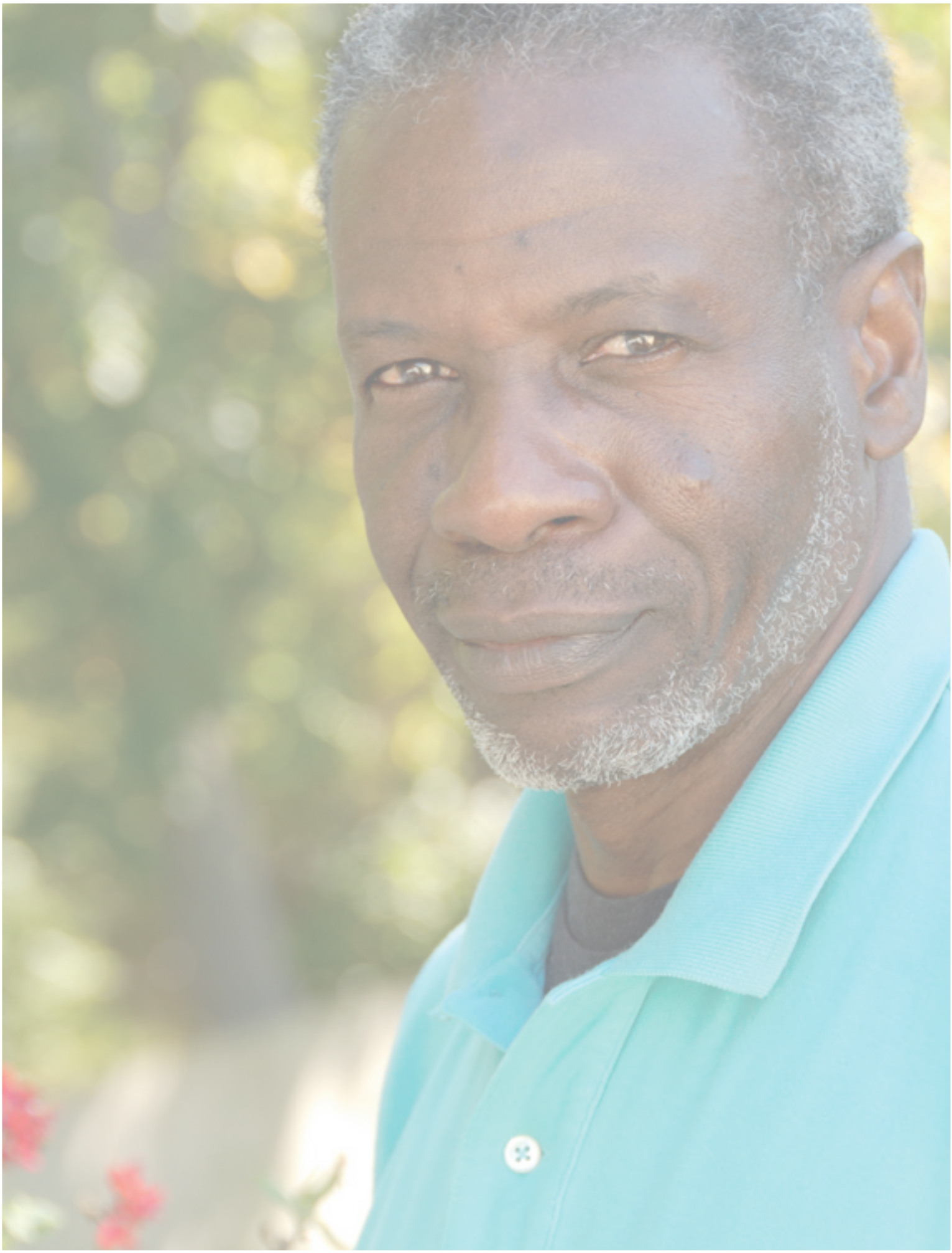
Advancing Your Health Care Connections

Commonwealth of Virginia PPEA Conceptual Proposal with Redactions

September 5th, 2008

Anthem



Anthem

September 5, 2008

Mr. Dan Hinderliter
Director of Contracts and Finance
Department of Human Resource Management
101 N. 14th Street, 12th Floor
Richmond, Virginia 23219

Re: PPEA Conceptual Proposal Additional Information Request

Dear Mr. Hinderliter:

Pursuant to Virginia Code Sections 2.2-3705.6(11), 56-575.17(A)(2), 56-575.17D and the Commonwealth's PPEA guidelines, Anthem Blue Cross and Blue Shield ("Anthem") requests the Department of Human Resource Management to protect, exempt and exclude from public disclosure under the Freedom of Information Act the portions of this response to PPEA Conceptual Proposal Additional Information Request marked as "Confidential Proprietary Information-Exempt from FOIA Release." Those portions of the additional information submitted for which the protection from disclosure is sought have been identified with the language stated above. Pursuant to the cited Code Sections and the PPEA guidelines, the materials, records, items and information so marked and, for which protection for public disclosure is sought, contain financial records and/or confidential proprietary information , where the public disclosure of such materials, records, items and other information would adversely affect the financial interest and/or bargaining position of the Anthem team.

If the Department is not prepared to grant the requested protection of confidentiality or seeks to limit the documents covered by the request, please contact the proposer prior to any disclosure to discuss this matter further.

Sincerely,

MacGregor T. Gould
Director of Sales and Marketing
State and Local Government Programs

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Introduction

Anthem's total health solution touches 100% of the Commonwealth's employees and their families

Section 1: Introduction

Thank you for giving Anthem Blue Cross and Blue Shield (Anthem) the opportunity to showcase our ability to advance your health care connections through sophisticated analytics and comprehensive care management solutions. In collaboration with the Commonwealth, we have historically provided access to quality health care and innovative programs and services to engage the Commonwealth's employees and their families. We firmly believe that Anthem can help the Commonwealth achieve elevated goals that are becoming clearer with the onset of new technological advances and innovative service and engagement strategies.

Anthem's total health solution touches 100% of the Commonwealth's employees and their families. As such, our analysis shows that the philosophy currently in place is the foundation to support enhancements as follows:

- Introduction of Dedicated Care Coaches
- Continued Integration/Innovation
- Increased Member Identification leveraging advanced analytics
- Expansion of Member Engagement

What does this mean for the Commonwealth?

We are committed to the overall health of all residents of Virginia. To help ensure quality of care for the communities we serve, we can leverage the breadth and depth of total population member data.

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By leveraging our successful partnership, the Commonwealth will realize incremental savings through Anthem's more comprehensive and integrated approach that provides an additional layer of value orchestrated by the Care Coach services, which integrate with Anthem Behavioral Health, Anthem's Pharmacy Benefit Manager, and MyHealth Advantage.

In the following sections, we will highlight our data and clinical capabilities as well as provide case studies of members with various needs:

- **Section 2 – Enhanced Health Care Connections**

  A high level overview of the data analysis results as well as more detailed charts including details on specific populations.

- **Section 3 – Enhanced Clinical Capabilities**

  An extensive description of our wide array of clinical capabilities as well as the positive financial impact of more effectively managing care.

- **Section 4 – Connecting to Your Employees**

  Snapshots of how members with various health care needs can successfully navigate their way through different care paths.

- **Section 5 – Conclusion**

Enhanced Health Care Connections

Section 2: Enhanced Health Care Connections

Data Analysis Methodologies

With a multidisciplinary team including representatives from Advanced Analytics, Actuarial, Underwriting and Clinical Management (Medical, Behavioral Health and Prescription), we take an integrated approach to Clinical Data Modeling and Financial Forecasting. The results of our work in this exercise will demonstrate to you that, with our advanced claims analytics capabilities, we are able to identify members appropriate for clinical interventions and work the impact of those clinical interventions and other care management programs into our financial modeling. We take the same integrated approach in the actual management of your members and the resulting financial impact is greater than each program could deliver in isolation.

The team followed these basic steps in completing the requested exercise. The results of these steps will be spelled out in the following sections and some of the more detailed documentation of the analysis can also be found in the completed worksheet.

A. Assumptions/Demographics
Perform high level review of data to identify important characteristics that may impact the analysis and develop working assumptions that will be used throughout the analysis.

B. Clinical Analytic Modeling Application
Perform clinical modeling to identify members eligible for each component of our integrated clinical management programs, both existing and newly proposed.

C. Actuarial Trend Analysis
Perform actuarial trend analysis to develop underlying utilization trends for existing care management programs.

D. Impact Analysis
Apply known results of clinical management programs to the claims experience in the data set provided to develop factors to be used in the financial model provided.

E. Factor Application
Apply resulting factors to the appropriate sections and categories of the financial model provided.

F. Final Review
Perform final clinical and actuarial review of financial model to ensure the integrity of the results.

Data Analysis Results

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Summary

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Enhanced Clinical Capabilities

Section 3: Enhanced Clinical Capabilities

Employing state-of-the-art technology, evidence-based practice guidelines and a team of experienced health care professionals, our award-winning programs provide a strategy for all participants with various risk levels, allowing for increased outreach to our pool of eligible members. This strategy enables us to focus the most appropriate level and timely application of evidence-based interventions necessary for the successful and cost-effective management of the member's condition.

Utilizing the data set provided by the Commonwealth, the following illustration highlights our interventions and capabilities in relation to the advanced health care connections for the following:

Care Coaching

Anthem's Care Coaches provide your employees and their families with a dedicated, personal resource for all of their health care needs ranging from general to detailed, health-condition specific questions. Care Coaches are registered nurses with a variety of clinical backgrounds and serve as a central point of contact for engaged members for a variety of health concerns. This allows us to provide the most comprehensive and personal coaching experience based on each individual member's needs. Through one-on-one interventions, the Care Coach can achieve the following:

- Assessment of the member's level of motivation
- Provision of increased education to the member
- Improved safety through collaboration with the treating physician(s)
- Adherence to the physician's plan of care
- Enhanced monitoring of quality of care orchestration on behalf of each member

Care Coaches integrated the member experience across all of these conditions to create a seamless experience for the member

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Care/Utilization Management

The Commonwealth employees will also be identified for Care/Utilization Management either by the Care Coach or through our enhanced analytics predictive modeling tools. These services provide outreach to members with very specific health concerns who need a more intensive level of assistance or who have gaps in care not typically addressed. These members are particularly vulnerable and potentially represent the Commonwealth's most unstable population. The Care Coach working with the Care/Utilization Management team engages the Commonwealth's employees at a moment when they are most amenable to engaging with and entering into long-term clinical relationships with the Care Coach team. This increased engagement for these high cost members results in improved member health outcomes.

The tables below illustrate the actionable conditions identified through Anthem's advanced analytics that receive outreach by Care Coaches. Care Coaches integrate the member experience across all of these conditions to create a seamless experience for the member.

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Advancing Your Health Care Connections

While each of the clinical capabilities listed above achieves targeted engagement and drives individual clinical outcomes, the true value of Anthem's proposed offering rests within our integrated model. Our success is achieved through the following means:

1. Care Coaching

One key feature of our Care Coaching is its associated health care services. All of the Commonwealth employees and their families will be assigned a dedicated registered nurse who can provide education, counseling, tools, and support to help members with the following:

- Navigating the health care system more effectively
- Promoting greater physician engagement
- Understanding the benefits of lower cost prescription drug options
- Making informed decisions around elective treatments
  - Glide Path analysis for Low Back Surgery is a process where we can identify members with care patterns most at-risk for the high-cost procedures. The analysis allows Anthem to ensure appropriate support and offers opportunities to work with members and their providers to find the most appropriate treatment options. A Commonwealth-dedicated Care Coach supports identified members with information, guidance, goal setting and attainment with the goal of improving their condition and potentially avoiding costly surgery.

Care Coaches are trained specifically to assist members with their immediate need and then warm transfer members to the appropriate Care/Utilization Management. The Care Coach works with the Care/Utilization Management teams corroboratively to identify "triggers" for referral and have established an automated process to keep both the medical management team and the clinical team aware of all member interactions, interventions, and activities. Care Coaches serve as the central resource to ensure coordination related to all available services including programs associated with the Commonwealths' third party vendors, such as your disability vendor. This added resource further integrates a more positive health care experience for your employees.

The Commonwealth employees will be motivated to engage with Care Coaches because of the valuable service they provide, but Anthem also understands how powerful effective motivation can be by providing incentives to jumpstart behavior change. The Commonwealth employees will continue to receive the current maternity deductible waiver linked to Future Moms participation for enrollment in the program in the first trimester and stay engaged throughout their pregnancy. Anthem also proposes incentives include rewards for MyHealth Assessment completion and Engagement in Care Coaching.

2. Advanced Engagement Strategy

Anthem is constantly seeking and remains committed to leveraging advanced engagement strategies. One excellent example Anthem has already brought to the Commonwealth is dLife.

Not all members want to be engaged in the same way with their health care. Anthem has partnered with dLife, an alternative media company, to offer the current Commonwealth employees and family members. Diabetes Condition Care Program participants with new tools and resources with the goal of driving more effective

Anthem drives financial results through innovative engagement methods that motivate Commonwealth employees to make health behavior changes

member management. dLife was the winner of Best Health and Health Care Website in 2007 from the Web Marketing Association's WebAward.

dLife is an equally as personal alternative to Care Coach interaction for members who may not want to engage over the phone, or it can be an adjunct to the support they receive from their Care Coach. These enhanced tools and resources include:

- Telephonic inbound (toll free) and outbound IVR information
- A customized dLife DVD that provides engaging information on various real-life diabetes-related topics
- Access to the dLife website where members will find the following:
  - Diabetes blogs
  - Streaming video from a weekly diabetes series
  - Nutrition & Meal information including recipes, nutrition advice, and food substitution suggestions
  - Information specific to Type 1, Type 2 and Gestational Diabetes
  - Self-care tips
  - Ethnically focused content
  - Newsletters

3. Enhanced Information and Technology Platform

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Our Enhanced Information and Technology Platform connect our sophisticated analytics with Care Coaching that subsequently drives member engagement across all proposed services. By sharing information through a conventional web-based platform, Anthem provides a more meaningful experience because all clinical team associates are involved in the member's care, addressing the member's need proactively, efficiently, safely, and consistently. This is achieved through:

- Member profiles that are updated daily
- Automated referrals between programs
- Key member contact information (i.e., telephone numbers, preferred time of day for contact)

Our Platform facilitates seamless communication between members of the Care Coaching and Care/Utilization Management teams resulting in a more poignant, personal and engaging member experience.

4. Integrated Benefits – A Holistic View

Anthem is proposing further engagement and potential cost savings based on an integrated benefits model that brings the pieces of the health care puzzle together in one place. By leveraging our full spectrum of product offerings, the potential for reaching the ultimate continuity of care increases exponentially. This next level of care management can be achieved by the following:

Co-morbid depression impacts medical costs by more than 50%. Integrating behavioral health services in to Care Coaching will drive guidelines-based treatment for depression and overall decrease medical costs

Behavioral Health

Integrating a behavioral health component over the entire program drives medical cost savings which would otherwise go undetected and also offers the potential for lower costs specifically within the behavioral health treatment arena. For example:

People with chronic illnesses have a depression rate of 25% to 33%; if left untreated, that depression rate can increase total medical expenditures by 50% to 100%. Engaging Anthem's Behavioral Health program within the PPEA opportunity allows us to successfully identify and treat the underlying depression prevalent in these populations. The resultant effect is increased compliance with optimal medical care and reduced overall medical costs. For example, if a diabetic member shows symptoms of a mental health issue, the Care Coach will refer the member, with their consent, to the Commonwealth's mental health resources for further assessment, diagnosis, and counseling. The member may then be co-managed by Anthem and the behavioral health resources available to the Commonwealth's employees and their families.

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All of the telephonic contacts can be supplemented with mailings of written material.

Pharmacy

Breakthrough medications, increased utilization, and an aging population present unique cost management challenges. Anthem's experienced PBM, NextRx, serves a full spectrum of clients including health plans, employer groups, and third-party administrators, by offering smart solutions. Our distinctive approach is based on delivering prescription products safely and reliably while managing the cost of pharmacy care. Specific to achieving the Commonwealth's goal through the PPEA, integrating our PBM solution would accomplish the following:

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Care Gaps

This system integrates Anthem's PBM, medical, and lab data on a daily basis to identify and intervene in the following situations:

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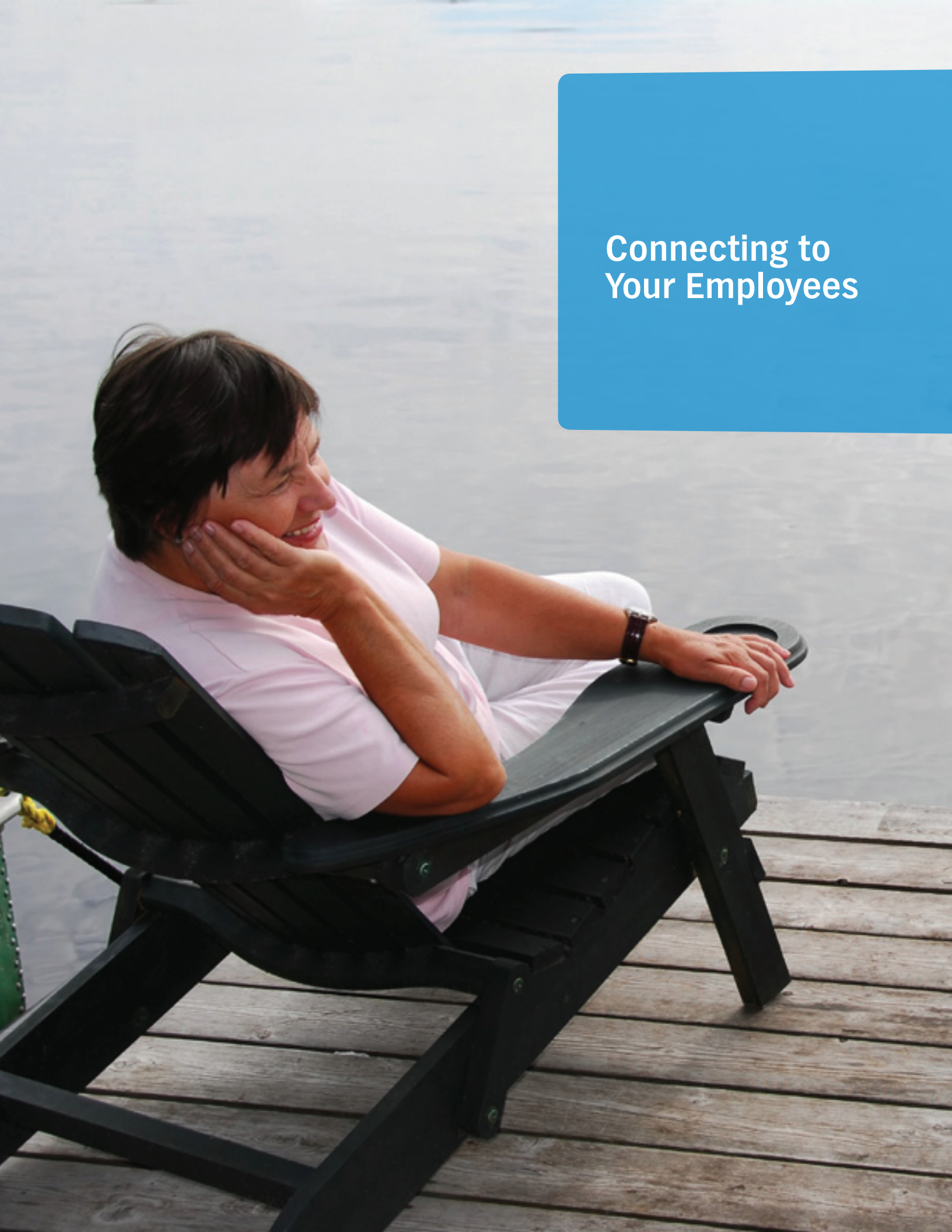

Connecting to Your Employees

What does this mean for the Commonwealth employees and their families?

- Trust in the clinical expertise of our dedicated Care Coaches and integrated multidisciplinary teams.
- Access to our programs and services from a single platform – consistently, simply and confidently.
- Improved clinical outcomes and fewer costs. The advanced health care connections are performance-based and data-driven. Results=Value.

The following narrations portray a real life view of how the identification, engagement, and integration of Care/ Utilization Management, including Behavioral Health, Pharmacy Benefit Management and MyHealth Advantage, are orchestrated by the members' dedicated Care Coach.

Diabetes

High Risk

Joe is a 60-year-old diabetic. He has frequent emergency room visits and inpatient admissions because of his non-compliance with his insulin. Upon identification, Joe receives a mailer to confirm his diagnosis and demographic data. He is then contacted by his dedicated Care Coach so that Joe's health goals, barriers, motivation to change and condition knowledge or knowledge deficits can be captured and reflected in his Individualized Intervention Plan (IIP). Any of Joe's clinical values, pharmacy information and signs and symptoms are tracked in designated fields within the care management system platform (HRS) allowing for complete, reportable data collection. This system is the main repository for all member driven contact, regardless of where along the continuum of care that contact occurs.

Through the Commonwealth's dedicated Care Coach's initial assessment, Joe was found to be not only non-compliant with his insulin injections but he also did not maintain a diet appropriate for preventing him from experiencing symptoms or further exacerbating his diabetes. Joe's Care Coach logs all of these issues within HRS which drives corresponding goals.

To help Joe reach his goals of medication compliance and a healthier diet, Joe's Care Coach calls upon the expertise of other members of the Care Coach team including pharmacists and nutritionists who can assist with Joe's non-compliance with his insulin and his diet. Through his participation in our program, our pharmacist and Care Coach work with Joe so he understands the importance of regular insulin level monitoring. They also work with him to develop strategies to improve compliance – including wearing a watch with an alarm to remind him to check his levels and take the injection as needed. Our nutritionist helps Joe develop meal plans that are diabetic-friendly. Healthy weight maintenance is also key in ensuring the successful management of diabetes. The Care Coach refers Joe to an Anthem exercise physiologist who can support any weight management goals he may have as a result of his new diet plan.

As an additional service, Joe's Care Coach refers him to our multi-media offering through dLife – an online diabetes resource where Joe can access toll free telephonic inbound and outbound IVR information, newsletters, diabetes blogs, streaming video from a weekly diabetes series and more nutrition and meal information including recipes, nutrition advice and food substitution suggestions to name a few tools.

The Care Coach also discovers that Joe does not have a weight scale at home. Part of the Care Coach's role is to ensure that all program participants have the appropriate

On average, all high-risk Care Coach participants receive an average of 23 'touches' per year

equipment and resources needed to successfully manage their condition. The Care Coach works with Joe to obtain a weight scale.

Joe is also asked to provide the results of his blood glucose home tests. Joe and his Care Coach discuss the ranges to ensure Joe understands the importance of both home and lab testing including regular hemoglobin A1C tests and physician follow-up. With Joe's permission, the Care Coach also enlists the support of Joe's wife who primarily prepares the meals in their household. Together they discuss Joe's dietary needs and his wife is given menu ideas and our web resources for healthy recipes.

After a few months, Joe is eating better and feeling better. He has a new watch that helps him remember to test and take his insulin, his wife is making delicious and healthy recipes, and through his engagement with the program, Joe has earned a gift card reward as an added bonus to the health benefits he is now enjoying.

On average, all high-risk Care Coach participants receive an average of 23 'touches' per year. These 'touches' include mailings and outbound telephone contacts. The frequency of contact is determined by the coaching plan and identified issues and goals.

Moderate Risk

Becky is a 40-year-old diabetic. She has previously successfully managed her condition, but was recently prescribed an insulin regimen. Becky receives a diabetes packet in the mail and a phone call from her dedicated Care Coach to obtain goals, assess condition knowledge or deficits in knowledge, barriers, and motivation to change.

Because of Becky's new prescription for insulin and her concerns about how to dispense the medication herself, Becky's Care Coach calls upon an Anthem pharmacist to speak with Becky and provide her with instructions and answer any questions about how to properly administer her insulin.

Also as part of all of our Care Coach interventions, Becky's Care Coach assesses for the presence of depression and/or the anxiety-related disorders. These mental health issues often accompany chronic disease and hinder compliance. Using the Patient Health Questionnaire – 2 (PHQ-2) or Generic Health survey tools, Becky's Care Coach logs her results into her member record housed with HRS. Becky has assessed positive for depression. After obtaining Becky's consent to avoid breach of privacy, her Care Coach refers her to the Commonwealth's mental health resources for further assessment, diagnosis, and counseling to ensure Becky receives the highest level of care. Becky is then co-managed by Anthem and the behavioral health resources available to your members and their families.

Through continued integration, an outreach call is then placed to the member by a Behavioral Health (BH) care manager. On this call the BH care manager attempts to engage the member, provide further assessment, offer psychoeducation, and to link the member with the appropriate resources – everything from web sites to community groups to professional treatment. One of the most delicate parts of this process is helping the member gain insight and acceptance – this is where the BH care manager expertise makes a difference. Once the member is linked to needed resources, the BH care manager follows up telephonically at regular intervals until the BH care manager determines the member is at optimal benefit or the member requests no further

Through our incentive strategy we have successfully motivated Ann to complete the assessment – earning her a gift card incentive but also a more long-lasting reward through continuing the successful management of her diabetes, attaining a healthier weight and living a healthier lifestyle

contact. Throughout this process there is ongoing communication with the dedicated Care Coach. Once the BH Care Manager determines that their services are no longer needed, Becky will continue to engage in contact with her Care Coach to address her diabetes issues.

Current literature indicates those with chronic illnesses have a depression rate of 25% - 33%, and that untreated depression can increase total medical costs by 50% - 100%. Engaging Anthem's Behavioral Health (BH) program in the PPEA plan will allow us to successfully identify and treat the underlying depression prevalent in these populations and thereby increase compliance with optimal medical care and reduce overall medical costs.

Becky is also on the diabetes drug metformin, but she has not been taking the medication as prescribed. She receives a Care Alert through the mail. The alert advises her that we have found that although she has recently filled her prescription, she is not taking the medication as often as she should. The letter informs her that taking metformin along with her insulin will not only help her better manage her diabetes, but it will also lower her risk of heart disease, stroke and blindness. The alert urges her to speak to her physician. The alert information is then stored in our care management system so the message and non-compliance issue can also be addressed by Becky's Care Coach.

In addition to any Care Alerts, Becky continues to receive other mail-based communication through her participation in our diabetes program, we continue to send her mail-based communication that includes diabetes-specific educational information, a quarterly diabetes newsletter, and letters to identify any risk changes or new non-compliance issues. We average 12 'touches' per moderate risk participant per year. 'touches' include mailings and outbound telephone contacts.

With her engagement with a Care Coach, Becky is using her insulin properly and continuing to manage her diabetes well. She has also earned a gift card incentive for her participation and is receiving the mental health support she needs as she learns to live her life successfully with a chronic condition.

Low Risk

Ann is a 55-year-old with well-managed diabetes. She has been receiving mail-based education materials specific to diabetes including annual screening reminders and information on diet and exercise.

Through the promotion of the Commonwealth's new incentive program, Ann has learned that she could earn a gift card reward for completing an online health assessment. Since she has had some concerns about her weight and how it may affect her diabetes, Ann logs on to MyHealth@Anthem and completes her online MyHealth Assessment. She agrees to be contacted by member of the Care Coach team. Through the MyHealth Assessment triggers integrated within our identification processes, Ann's weight triggers an outreach call by a member of our Care Coach team. Through her interactions with her Care Coach, Ann can work toward addressing her weight management issues and work with her Care Coach team including exercise physiologists and dietitians to attain a healthy weight as part of successful diabetes management.

Once again, through our incentive strategy we have successfully motivated Ann to complete the assessment – earning her a gift card incentive but also a more long-lasting reward through continuing the successful management of her diabetes, attaining a healthier weight and living a healthier lifestyle.

We estimate that a low risk participant receives at least eight mailings their first year in the program and at least six during subsequent years of participation.

Asthma

High Risk

Michael is a 45-year-with asthma. He has been flagged as high-risk because of his frequent emergency room visits with exacerbated symptoms including difficulty breathing.

Michael's first touch by our dedicated Care Coach team begins with a mailing to inform Michael about the benefits of the program, confirm his diagnosis and other demographic details. After an initial call conducted by a health outreach specialist, Michael then receives a call from his assigned Care Coach. The coach, dedicated to the Commonwealth's employees, works with Michael to identify his goals, condition knowledge or knowledge deficits, symptoms, barriers, readiness to change and co-morbidities. Through motivational interviewing techniques, the Care Coach draws out information from Michael that can drive goal management and behavior change. Through their initial conversation, the Care Coach determines that Michael has not been using his inhaler and continues to smoke one to two packs of cigarettes a week.

Michael's Care Coach will track these details in an Individualized Intervention Plan (IIP) created and maintained within HRS. The HRS care management system platform is the main repository for all member driven contact, regardless of where along the continuum of care that contact occurs. Also housed within HRS is Michael's profile that stores all other pertinent data including information from medical, pharmacy and lab claims that are fed into HRS monthly. Michael's responses to our health assessment are also fed and housed in HRS. This pertinent information is viewable across the technological platform to ensure all experts of the multi-disciplined team has access to Michael's information and care management plan. The resulting individualized care management plan, which is a composite of all of Michael's issues and goals, prioritizes his goals and provides the basis for a recommended case contact frequency. This comprehensive plan includes telephonic management, educational counseling and is based on Michael's physician's plan of care.

Any specific non-compliance issues, like Michael's inhaler non-compliance, are identified within his IIP and linked with a corresponding, outcome-oriented goal that has a set of defined interventions and action steps. Michael's engagement with his Care Coach has also made him eligible for our proposed incentive strategy. We understand how powerful effective motivation can be toward jumpstarting positive behavior change. Through his participation, Michael has earned a reward for engagement that includes $25 drugstore gift card.

To address Michael's inhaler non-compliance, his Care Coach refers him to our Care Coach pharmacist who can further assess his medication compliance and frequency of use. This integration of 'touches' enables Michael to fill any gaps in education and provides the advocacy he needs to improve compliance.

To support smoking cessation efforts, Michael's Care Coach begins working with him to develop a quit plan. The Care Coach refers Michael to our other smoking cessation tools and resources including the 'Quit Kit' tools available free at anthem.com or discounts for smoking cessation therapy through SpecialOffers@Anthem also available online at our website.

Michael also soon develops hypertension and is subsequently prescribed a beta blocker. Through the daily claims feed with NextRx, our systems generate an urgent care alert because Michael has started clonidine as part of his smoking cessation efforts. The care alert prompts review by an Anthem pharmacist who then calls Michael's physician. The issue is that current medical literature indicates that taking a beta blocker and clonidine can slow heart rate. The physician is urged to consider alternative medication.

A record of the alert is also sent to Michael's Care Coach through HRS. The Care Coach can discuss then both his hypertension management and the alert during their coaching calls. All of Michael's Care Coach interventions drive and support his goals at every contact. His care plan is monitored throughout his participation and changed when necessary so that he has the best chance of success. With the support, education and reinforcement Michael receives from this one-on-one contact with his dedicated Care Coach, Michael becomes empowered and ready to handle difficult behavior changes with increased confidence and opportunity for success.

Care Coaches work with members with asthma to develop a symptom action plans and to promote medication adherence leading to fewer emergency room visits and sick days

As an additional resource, our Care Coach team has access to an online system, which assists them with the management of calls. This online library is used to provide members with additional education information. After discussing a health topic with a member, the Care Coach can print copies of the information accessed on the system, referred to as "teaching topics," and send copies of this information to members via fax or mail. This system includes hundreds of topics such as acne, animal bites, back problems, burns, choking, common cold, diet, dizziness, epilepsy, eye problems, food allergy, ganglion cysts and heartburn, etc. The system is updated bi-annually and further supports our ability to advance your members' health care connections by ensuring we address all of your members' concerns at every available opportunity through the various tools and resources available to our highly qualified staff of professionals.

On average, all high-risk Care Coach participants will receive 23 'touches' per year. These 'touches' include mailings and outbound telep hone contacts. The frequency of contact is determined by the coaching plan and identified issues and goals.

Moderate Risk

Jane is a 35-year-old asthmatic identified as a moderate risk participant for Care Coaching. She has also been triggered by claims for emergency room visits. Like Michael, Jane also receives both mail-based and outbound telephonic interventions. Also similar to Michael, Jane receives a mailer to verify her asthma diagnosis and validate other demographic data. This outreach is the first 'touch' to engage Jane into the care management program. Shortly after receiving the first mailer, Jane's assigned dedicated Care Coach contacts her telephonically for an initial condition-specific assessment to capture Jane's goals, condition knowledge or knowledge deficits, symptoms, barriers, readiness to change and co-morbidities. All of the information is entered and tracked within Jane's IIP which then generates a member-specific care management plan that is also based on her physicians' plans of care. Jane's care plan is monitored throughout the member's participation and revised as Jane's care plan or goals change.

Through her assessment, Jane's Care Coach finds that Jane is not compliant with her inhaler use which is often the trigger for her emergency room visits. The Care Coach also discovers that Jane's physician has recently prescribed the use of a nebulizer with the goal of improving her compliance. Jane's compliance barrier involves her anxiety with using the inhaler and the burst of liquid medication. To help Jane with her new nebulizer, her Care Coach refers her to a Care Coach respiratory therapist to help Jane understand how to use her nebulizer. The Care Coach also refers Jane to our Care Coach pharmacist to help her work through her barriers with her inhaler so that Jane can successfully have two relief resources when she experiences symptoms.

As part of her care management plan, Jane's Care Coach assesses Jane's 'sick day' plan to determine her knowledge and ability to manage her condition during acute episodes and works with Jane to identify, understand and minimize her asthma triggers. Minimizing triggers and support of Jane's 'sick day' plan may require the involvement of family members including Jane's spouse as needed. The Care Coach can work with Jane's husband to ensure she has a solid support system in place for effective asthma management.

As a moderate risk member, Jane receives less frequent contact from her Care Coach. However, the frequency of Jane's contact with her Care Coach is entirely dependent on her unique needs throughout her participation. Jane's Care Coach provides her with ongoing education, monitor of clinical parameters, update severity, stability and compliance issues, and to determine progress toward established goals. Jane's engagement also earns her an incentive gift card reward.

While moderate risk members are those found not to be the highest cost drivers for the Commonwealth, we found that this population of employees also meets certain criteria and thresholds that could negatively impact outcomes. This further analysis takes into consideration criteria outside of their chronic condition for a holistic approach to population management. The premise is that by identifying those that meet certain impact producing thresholds, we could target interventions that would likely result in improved overall health for the participant.

Care Coaches work with members with asthma to develop symptoms action plans and medication adherence to avoid visits to the emergency room and sick days

Mail-based communication includes asthma-specific educational information, a quarterly asthma newsletter, and letters to identify any risk changes or new non-compliance issues. We average 12 'touches' per moderate risk participant per year. 'touches' include mailings and outbound telephone contacts.

Low Risk

Sarah is a 35-year-old who has been diagnosed with asthma in the past. She has not recently experienced any symptoms nor is she currently in need of an inhaler to manage her symptoms.

Sarah learns that she could earn a gift card incentive by completing an online MyHealth Assessment to determine if she could benefit from any of the programs that the Commonwealth offers and to learn about any risk factors she may have. Sarah logs on to anthem.com and completes her online health assessment. She gives her consent to be contacted by a member of our Care Coach team based on her assessment results.

Her response regarding her previous diagnosis with asthma triggers her identification for our dedicated Care Coach program for asthma. Sarah is considered a low-risk participant because she has not been experiencing any symptoms and has her asthma under control. After receiving her initial condition-specific kit of information, Sarah decides that it would be best for her to try and quit her five-year cigarette smoking habit before her asthma symptoms return.

Sarah finds the telephone number for our Care Coach team in her packet and reaches out to sign up for intervention calls. Now engaged with the program, Sarah's dedicated Care Coach can work with her to develop a quit plan. Through this simple action, Sarah has made herself eligible for our new incentive offering, but more importantly, she has proactively sought out the resources needed to help her avoid future health care needs and helped the Commonwealth prevent avoidable health care costs.

We target low risk asthma members, like Sarah, with mail-based interventions because these are members we have found as having stable, well-managed conditions and do not currently require intensive management. These members receive asthma-specific written education materials such as flu shot reminders and helpful hints on trigger avoidance.

However, through the course of her participation, Sarah struggles to quit her smoking habit and has now exacerbated her asthma condition forcing her to visit the emergency room on several occasions for difficulty breathing. Embarrassed by her inability to quit her smoking habit, Sarah opts not to tell her Care Coach about the ER visits. Even so, Sarah's ER claims are fed into her profile within HRS prompting intervention by her Care Coach despite Sarah's lack of disclosure. The ER claims qualify Sarah for restratification into a higher risk level. She begins to receive increased telephonic outreach by her Care Coach team as a moderate risk member experiencing asthma symptoms and struggling with a smoking addiction.

On average, a low risk participant receives at least eight mailings their first year in the program and at least six during subsequent years of participation.

Conclusion

Section 5: Conclusion

For many years, the Commonwealth and its employees and their families have depended on Anthem for their health benefits. By implementing a dynamic and innovative solution, we will continue and deepen our commitment to you.

We understand and share the Commonwealth's goal of providing its employees and their families with a solid portfolio of products and services that demonstrate real value and true savings. The success of health care behavioral change within a population is directly linked with the integration of these products and the service team that supports them.

Our analysis of the provided data set demonstrates that our total member approach through advanced health care connections, lead by dedicated Care Coaches, can identify gaps in care. We can close these gaps and improve memember health outcomes by identifying, integrating, educating and engaging the Commonwealth's employee population.

By offering a full suite of products to the Commonwealth's employees and their families, Anthem is able to provide member-centric engagement towards their own health management and/or maintenance. Specifically, we can use our data to employ the appropriate interventions to meet member's needs along the continuum of health. Transparent to the Commonwealth, our various products and programs communicate on a common technological platform that allows us to capture and report on emerging trends. This global view paired with the ability to take a deeper dive into a larger pool of members creates further opportunities for developing influential programs through a continued partnership between the Commonwealth and Anthem. The success of this proposed project plan will be directly impacted by the scope of our continued partnership.

As always, Anthem appreciates the opportunity to serve the Commonwealth's employees and their families. We greatly value our relationship and our ongoing goal is to consistently share new technologies and services that will enhance your population's experience within the health care continuum resulting in better health for the member and financial savings for the Commonwealth. Thank you for your consideration and ongoing trust – we look forward to taking the next step together in this process.

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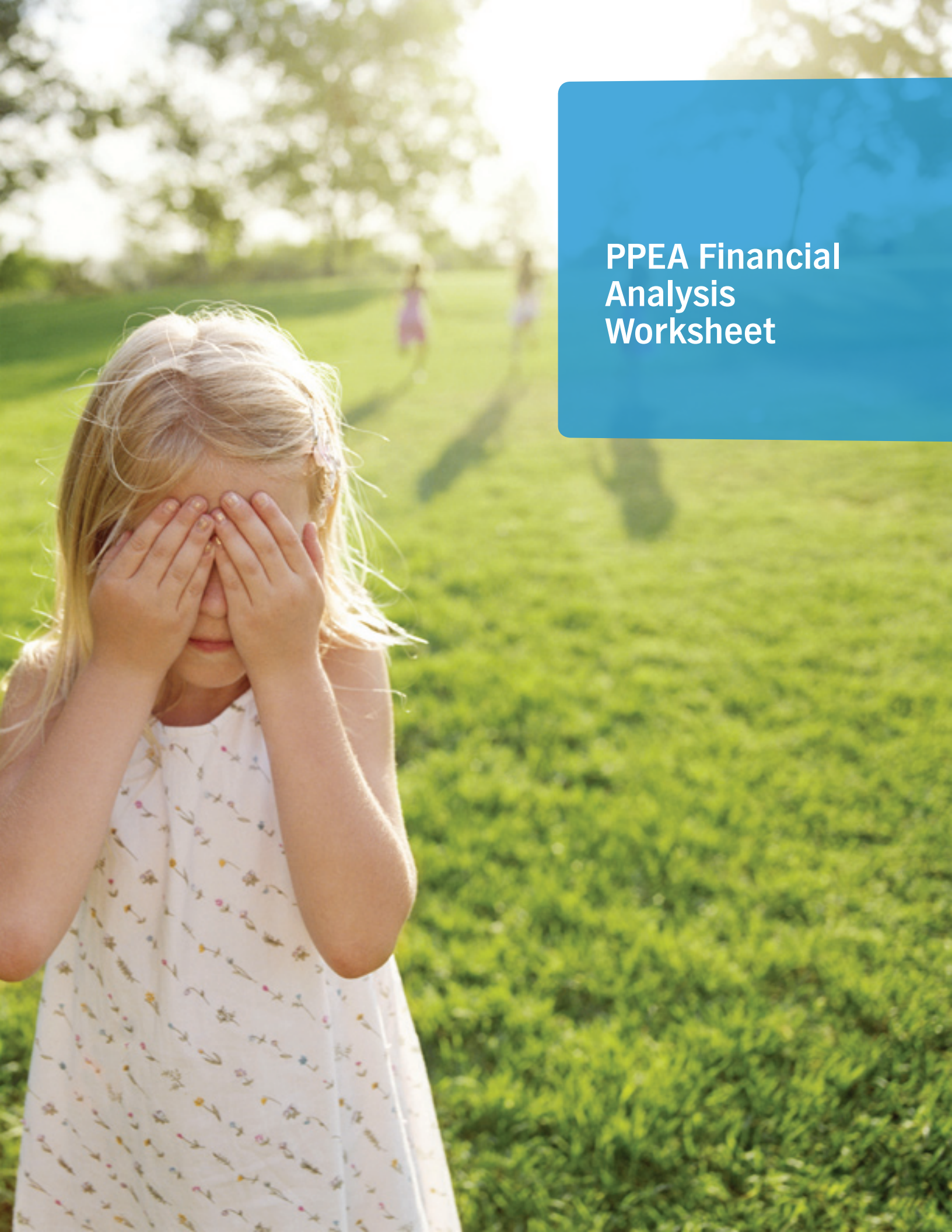

PPEA Financial Analysis Worksheet

Confidential Proprietary Information - Exempt from FOIA Release

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