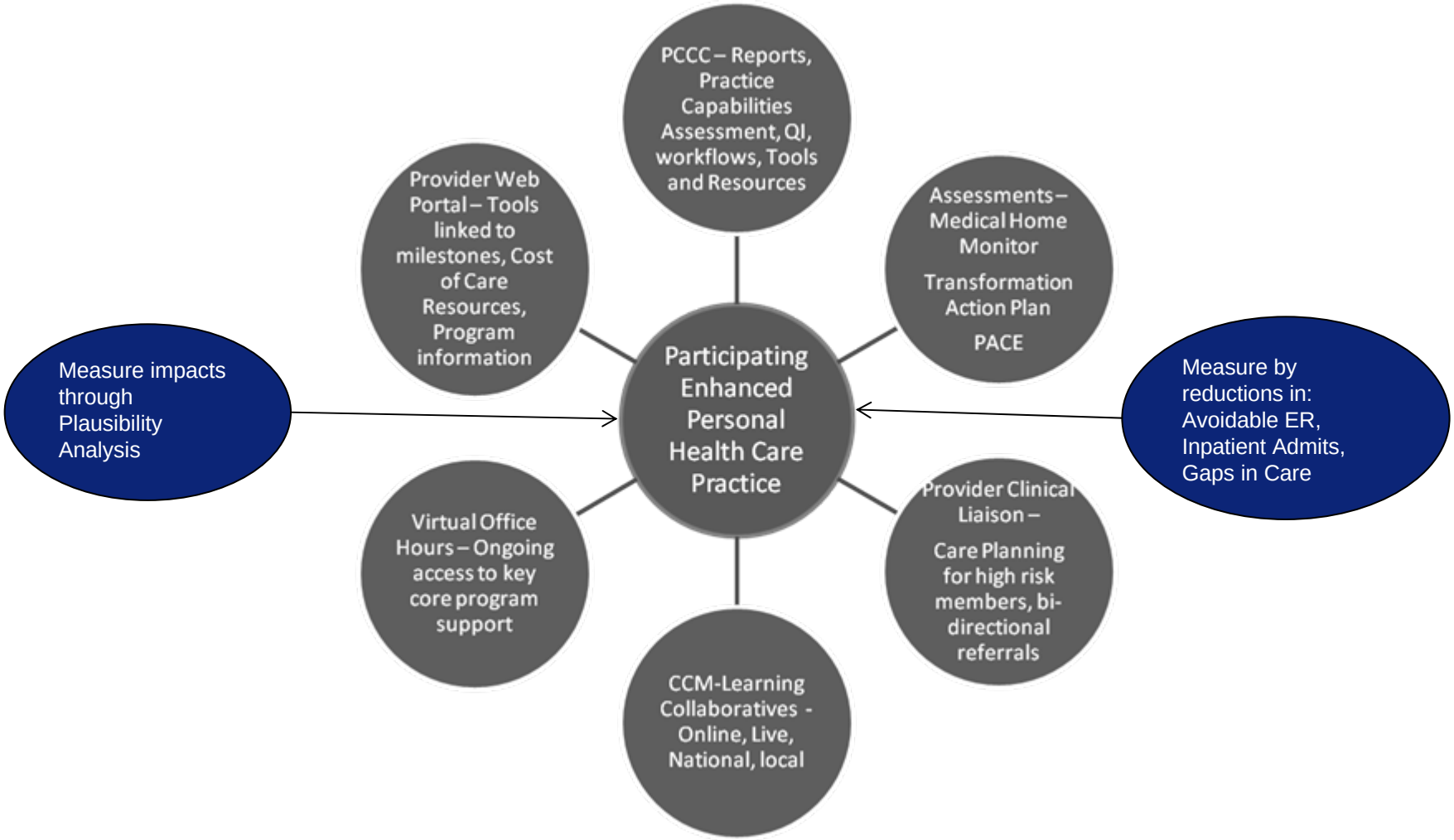
Current Information and Transparency Core Report Set

Aligning payments and providing meaningful information drive appropriate action and accountable care

Information we provide…	…enable providers to take action
Attribution Reports	Population health management intelligence around attributed membership's quality and resource use patterns (tied to shared savings quality and resource use measures)
Hot Spotter List identifies high risk members for care plans	Develop care plans for high risk members who will benefit from care management and coordination
Daily Inpatient Authorization Reports with RHI predictive readmission indicators	Identify members for post discharge planning, begin care coordination for post-acute care management, and reduce readmissions (readmissions part of shared savings resource use measures)
Care Opportunity Reports	Proactively manage member health and wellness ("opportunities" part of shared savings quality measures)
ER Reports	Identifies Attributed Members with emergency room (ER) volume, categorizing "frequent fliers" and offering information around ER avoidance opportunities. Detail includes: Demographics, ER visit details and Potentially avoidable visits identified

We also provide access to a clinical registry via our Member Medical History Plus (MMH+) tool that allows physicians to view and address member health holistically

Surrounding Provider with People, Support, Tools – and Measuring Impact



Aligning Provider Payments with Improved Clinical Performance

Provider performance is evaluated using 32 quality and utilization measures that are based on accepted, national standards

Clinical HEDIS Based Measures

Preventive

- Cancer Screening: 1 Breast 2 Cervical
- Childhood Immunization: 3 MMR 4 VZV
- Well Visits: 5 <15 months 6 3-11 yrs 7 12-21 yrs

Chronic and Acute

- Appropriate Testing for Children: 8 Pharyngitis 9 Upper Respiratory Infection
- Depression 10 Acute Phase 11 Continuation Phase
- Cardiovascular: 12 AMI – Beta Blocker Treatment 13 CAD – ACE/ARB Therapy 14 Complete Lipid Profile 15 HF –Beta Blocker Therapy
- Proportion of Days Covered: 16 Hypertension 17 Cholesterol 18 Oral Diabetes
- Diabetes: 19 Eye Exam 20 HbA1c Testing 21 Lipid Profile 22 Urine Protein Screening
- Monitor Chronic Rx: 23 ACE/ARB 24 Anticonvulsants 25 Digoxin 26 Diuretics
- Arthritis: 27 Disease Modifying Antirheumatic Drug Therapy
- Osteoporosis: 28 Management in Women Who Had a Fracture
- Asthma: 29 Use of Appropriate Medications

Utilization Measures

- 30 Avoidable ER
- 31 Ambulatory Sensitive Admissions
- 32 Generic Dispensing

Our New Normal

Efforts continue to further build and expand our Enhanced Personal Health Care offerings

Current

- Started with a focus on provider organizations with a primary care foundation
- All fully insured and nearly all (>95%) of self-insured business participate
- Program in nearly all our markets, covering more than 25% of our PCPs.
- Build out medical neighborhood:
  - Currently expanding hospital P4P and bundled payment programs
  - Launched Patient Centered Specialty Care pilot 1/1/14 covering covers Cardiology, Endocrinology and Maternity

2015-2016

- Continue to build the medical neighborhood, ensuring that all providers across the continuum share common patient centered goals around improved quality and reduced cost
- Launch National Solution providing seamless access to a national Blue Plan patient centered care network
- The patient centered framework will cover up to 75% of our PCPs
- Optimize alignment of incentives across the provider continuum and with member incentives around common patient centered goals

Increasing benefits to all – better outcome, lower costs – as providers ramp-up and our program footprint expands