WELLPOINT

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

The Alliance for Health Reform: PCMH Briefing

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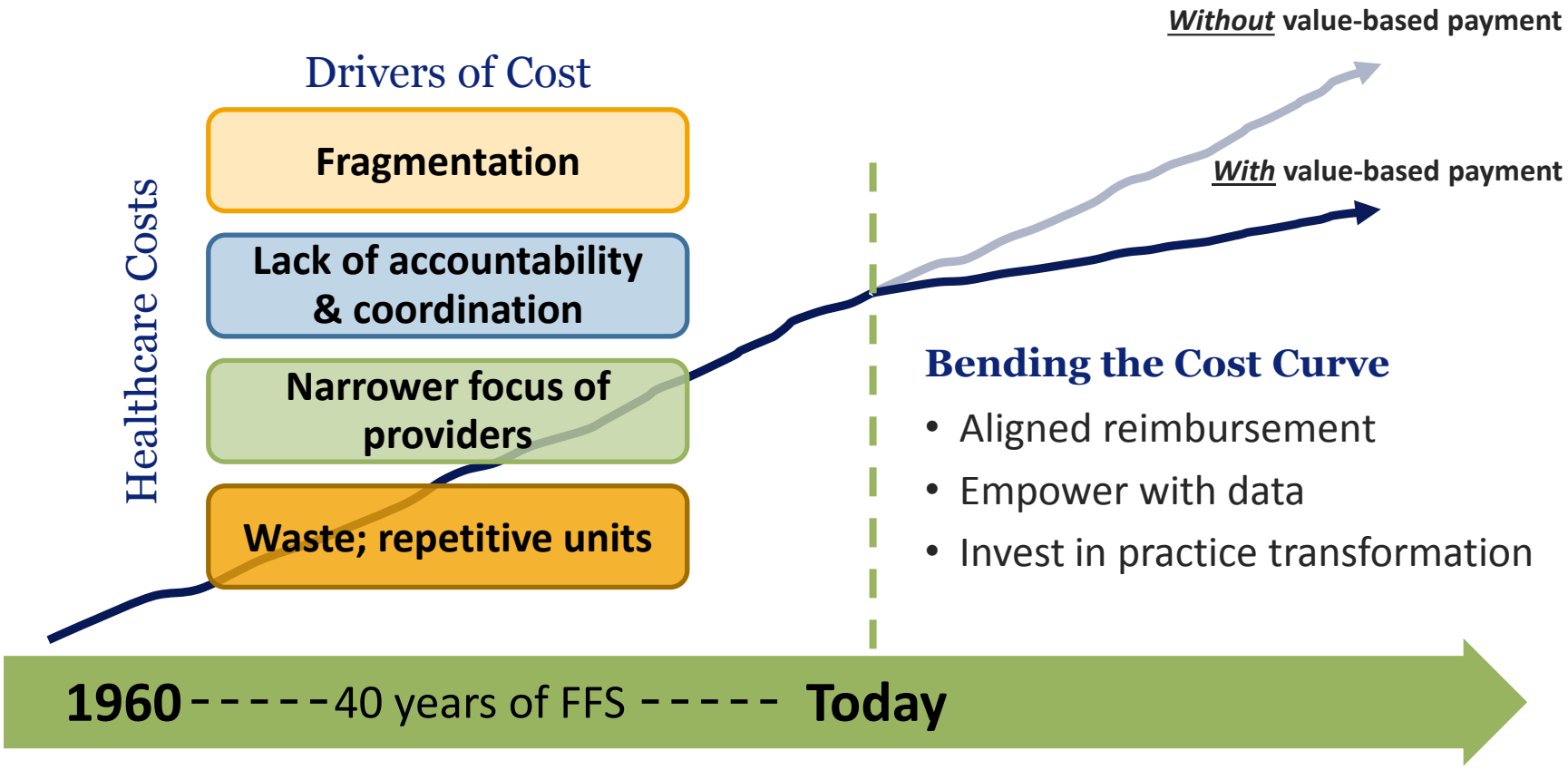
WellPoint is committed to transforming the system

Fee-for-Service

Introduction of Value-Based Payment



Primary care is the foundation of our healthcare system

Significant opportunities to enhance and leverage primary care

Insufficient Resources Directed to Primary Care

Forecasted PCP shortage by 2020	**45K**
Americans without access to primary care	**60 Million**
Wait for non-emergency appointment	**20.3 Days**
PCPs accepting new patients	**49.8%**

Initiatives Empowering Primary Care Drive Better Outcomes

23% FEWER
HOSPITAL ADMISSIONS

18% FEWER
AVOIDABLE ER VISITS

9% LOWER
READMISSION RATE

15% BETTER
ON DIABETES MEASURES

ACA related market expansion and provisions reinforce need to strengthen primary care

References: Association of American Medical Colleges, American Journal of Managed Care., Health Affairs

Empowering PCPs Works: Results from Our Pilots

Our patient centered care pilots nationwide demonstrated 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

California ACOs

35% increase
appropriate mammograms

44% increase
appropriate antibiotics for bronchitis treatment

Scaled, comprehensive approach that drives change by rewarding and empowering physicians

Building blocks for health care transformation include BOTH payment and care delivery reform solutions

PAYMENT INNOVATION

Moving from volume to value-based payment models

PROVIDER EMPOWERMENT

Providing information, tools, practice support and resources to thrive under an outcomes-based compensation model

POPULATION HEALTH

Promoting accountability and care coordination across the healthcare continuum to improve the overall health of the population

PERSONALIZED CARE PLANS

Ensuring awareness and alignment of care plans among the provider team, our care management and caregivers

Our New Normal of Collaborating with Physicians in a Patient-Centered, Value-Based Manner

Key Components of Our New Contracts Focus on Improving Quality and Affordability

PAYMENT REFORM

Incentives enabling delivery of patient-centered, value-based care

- **Quality care foundational to value-based payment**
  - PMPMs for care outside traditional visit
  - Opportunity to share in savings when quality thresholds are met
- **Annual performance evaluation**

CARE DELIVERY TRANSFORMATION

Support for participants to operate in a value-based environment

- **Practice care coordinator works closely with Anthem staff**
- **Actionable data and tools supports patient care and engagement**
- **Learning Collaboratives supports education, best practice sharing**

Enable Provider Transformation to Improve Access, Patient Health Outcomes and Costs

Anthem BlueCross BlueShield — Transformation Team

1. Community Collaboration Manager
2. Care Consultant
3. Provider Clinical Liaison

SUPPORTS

Small, Independent PCPs	IPAs PHOs	IDSs, ACOs, Hospital Systems

Practice Care Coordinator
(PCP, Care Team)

AVAILABLE ANTHEM CAPABILITIES / TOOLS ENABLING TRANSFORMATION

Clinical registry tool

Class leading reports

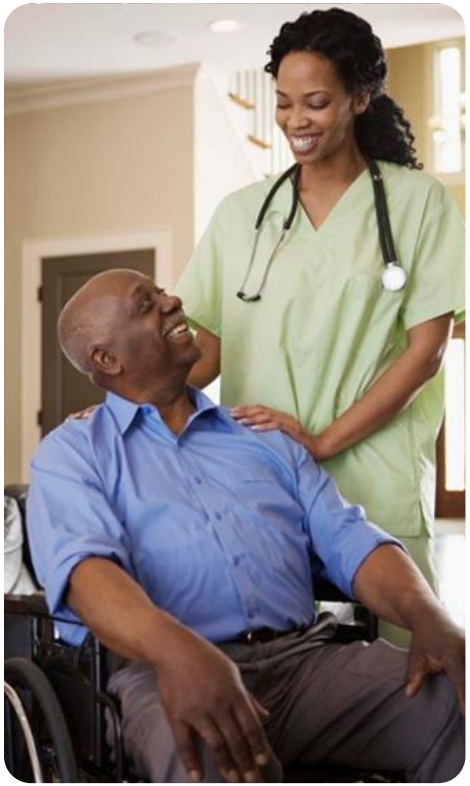
Care plan resources

Collaborative Learning

Educational resources

Promotes patient-centered health care decision making at all patient touch points: pre-visit, at site of service, post-visit/follow-up

Case Study:
Improved Coordination and Chronic Care Management



Background:
49 yr-old w/ diabetes, high blood pressure, and obesity. No recent PCP visits but had a recent hospitalization

Enter Enhanced Personal Health Care

Transformation Team **educated** practice on available resources: reports, clinical registry and care management

- Appeared on **Hotspotter** with history of diabetes, hypertension
- Appeared on **Inpatient Authorization** with surgeon referring patient back to PCP
- **Clinical registry tool, MMH+,** showed no medical care since 2008 until recent hospitalization

Patient is on path to better health

- **Care plan** created and reviewed with patient: recommended lifestyle changes, self-management and Rx
- Patient adhered to care plan: **attended classes, improved diet, tracked and reported HgbA1c regularly**
- HbA1c level now normal; **fewer Rx** with better control

Market Leading Value-Based Payment Footprint

110,000 Physicians
PCPs and specialists

Participating in Value-Based Arrangements
P4P, bundles, capitation, shared savings/risk arrangements

44,000 Physicians;
32,000 PCPs
2.7 million attributed members

In Shared Savings/Risk Framework
Includes participation in CMS' Comprehensive Primary Care initiative

90 health systems

Accountable Care Organizations (ACO)

2,300 designated facilities

Blue Distinction Centers of Excellence

760 hospitals
76% of inpatient admissions

Hospital Payment for Quality and Safety

Represents more than $30 billion of our annual commercial spend

Collaborating with Government

Opportunities exist to collaborate with healthcare stakeholders to accelerate transformation and generate efficiencies

Measure Standardization

Secure Data Exchange

It takes a village…

Questions