



Anthem is a health benefits company. Its purpose is: "Together we are transforming health care with trusted and caring solutions". Its vision is "To be American's valued health partner". Its values are to be accountable, caring, easy to do business with, innovative and trustworthy.

Anthem has medical plan enrollment of 40.3 million members with annual revenue of 88 billion dollars. Fully insured members number 15.3 million and 25 million are in self-funded plans. There are 8 million members enrolled in Medicare and Medicaid plans.

Anthem recognizes that the care of the seriously ill patient is important. Under ideal circumstances, patients with incurable advanced illness are treated by a palliative care team early in the course of their disease, and preferably in the outpatient setting (either clinic or home based). During these visits, the patients can receive a formal symptom assessment and an evaluation of their psychosocial needs. However, the availability of outpatient palliative care is severely limited by a shortage of practitioners and a poorly defined financial model.

Anthem has chosen to address the palliative care needs of its patients in two ways: 1) Our Enhanced Personal Health Care Program, and 2) Our Advanced Illness Support Program.

Enhanced Personal Health Care Program (EHPC)

The EHPC is a value-based payment model designed to provide resources to provider practices to encourage the move from the fee-for-service environment to a value-based payment model. The EPHC began in 2012 and after three years included 54,000 participating providers caring for 4.6 million members in Anthem plans. Anthem has developed transformation teams to assist practices in transformation of their practice and has positioned clinical liaisons to help practices interpret data, develop care management skills and help in identifying and managing high risk patients.

The EPHC is designed to achieve three main goals:

- 1) Support the transformation of care delivery through collaboration with providers that have varying levels of experience with risk-based contracting.
- 2) Improve patients' quality and experience of care and their health status and outcomes.
- 3) Slow the growth of total cost of care in order to ensure the affordability of high-value coverage.

The EPHC achieves these goals through flexible infrastructure design that can serve the needs of solo practitioners all the way up to large ACO organizations. Participating providers receive upfront clinical coordination payments to offset the costs of care coordination and program implementation. Subsequently, providers are eligible to share in savings (30-35%) if attributed members have a lower cost of care than projected and also are eligible for enhanced reimbursement if quality measures improve. Conditions of participation in the program are as follows:

- 1) Provide 24/7 access to members through extended hours and/or call coverage.
- 2) Have a dedicated position in the practice that supports participation in EPHC and practice transformation.
- 3) Regularly participate in collaborative learning sessions and use support tools, such as hot-spotting reports, to identify gaps in care.
- 4) Use a disease registry to manage care for patients with certain chronic conditions and engage in care planning for high risk populations.
- 5) Use generic prescription drugs when clinically appropriate.
- 6) Engage in quality and performance measurement, and meet appropriate performance standards on nationally endorsed quality measures.



Initial analysis of EPHC in 2013-2014, demonstrated 7.8% fewer acute inpatient admissions, 5.1% decrease in outpatient surgery costs, 5.7% fewer inpatient days, 7.4% decrease in acute admissions and an increase in outpatient visits for high risk patients with chronic comorbidities, and finally a 3.5% decrease in ER costs. Overall net savings from the program over this time period was \$6.62 per attributed member per month as compared to members not enrolled in the program. Care coordination quality metrics and patient satisfaction scores were also significantly improved.

A significant part of the EPHC is the sharing of actionable data. There is a clinical application, Provider Care Management Solutions, which provides practices with real time data to determine which patients require attention. Data feeds also include longitudinal member records, hot-spotter reports and gaps in care reports designed to help providers target their care management efforts. These interventions are particularly important for the care of the seriously ill.

Advanced Illness Support Program

Delivering palliative care in the community is limited by three major barriers. The first is the Medicare Hospice Benefit which effectively requires patients to stop disease-modifying therapy to enter hospice care. The second is the shortage of palliative care practitioners and the third is a reimbursement structure that impairs the development of a stable financial model. Anthem is currently formulating solutions to these limitations.

The Advanced Illness Support Program is a combination of two initiatives. The first is an expanded hospice benefit program. The plan is to offer hospice benefits to commercially insured/Medicaid members with an anticipated prognosis of 6-12 months. They would be allowed to continue to receive disease-modifying therapy like chemotherapy and transfusions. It is hoped that as the patient and their family become comfortable with their hospice team, that advance care planning discussions are completed, goals of care are ascertained, and ultimately, late aggressive care will be avoided. It is anticipated that there will be significant cost of care savings.

The second initiative is an investment in palliative care assets to develop a home-based palliative care program. Our strategy is centered on three programs: 1) A home-based telehealth program to offer home-based palliative care, 2) A home-based multidisciplinary palliative care team making home visits, and 3) The potential for clinic-based palliative care embedded in practitioners' clinics (i.e. – oncology clinics). It is expected that these programs will more effectively disseminate palliative care to our members, will provide members 24/7 access to a palliative care team, and provide highly-trained palliative care professionals to our members.