Patrick Brennan, MD
SVP & Chief Medical Officer
University of Pennsylvania Health System

Mai Pham, MD, MPH
VP, Provider Alignment Solutions
Anthem

Paul Meyer
Chief Executive Officer
The South Bend Clinic

Moderator: Richard Snyder, MD
SVP & Chief Medical Officer
Independence Blue Cross

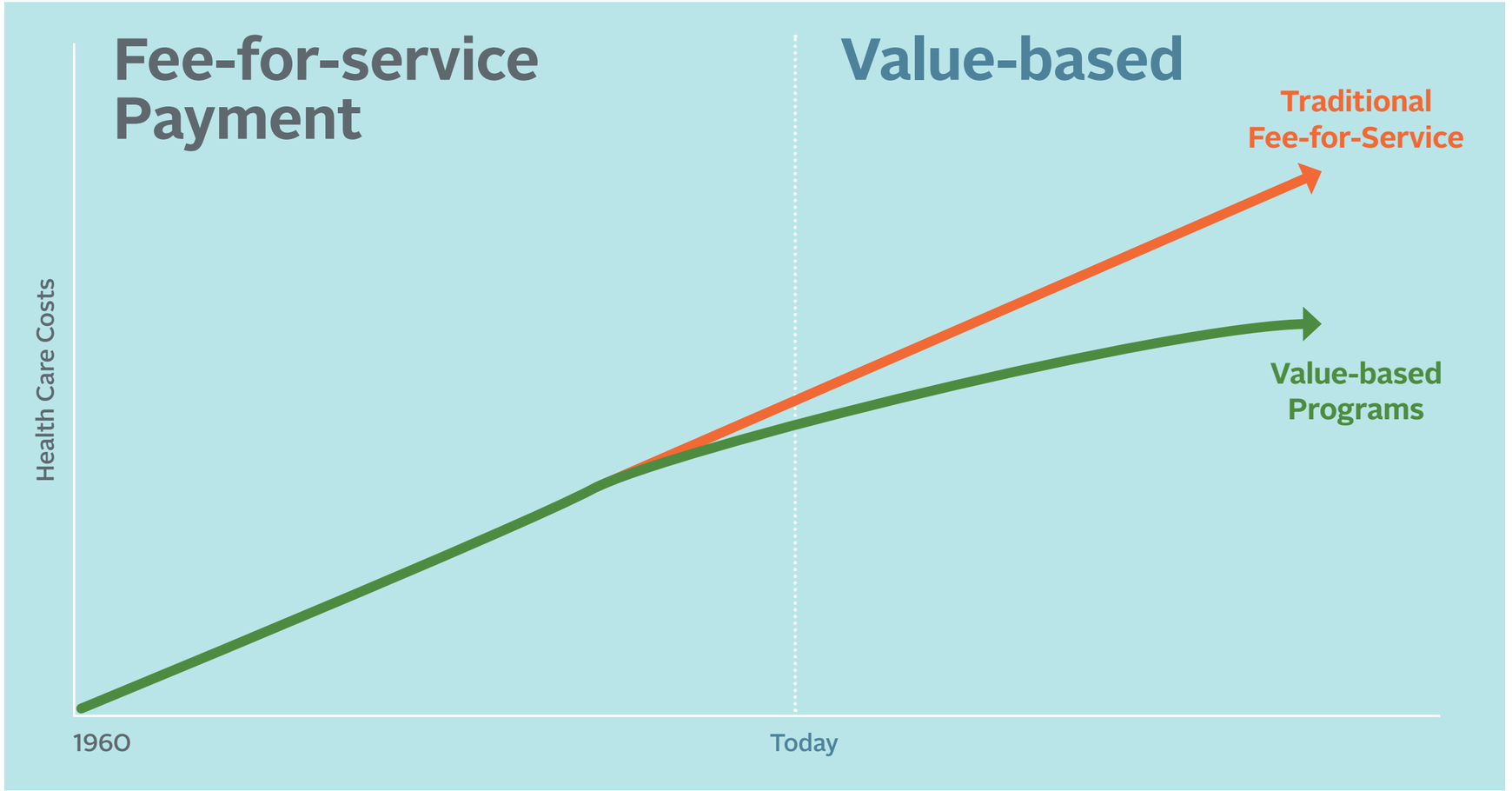
Independence

2018
HEALTH CARE FORUM

PROVIDER COLLABORATIONS FOR BETTER HEALTH OUTCOMES

Value-Driven Care Bends the Cost Curve

Independence



Cost drivers

- Rewards for volume, not value
- Lack of accountability & coordination
- Focus on sick care
- System is hard to navigate

Bending the trend

- Aligned reimbursement
- Data empowers providers
- Focus on overall health
- Shared decision-making
- Practice transformation investments

Facilitated Health Networks

Community-tailored

Independence

Engage

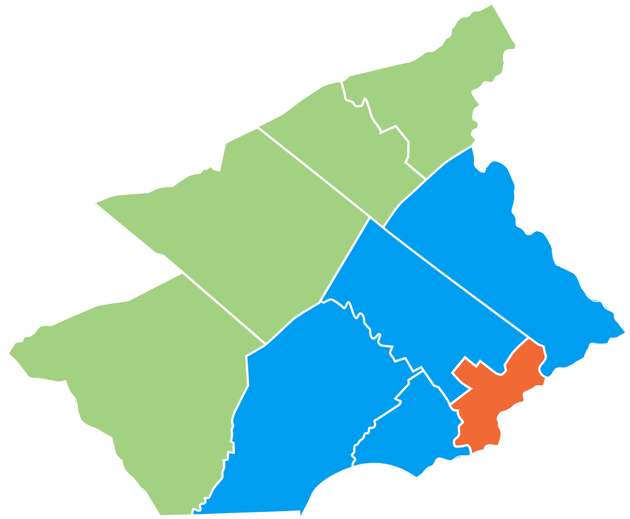
Engaging with doctors and hospitals to design business models that emphasize shared accountability for the quality and cost of care being delivered to members.

Enable

Enabling doctors with targeted, actionable reports that identify members who have had an avoidable ER visit, are at risk for hospitalization, can switch to generic drugs, or are due for a check-up.

Empower

Empowering doctors and hospitals by working face-to-face, providing tools and reports, and leading care groups where we bring physicians together regularly to share best practices.



How Can We Drive Lower Total Cost of Care?

Penn Medicine

We Must Look at Care Utilization for Patient Populations Across the Continuum of Care

Better diagnoses

Reduce unwarranted diagnostic or surgical procedures due to unknown/incorrect diagnoses.

CPD

More accurate diagnoses can lead to fewer treatments that would be ineffective.

Advanced care

Evidence that patients have better outcomes for select diseases when they come to higher volume physicians/hospitals first (e.g. cancer).

Better follow-up and coordination of care

Through an integrated health system, better follow-up care can lead to fewer readmissions and emergency room visits.

Better patient management

Better management of chronic conditions can lead to better medication adherence, resulting in better outcomes and lower future use of care (hospitalizations and ER visits).

Post-acute care

Preferred provider network. “Hovering” over patient at home rather than in a SNF can lower the total cost of care.

Sites of Care

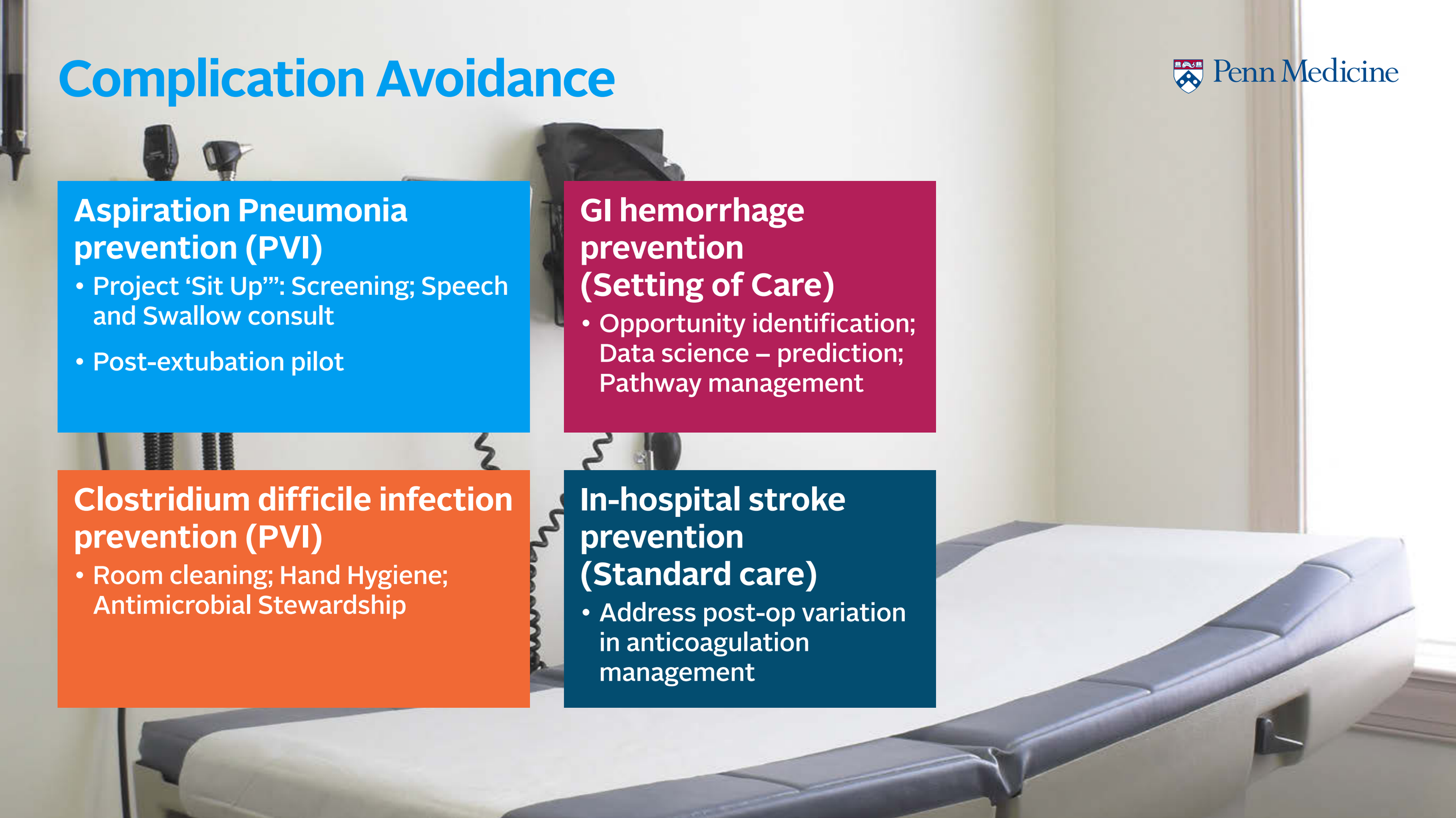
Selecting appropriate site for delivery of care, especially outpatient and home.

Reducing waste and duplications

Single electronic medical record can help us reduce waste and duplication of services.

Complication Avoidance

Penn Medicine



Aspiration Pneumonia prevention (PVI)

- Project ‘Sit Up’”: Screening; Speech and Swallow consult
- Post-extubation pilot

GI hemorrhage prevention (Setting of Care)

- Opportunity identification; Data science – prediction; Pathway management

Clostridium difficile infection prevention (PVI)

- Room cleaning; Hand Hygiene; Antimicrobial Stewardship

In-hospital stroke prevention (Standard care)

- Address post-op variation in anticoagulation management

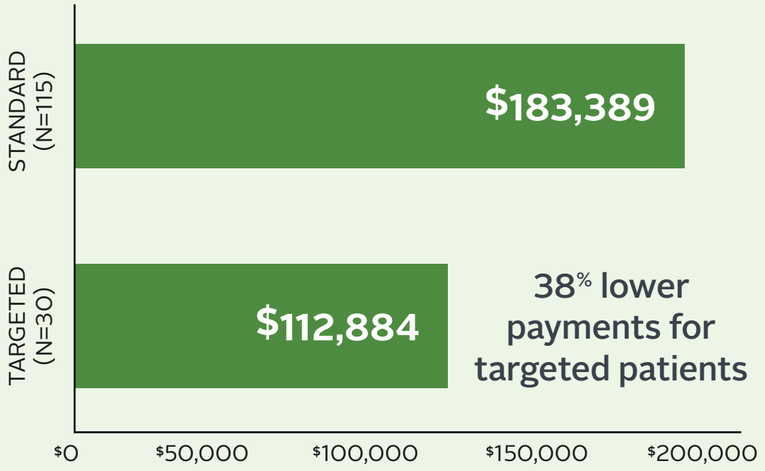
Effective Use of Targeted Therapy Improves Value

Penn Medicine

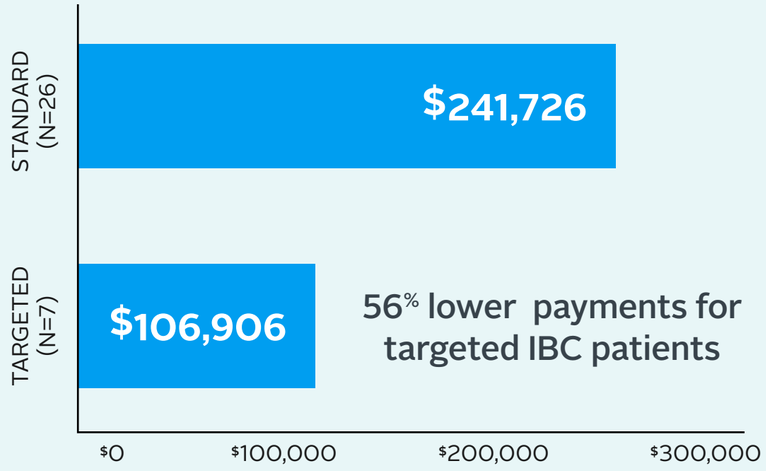
Stage IV Lung Cancer Patients

- 49 patients had actionable mutations found via CPD testing
- 215 patients either did not have CPD testing or had it but did not have any actionable mutations (113 had CPD testing; 102 did not have CPD testing)

All patients that presented over a year ago and restricted to one year of data



Since payments can be influenced by insurer type, the same analysis was performed only on IBC patients



Patients treated with targeted therapy had 38% lower payments in the first year after presentation compared to patients treated with standard therapy. When including only IBC patients, the difference is even larger with 58% lower payments for patients treated with targeted therapy.

Note: Payment data from FY12 to March FY16 for HUP, PPMC, PAH, CPUP, and CCA Accounts

Physician Judgment: Better Drug Utilization

Penn Medicine

We recently made a decision to not offer two phenomenally expensive cancer drugs to our patients.

- Necitumumab: OS HR 0.84 (1.6 mos)
- Ramucirumab: OS HR 0.857 (1.4 mos)

THE WALL STREET JOURNAL.

BUSINESS

Experimental Lilly Lung-Cancer Drug Stirs Price Debate

Some doctors argue for lower price based on drug's effectiveness

At UPHS, we did not just bargain for a lower price … we decided not to use these drugs at all

- Both have immaterial benefits while their prices (likely >$10,000 per month) are much higher than equivalent drug

UPHS Value Programs

Penn Medicine

UPHS is Involved in Many Value Programs Both Independent and in Partnership with IBC

In Partnership with Independence

- Participation in IPPIP Hospital Quality P4P
- Participation in IPPIP Medical Cost Management
- Participation in Joint Replacement Bundles
- IBC support of automated hovering program
- IBC support of Telederm pilot program
- Transitions in Care program
- IBC grant to support defibrillator coaching and training
- IBC/UPHS Data Sharing Agreement
- Proton Therapy program to support evidence development
- DreamtIT

Independent Programs

- Service Lines and Disease Pathways
  - Cancer
  - Heart and Vascular
  - Neurosciences
  - Musculoskeletal
  - Women's' Health
- Center for Personalized Diagnostics
- Glowing Tumors
- Improving medication adherence in MI patients
- Tele-monitoring of CHF patients
- Impact Community Health Worker Program
- Patient-Centered Medical Homes

Joint Operations Committee

Penn Medicine

Post-Acute Care Management

- Penn's Preferred Provider Network
- Inclusion of Tandigm Preferred Provider Network

Prescription Cost Transparency

- Win-win
- Assures formulary adherence at point of prescribing
- Cost transparency benefits patient, provider and payor

Pain-Opioid Dependency

- Limitations on doses prescribed
- Tracking of utilization
- 'Warm-handoffs'

Opportunities to Improve Access

- Telehealth
- Palliative Care

Value Efforts

Penn Medicine

- 30 day All Cause Readmission Warranty
- Acute Bundles/Chronic Episodes
- ACO/CPC+ Model
- Rx Prescription Model
- Early intervention for tertiary/ complex care
- Integration of Innovation activity
- Open ended mutual desire to pursue new opportunities

Common thread among all these efforts is the necessity of an integrated and common information platform across the delivery system.

Summary

Penn Medicine

- UPHS is the ***only*** fully integrated health system in the region – inpatient, ambulatory, post-acute, rehab, home care all under one electronic medical record and one management structure – that can deliver on these programs in a coordinated way.
- Value programs interact with all parts of UPHS.
- Impact of the value programs is very broad: lower health care utilization, better patient outcomes, higher quality of care, coordination over care episodes, improved patient experience.
- The focus is on improving care management for patient populations with chronic disease and the “acute expression of chronic disease” (complex care).
- These programs are driving improved patient outcomes that matter to patients and IBC (e.g. fewer hospitalizations, lower readmissions, better functional status) that lead to lower costs.

Our Commitment to Value-based Care

PROVIDER RISK & SOPHISTICATION

Menu of Payment Models

Capitation
Partial and Global

Bundled Payment
Joints, Maternity, Cardiology, Transplants

Shared Savings
Upside only, Shared Risk, Multi-Payer

Pay for Performance
Hospitals and Primary Care

Programs at Scale

53% of enterprise medical spend in shared savings/risk and capitation

>76,000 providers in shared savings/shared risk contracts

7.3M members attributed to ACOs and PCMHs

- 805 Hospitals in Commercial P4P programs
- 192 groups in Medicaid Specialist P4P pilots

Continual Innovation

Future State:

- Differentiating high-value providers
- Shift to outcomes-based quality metrics
- Marry network, benefit and payment design
- Encourage sustained consumer-PCP relationships
- Condition and Chronic Care Bundles

Our Next-generation Global Payment Model

Total Cost-of-care Model

"A Better Mousetrap": increased accountability for financial, clinical and experiential outcomes

Specialist Engagement

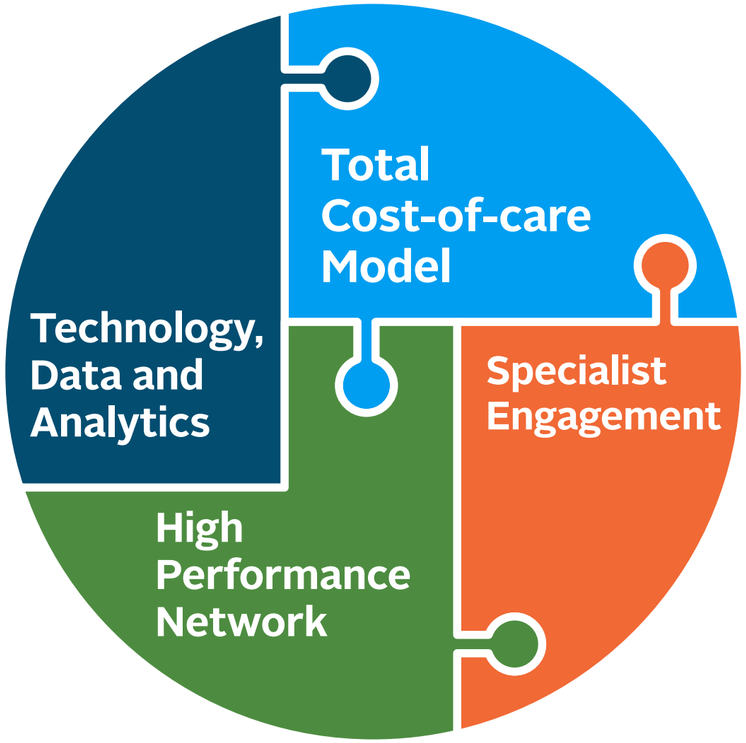
Rewards specialists for improving care coordination and outcomes; discourages low-value activity

High Performance Network

Greater affordability, deeper member engagement and superior member experience

Technology, Data and Analytics

Convenience for patients, better reporting for employers and providers, administrative simplicity



Input from nationally recognized provider groups and key employers drove refinements in our payment model, leading to improved outcomes, cost containment and a differentiated patient experience

American Hospital Association
AHIP America's Health Insurance Plans
AMA American Medical Association
APhA
BlueCross BlueShield Association
MGMA

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - ***Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine***
   - ***Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers***

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Reinventing Prior Authorization

Anthem BlueCross BlueShield | The South Bend Clinic

- Movement in the industry to simplify prior authorization processes
- Provider NPS survey research highlights pain points and administrative burden associated with prior authorization requirements.
- Opportunity to act upon our Provider Promise and deliver a best-in-class provider experience
- HDAC members, South Bend Clinic and Cleveland Clinic, are ready to work together to build and implement a solution

Co-Designing a New Solution

Piloting June 2018

Criteria

1. Includes all eligible Anthem BCBS members (Excludes Blue Card*)
2. Services performed by defined health service provider (TIN)
3. Eligible service categories

*UM requirements are managed by the applicable Home Plan

How it Works

Provider will not be required to submit prior authorizations for eligible service categories prior to delivering service and may be subject to submitting clinical information.

Provider: Verify member eligibility and benefits through current established processes	
Provider: Provide eligible service for defined Anthem BCBS LOBs without submitting a PA	Anthem BCBS does not need to be notified when eligible service provided
Provider: Submit claim for eligible service	Claim system edit for missing PA will have been removed for defined provider and eligible services
Provider: Share clinical information on demand or provide EMR access	Anthem BCBS and provider will establish focused retrospective reviews

Eligible Services – Fact Based Decisions

Proposed solution has potential to relax a large portion of currently required prior authorizations

Radiology
(example: CT Abd & Pelvis W/O Contrast, MRI Lumbar Spine W/O Dye)

Medicine
(example: TTE W/Doppler Complete, Stress TTE Complete, Therapeutic Exercises)

Durable Medical Equipment
(example: CPAP)

Digestive
(example: EGD Lesion Ablation, Diagnostic colonoscopy)

Procedures/ Professional Services
(example: Home Sleep Study – Portable Monitor with 4 Channels)

Respiratory
(example: Endoscopy Maxillary Sinus, Repair of Nasal Septum)

Service Categories Excluded:
- Inpatient
- Cosmetic
- Investigational
- Transplant/Bariatric
- Genetic Testing

*Select health service code examples displayed; actual list would be broader.

Note: Specialty Pharmacy is under consideration.

Effective Backend Monitoring

Collaborative monitoring process

- Greater rigor at initiation; once comfortable with processes, ongoing utilization pattern monitoring
- Agreement will define guardrails
- Implement claims withhold against utilization spikes above guardrails for non-risk providers. Claims withhold to be reconciled annually.

- Establish baseline utilization for providers prior to implementing
- Identify parameters for upper/lower changes to baseline utilization range as audit metric

Medical records shared through preferred electronic data acquisition (e.g., EMR access, data feeds)