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IN THE SUPREME COURT OF PENNSYLVANIA

Case No. 46 MM 2019

COMMONWEALTH OF PENNSYLVANIA,
by Josh Shapiro, Attorney General; et al.,

Petitioner,

v.

UPMC, A Nonprofit Corp.; et al.,

Respondents.

On appeal from the Order of the Commonwealth Court of Pennsylvania, Honorable Robert Simpson presiding, Filed April 3, 2019, in No. 334 MD 2014

RESPONDENT UPMC'S ANSWER TO PETITION FOR PERMISSION TO APPEAL, OR IN THE ALTERNATIVE, APPLICATION FOR ALTERNATIVE RELIEF

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The Office of Attorney General ("OAG") asks this Court to consider, again, whether UPMC's Consent Decree, with an explicit termination date of June 30, 2019, really means what it says. Just a few months ago, OAG asked this Court to force UPMC to continue contracting with Highmark Inc. ("Highmark") beyond that termination date for the supposed benefit of seniors, whom the Consent Decree designates as a "vulnerable population." In rejecting that claim, this Court specifically held that the Consent Decree cannot be interpreted in a way that allows one provision to override another.

In its current appeal, OAG has tried to pour its old wine into a new legal bottle, contending that the Consent Decree's general modification provision overrides all other provisions in the agreement, supersedes the Court's 2018 opinion, and authorizes imposing on UPMC—in perpetuity—a slate of new and unprecedented obligations set forth in a modified "consent" decree to which UPMC never agreed. In support of this extraordinary request, OAG again cites the supposed plight of seniors after June 30 as well as vague (and false) allusions to "the health and welfare of millions of Pennsylvanians." Petition for Permission to Appeal at 1 ("Petition").

The Commonwealth Court correctly rejected this latest attack on the Consent Decree's expiration, specifically citing this Court's 2018 decision addressing the "vulnerable population" of seniors, as well as basic legal principles

that OAG does not even dispute. Rather than offer legal authority to the lower court, OAG essentially argued—and is arguing now—that by agreeing to a boilerplate modification provision in a five-year consent decree, UPMC somehow put itself under OAG's unfettered control forever. That defeats the purpose and plain intent of having a termination provision in the first place. If it actually believed that the termination provision could be "modified" out of existence, OAG should have sought modification a year ago, when it last contested the Consent Decree's termination date for seniors.

It did not do so then, and it should not be allowed to do so now, because a claim to "modify" the parties' agreement by repudiating its unambiguous and material terms has no place in law or the meaning and intent of the Consent Decree. OAG has now filed two briefs in support of its request and has not once cited any legal authority to support nullification of the Consent Decree's express and unambiguous termination provision. Nor has OAG acknowledged, much less tried to overcome, the basic legal precepts this Court has (twice) held govern the interpretation of UPMC's Consent Decree.

Despite this total lack of legal authority—and despite having waited nearly *five years* to seek elimination of a termination date that it expressly endorsed in 2014—OAG petitions this Court not only to exercise its discretionary and extraordinary jurisdiction, but also to accommodate false exigencies that are

entirely of OAG's own making by rushing through an impossibly compressed judicial process that would go from OAG's opening brief to this Court through post-trial judgment by the Commonwealth Court before June 30—not including any post-trial appellate practice. For multiple independent reasons, the Court should deny OAG's Petition.

First, OAG has not demonstrated a "substantial ground for difference of opinion." 42 Pa. C.S. § 702(b). Pennsylvania law requires reading the Consent Decree as a whole, giving meaning to each of its terms, and—most importantly—effectuating the parties' intent, which always included the termination that OAG is now trying to void. OAG fails to show any substantial ground to dispute the lower court's application of those principles to the Consent Decree at issue.

Second, OAG has not demonstrated that an immediate appeal will "materially advance the ultimate termination of the matter." 42 Pa. C.S. § 702(b). On the contrary, granting an interlocutory appeal in this matter will (1) confound everyone's long-standing expectations about what is to happen on June 30; (2) require the parties to make frenetic preparation for a possible trial (now scheduled to begin May 29) on the underlying merits of Count One of OAG's Petition; (3) almost certainly guarantee an eventual appeal from any ultimate judgment rendered on Count One by the lower court; and (4) depending upon final disposition on the merits of Count One, lock the Commonwealth Court and this

Court into perpetual supervision of a radical re-ordering of all healthcare delivered in the Commonwealth. To "advance the ultimate termination of this matter" the Court should promptly exercise its discretion to deny OAG's request for interlocutory review.

Third, OAG comes nowhere close to overcoming the high bar this Court sets for exercising its extraordinary jurisdiction under 42 Pa. C.S. § 726. A necessary predicate to the exercise of this jurisdiction is a clear right to relief, but OAG does not even argue that such a right exists here. Petition at 17-18. Indeed, OAG stretches its credibility to the limits in asserting that there is even a substantial ground for a difference of opinion on the underlying issue, let alone a "clear right to relief." Nor can OAG meet the other requirements for Section 726 jurisdiction—immediacy and public importance—when it knowingly delayed seeking modification for years, and when this Court has already considered the only circumstances that OAG cites in support of its request for extraordinary jurisdiction.

The parties agreed to the Consent Decree in 2014 and are now nearing the end of that agreement. In a collateral assault on the straightforward contractual interpretation that this Court announced just a few months ago, OAG is trying to conjure into existence a new, radical decree that has nothing whatsoever to do with "consent" or "modification." Its request that this Court enlist itself in that effort by

reversing—on an interlocutory and expedited basis—the decision of the court below should be declined.

COUNTERSTATEMENT OF THE CASE

This Court has already decided two appeals in this case and is familiar with the background facts. *See generally Commonwealth ex rel. Shapiro v. UPMC*, 188 A.3d 1122, 1123-35 (Pa. 2018); *Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441, 445-57 (Pa. 2015).

In brief, UPMC, OAG, the Pennsylvania Department of Insurance ("PID") and the Pennsylvania Department of Health ("DOH") are parties to a 2014 Consent Decree that was intended to provide a five-year, orderly transition and wind-down of numerous contractual relationships between UPMC and Highmark. The Consent Decree mapped out that transition while emphasizing in its opening paragraph that it was not an extension of any of those contractual relationships "and shall not be characterized as such." *See* Appendix 1 at I.A. The in-network access it provides is limited to particular services for certain kinds of Highmark members under specified circumstances. *See id.* § IV.A. The Consent Decree—which the Commonwealth Court approved on July 1, 2014—also includes a provision labelled "termination" stating that "[t]his Consent Decree shall expire five (5) years from the date of entry," or June 30, 2019. *Id.* § IV.C.9.

On February 7, 2019—more than four years after signing the Consent Decree—OAG filed a "Petition to Modify Consent Decrees" in the Commonwealth Court. That Petition asks the Court to "modify" UPMC's Consent Decree by entering, effective the day after the existing Consent Decree expires, a "Proposed Modified Consent Decree" that bears no resemblance to the existing Consent Decree, repudiates the intent and plain language of the parties' agreement, has nothing whatsoever to do with "consent," and would impose on UPMC and others a complex and radical set of new legal obligations—all in perpetuity. Although PID and DOH signed the existing Consent Decree, neither joined OAG's request for modification.[1]

The proposed decree includes the following provisions, among others:

- **No termination date** – The proposed decree would "remain in full force and effect until further order of the Court." Appendix 2 § 11.
- **Forced provider contracting** – The proposed decree would require that all UPMC hospitals and doctors enter into a contract with any insurer that desired a UPMC contract, including for federal programs. *Id.* § 3.2.

[1] Those agencies have conspicuously avoided opining in this Court on the merits of OAG's proposal. *See* Apr. 11, 2019 No Answer Letter. In the proceedings below, they are also refusing to participate in any discovery that might reveal their analyses of OAG's proposals. *See* Mar. 28, 2019 Application to Quash. It is remarkable that the other state agencies that co-signed the Consent Decree and that have explicit regulatory oversight of healthcare and health insurance insist on having no involvement with the radical changes now being proposed, and that OAG, to which the General Assembly delegated no such regulatory authority, is alone in pushing for these extreme changes.

- **Forced insurer contracting** – The proposed decree would require that all of UPMC's insurance subsidiaries enter into a contract with any provider that desired a UPMC Health Plan contract, including for federal programs. *Id.* § 3.2.

- **Forced arbitration** – Any UPMC subsidiary who failed to negotiate a contract with an interested counter-party would be forced to accept terms imposed on it through "baseball arbitration." *Id.* § 4.1.

- **Board terminations** – UPMC would be required to replace a majority of its board members. *Id.* § 3.11.

- **Ongoing Commonwealth Court supervision** – Interpretation and enforcement of the modified consent decree would remain in the original jurisdiction of the Commonwealth Court. *Id.* § 13.

On February 21, 2019, UPMC filed a motion to dismiss the Petition to Modify. While briefing on that motion was still underway, the Commonwealth Court *prospectively* certified any dispositive order it might issue for interlocutory appeal. The court's March 12, 2019 Scheduling Order II states that, in "recognition of the public interest, any dispositive orders pertaining to … the Petition to Modify shall be deemed to include permission to appeal from this Court … pursuant to Pa. R.A.P. 1311, and contain the statement prescribed by 42 Pa. C.S. § 702(b), without further application by the parties." Appendix 3.

On April 3, 2019, the Commonwealth Court, Judge Simpson presiding, issued a decision on the Motion to Dismiss. *See* Petition Appx. A. The court first noted that standard principles of contract interpretation apply when construing the meaning of UPMC's Consent Decree. *See* Petition Appx. A at 26. The Court then

held that it could not modify the UPMC's Consent Decree to alter the June 30, 2019 termination date. In the relevant part of its analysis, the Court held that,

> [a]s noted above, our Supreme Court has already decided that the June 30, 2019 termination date is an unambiguous and material term of the Consent Decree.... That Court also instructed that in the absence of fraud, accident or mistake, courts have neither the power nor the authority to modify or vary the terms set forth.... Whatever preclusion label is applied, our Supreme Court's ruling on this issue is binding here. Stated differently, regardless of the authority of the Attorney General or the remedies set forth in the Consent Decree, inherent limitations on this Court's power prevent relief inconsistent with the Supreme Court's prior ruling in this case. Because the OAG does not plead fraud, accident or mistake, this Court lacks the power or authority to modify the termination date of the Consent Decree without the consent of the parties, even if it were in the public interest to do so.

Id. at 34-35. Consistent with its earlier Order, the Court also certified its decision on this point for interlocutory appeal pursuant to Pa. R.A.P. 1311. OAG then filed the Petition in this Court.[2]

[2] The Petition presents a misleading Controlling Question of Law that suggests—wrongly—that the Consent Decree "expressly provided" for the power "to modify the duration" of the agreement. Petition at 11. The parties' Consent Decree does not "expressly provide" for the power to modify the duration of the agreement. The modification provision makes no reference to the termination provision at all.

LEGAL STANDARD

To permit appeal of an interlocutory order, the trial court must conclude that the petitioner has shown there is "substantial ground for difference of opinion" as to the question at issue, and "that an immediate appeal from the order may materially advance the ultimate termination of the matter." 42 Pa. C.S. § 702(b). Once the trial court certifies an interlocutory appeal under this statute, the appellate court may then, "in its discretion" permit the appeal if the appellate court "is satisfied with the trial court's certification." *Kensey v. Kensey*, 877 A.2d 1284, 1289 (Pa. Super. Ct. 2005). The trial court's determination does not control whether to permit appeal. *See id.* (declining appeal despite trial court's certification).

The Court invokes its extraordinary jurisdiction pursuant to 42 Pa. C.S. § 726 "sparingly." *Washington Cty. Comm'rs v. Pa. Labor Relations Bd.*, 417 A.2d 164, 167 (Pa. 1980). The presence of an issue of immediate public importance is necessary, but "not alone sufficient to justify extraordinary relief." *Phila. Newspapers, Inc. v. Jerome*, 387 A.2d 425, 430 n.11 (Pa. 1978). As with a request for mandamus, the Court "will not invoke extraordinary jurisdiction unless the record clearly demonstrates a petitioner's rights." *Id.*

REASONS WHY THE COURT SHOULD DENY THE PETITION

I. THERE CAN BE NO DIFFERENCE OF OPINION THAT THE REQUESTED "MODIFICATION" IS IMPROPER.

OAG's Petition fails right out of the gate. A "controlling question of law as to which there is a substantial ground for difference of opinion" under Section 702(b) typically is found with questions of first impression, conflicting lines of case law, or unsettled areas of the law. *See, e.g., Southeastern Pa. Transp. Auth. v. Dunham*, 668 A.2d 272, 273 (Pa. Commw. Ct. 1995) (conflicting case law).

This case is none of the above. As this Court has twice recognized in reference to the same agreement at issue here, the Consent Decree is a "judicially sanctioned contract that is interpreted in accordance with the principles governing all contracts." *Shapiro*, 188 A.3d at 1131. And as with any contract, the fundamental rule in interpreting the 2014 Consent Decree is to ascertain the intent of the parties through the plain, unambiguous language, and to read the contract as a whole. *See id.* at 1131-32; *see also Hazell v. Servomation Corp.*, 440 A.2d 559, 560-61 (Pa. Super. Ct. 1982); *Universal Builders Supply, Inc. v. Shaler Highlands Corp.*, 175 A.2d 58, 61-62 (Pa. 1961) (court lacked authority to modify "clear and unequivocal" provisions of consent decree); *Watson v. City of Sharon*, 406 A.2d 824, 826-27 (Pa. Commw. Ct. 1979) (same).

OAG does not dispute that these clear legal rules apply. Nor is there a dispute that the parties expressly intended the Consent Decree to end on June 30,

2019. As Judge Pellegrini recognized, the parties' intent was to provide for limited access rights for certain Highmark subscribers "during a period of transition to enable them to decide whether to remain with Highmark or change insurance carriers." *Commonwealth v. UPMC*, 2018 Pa. Commw. Unpub. LEXIS 393, at *3 (Pa. Commw. Ct. Jan. 29, 2018). In its very first provision (called "interpretive principles"), the Consent Decree states that it "is not a contract extension and shall not be characterized as such," Appendix 1 § I.A, and repeats later that certain access rights are not "a contract extension," *id.* § IV.A.10. And the Consent Decree sets a specific termination date of June 30, 2019. *Id.* § IV.C.9.

This Court held less than nine months ago that the expiration date of the Consent Decree was a material provision of the parties' agreement and that the courts cannot "alter[] an unambiguous and material term of the Consent Decree — the June 30, 2019 end date." *Shapiro*, 188 A.3d at 1132. Without even mentioning modification, OAG—acting without the joinder of PID or DOH—argued that this Court should force UPMC to continue contracting with Highmark for Medicare Advantage subscribers through at least June 2020, supposedly because seniors would be confused by a mid-year termination and somehow suffer harm. *Id.* at 1126. This Court refused to do that, ruling that it could not and would not "alter[] an unambiguous and material term of the Consent Decree—the June 30, 2019 end date." *Id.* at 1132. According to this Court's unanimous opinion, the

Consent Decree's requirement that UPMC "shall treat all Medicare participating consumers as In-Network," *id.* at 1124, had to be read in conjunction with the termination provision, and without fraud, accident, or mistake, courts simply do not have authority to modify or vary the unambiguous end of a consent decree. *Id.* at 1132. It is thus not surprising that the Commonwealth Court similarly held it has "neither the power nor the authority" to modify the termination date contrary to the parties' stated intent. Petition Appx. A at 35.

OAG now contends that the material, unambiguous termination provision can simply be "modified" out of existence because "[t]here is no carve out preventing the June 30, 2019 termination date of the Consent Decrees from being modified" under section IV(C)(10) of the decree ("Modification"). Petition at 3. But there is no allegation or credible argument that UPMC agreed, in advance, to unlimited modifications in perpetuity. No one would have executed a document with a termination clause that was subject to infinite change at the discretion of the adverse party.

Nor is what OAG proposes a "modification" of the termination provision. To "modify" is "to make minor changes in" something or "to change something slightly, esp. to improve or make it more acceptable or less extreme."[3] No one

[3] Miriam Webster Online, https://www.merriam-webster.com/dictionary/modify; Cambridge Dictionary Online, https://dictionary.cambridge.org/us/dictionary/english/modify.

understands "modify" to mean "eliminate," "annul," or "delete." Yet that is exactly what OAG asked the lower court and now this Court to do to the termination provision.

Merely stating OAG's position demonstrates its absurdity. As the record reflects, OAG and other Commonwealth agencies have expressly acknowledged they have no authority to require UPMC to enter into contracts with Highmark. *See* Appendices 4 and 5 hereto. Similarly, the Commonwealth Attorneys Act does not authorize the Attorney General to enact new policies through litigation or bring stand-alone "public interest" claims designed to remake healthcare. *See* 71 P.S. § 732-101, *et seq*. But because UPMC signed a Consent Decree—one that expressly acknowledged that it was *not* a contract extension, included an express termination date, and stated that it must be interpreted consistently with PID's prior public-interest assumption that there would be no contract—OAG contends it can now impose new, perpetual obligations on UPMC beginning the day after the existing Consent Decree expires. Such a reading improperly overtakes the parties' original purpose and intent, violates the material terms of the parties' agreement, and must be rejected. *Hazell*, 440 A.2d at 560-61.

OAG has not offered a single legal authority, either to this Court or to the court below, for this astounding proposition. To the contrary, a specific term like the termination provision "controls the general," such as the modification provision

contained in section IV(C)(1), not the other way around. *See Trombetta v. Raymond James Fin. Servs. Inc.*, 907 A.2d 550, 560 (Pa. Super. Ct. 2006). That is the only way to interpret the Consent Decree as a whole without annulling the termination provision. And, it is "fundamental that one part of a contract cannot be so interpreted as to annul another part." *Shehadi v. Ne. Nat. Bank of Pa.*, 378 A.2d 304, 306 (Pa. 1977).

For OAG to suggest that a general term like modification must specify when it does not apply or otherwise override a material, unambiguous term is literally unprecedented. And if the intent of the parties to *this* contract had been to allow for open-ended modification of infinite duration and new ongoing obligations past June 30, 2019, then they would not have (1) agreed to negotiate a transition plan of limited duration, (2) expressly stated the transition was not a contract extension, and (3) agreed to an absolute expiration date with no carve-out or other limitation. It is implausible to conclude otherwise. At a minimum, the Court cannot conclude there is a substantial disagreement on the law when OAG has not cited a single case in support of its position.[4] There is no reason for this Court to discard the

[4] Although Highmark is not a signatory to UPMC's Consent Decree, did not join OAG's Petition to Modify, and was not the subject of any adverse ruling (much less one certified for interlocutory appeal), Highmark filed a "Joinder" arguing that "the Commonwealth Court's *sua sponte* recognition that its ruling meets" the criteria of Section 702(b) "is reason enough to conclude there is a substantial ground for a different of opinion." Joinder at 4. Highmark cites

application of plain meaning or hornbook contract law and revisit a decision it issued less than one year ago.

II. AN IMMEDIATE APPEAL WILL ONLY PROLONG LITIGATION AND UNCERTAINTY.

Nor can OAG show that an immediate appeal from the Order will "materially advance the ultimate termination of the matter." 42 Pa. C.S. § 702(b). Advancing the ultimate termination usually means interlocutory review will *eliminate* the need for trial, not *create* the need for *more* litigation. *See Kensey*, 877 A.2d at 1289 (denying interlocutory appeal); *Miller v. Krug*, 386 A.2d 124, 127 (Pa. Super. Ct. 1978) (same).

Here, OAG's requested appeal will only ensure the need for additional legal proceedings—both immediately and stretching into perpetuity. If OAG's appeal is granted and the Commonwealth Court is reversed, the trial on OAG's central claim—that its radical recasting of healthcare in Pennsylvania is "in the public interest"—will commence on May 29 and presumably conclude before June 30. Any outcome of that trial will then be subject to direct appeal to this Court. And if OAG ultimately prevails on the merits of that claim, this Court—not the Legislature, the Governor, PID or DOH—will have to oversee Pennsylvania's new regime for healthcare in the complete absence of guidance from laws, regulations,

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nothing for that proposition, which—as discussed above—is contrary to the plain language of Section 702(b) and wrong as a matter of law. *See supra* at 9.

or legal precedent. Far from finality, there will be no limit to the disputes created by OAG's radical attempt to assert its dominion over the healthcare delivered in Pennsylvania.

Nor is there any reason for this Court to grab OAG's appeal on an expedited basis now. OAG has known for five years that the Consent Decree will expire in June 2019. By its own admission, OAG has been attempting to secure UPMC's agreement to "modifications" for two years. Petition at 8. But it waited until February 2019 to file the Petition to Modify. OAG could have and should have asserted these claims during its last trip to this Court—but did not even bother to mention them. Neither this Court nor the other parties should have to turn themselves inside out to accommodate an extraordinarily cramped schedule, compressing the timetable from Petition for Review to oral argument before this Court into just over one month, and the timetable for an incredibly complex trial on the merits into whatever time remains between this Court's decision and June 30.

Indeed, OAG's sole basis for suggesting that immediate, interlocutory, expedited review is needed is that certain Highmark subscribers will lose in-network access to certain UPMC services in Allegheny and Erie counties on June 30, thereby rendering those services more expensive. But ending the five-year transition period on June 30, 2019, was the express intent of the Consent Decree. Nothing was different in 2014, when the parties agreed to this end-date. Nor was

anything different in 2018 when this Court rejected the same arguments that OAG makes again here—that disruption to in-network access or public confusion warrant imposing obligations on UPMC beyond June 30, 2019. The June 30, 2019 end-date had been well advertised to consumers, and especially seniors. CMS, the federal agency that oversees Medicare Advantage, maintains "well-developed contingencies for" network disruptions that "diminish the proffered potential impacts of chaos and confusion, even in the case of significant network changes midyear." *Shapiro*, 188 A.3d at 1133.[5]

Underlying OAG's modification request is the suggestion that UPMC is violating the law by not giving Highmark system-wide contracts. But if OAG

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[5] Public outreach over the past year further confirmed the June 30, 2019 end date—and also puts the lie to the new and unverified factual claims that Highmark introduces in its Joinder. To this Court, Highmark claims that the end of the Consent Decree will "affect the public in profound ways." Joinder at 4. Outside of this Court, one of Highmark's most senior executives told the public that Highmark expects the termination of the Consent Decree "to be a nonevent." S. Twedt, *A year away, UPMC's split from Highmark has lost its sting*, PITTS. POST-GAZETTE (Jul. 5, 2018) (attached as Appendix 6). Highmark asks this Court to believe that the termination will cause "adverse consequences for hundreds of thousands" of Pennsylvanians. Joinder at 5. But just a few days before OAG filed its Petition to Modify, Highmark's CFO publicly stated "consumers have been hearing about it for six years. They are ready for this next stage.... And we're ready to go. For us, that's really kind of in the rearview mirror." T. Bannow, *CFO Karen Hanlon says Highmark is moving past the UPMC conflict* Modern Healthcare (Feb. 2, 2019) (attached as Appendix 7). As Highmark acknowledges, it is "the litigation"—all of it brought by OAG and Highmark in the last two years—that "has created confusion in the marketplace," not the well-advertised Consent Decree or UPMC's compliance therewith. Joinder at 7.

really believes that, it can file a complaint and the parties can litigate those claims. OAG should not be permitted, however, to short circuit that process; force the parties and courts to pay for OAG's own tardiness; and overwrite the plain language of the Consent Decree's termination provision.

III. OAG COMES NOWHERE CLOSE TO MEETING THE STANDARD REQUIRED FOR EXTRAORDINARY JURISDICTION.

As an afterthought, OAG asks in the alternative that the Court exercise its extraordinary jurisdiction pursuant to 42 Pa. C.S. § 726. Petition at 17. As noted *supra*, the rare cases when this Court grants appeal pursuant to Section 726 involve both issues of immediacy and public importance, and a record that "clearly demonstrates a petitioner's rights." *Jerome*, 387 A.2d at 430, n.11. OAG meets none of those requirements here.

First, there is no record at all, much less one that "clearly demonstrates [OAG's] rights." *Id.* As to the legal question at issue in its petition, OAG offers no legal authority or argument supporting its misreading of the Consent Decree, its call on this Court to reverse its 2018 decision, or its attack on the lower court's reasoning. More importantly for purposes of Section 726, however, OAG cannot show that it is entitled to any modification of the Consent Decree regardless of how the termination provision is applied. OAG stuffed its Petition to Modify with a series of unproven allegations about UPMC that are highly misleading or outright false. UPMC—which has not even filed an Answer to that petition yet—will fully

contest each of OAG's allegations at the appropriate time. But OAG does not benefit from the early posture of this case. This Court does not assert extraordinary jurisdiction by *assuming* the truth of allegations. It is OAG's burden to come forward with a record showing a clear right to relief, and its failure to do so—or even argue that it has done so—precludes jurisdiction under Section 726. *See Washington Cty. Comm'rs*, 417 A.2d at 167.

For a similar reason, the Court should not countenance any request for a special injunction extending the existing Consent Decree beyond June 30, 2019 and through "the ultimate resolution of this action." Petition at 19; *see also* Joinder at 4-8. That would be improper both under the Consent Decree, and as a matter of basic procedure. No one ever raised a claim for a special injunction below, and claims not presented to the trial court are waived on appeal. *See* Pa. R.A.P. 302(a). Section 726 should not be used as an escape hatch for claims that a litigant has waived. Nor should this Court exercise its extraordinary jurisdiction in order to hear in the first instance disputed questions of fact—such as those presented throughout OAG's Petition for Permission to Appeal and Highmark's Joinder—concerning whether to issue mandatory injunctive relief that would *change* the status quo by abrogating the termination date. *See Jackson v. Hendrick*, 503 A.2d 400, 408 (Pa. 1986) (excepting from the exercise of extraordinary jurisdiction "resolutions of fact which are best determined by the Court of Common Pleas").

In addition, the Petition does not identify any "immediate issues of public importance." The Petition argues that this case raises issues concerning the healthcare of Pennsylvania citizens, and that those issues are immediate because the Consent Decree terminates on June 30, 2019. Petition at 17-18. But the entire purpose of the Consent Decree was to provide a five-year runway to the end of UPMC and Highmark's contractual relationship. Any person or employer who might be impacted by the expiration of the Consent Decree has had *five years* to plan accordingly. The fact that OAG waited to file the Petition to Modify until four months before the Consent Decree expires does not turn the planned conclusion of a five-year transition into an "immediate" issue of public importance.

Similarly, the public importance of this issue has been reviewed twice already by this Court, and its prior opinion specifically rejected OAG's arguments that confusion and network disruption warrant extending UPMC's obligations beyond June 30, 2019. OAG offers no reason to revisit those same issues now.

CONCLUSION

For the foregoing reasons, UPMC respectfully requests that the Court deny OAG's Petition for Permission to Appeal, or in the Alternative, Application for Extraordinary Relief.

Dated: April 12, 2019

Respectfully submitted,

/s/ *Leon F. DeJulius, Jr.*

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CONCLUSION

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Dated: April 12, 2019

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CERTIFICATE OF COMPLIANCE

I hereby certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

/s/ *Leon F. DeJulius, Jr.*
Leon F. DeJulius, Jr. (Pa. 90383)
JONES DAY
500 Grant Street, Ste. 4500
Pittsburgh, PA 15219
Ph: (412) 391-3939
Fx: (412) 394-7959
lfdejulius@jonesday.com

Attorney for UPMC

CERTIFICATE OF SERVICE

I hereby certify that on April 12, 2019, true and accurate copies of Respondent UPMC's Answer To Petition For Permission To Appeal, Or In The Alternative, Application For Alternative Relief were served via PACFile on counsel of record.

/s/ *Leon F. DeJulius, Jr.*
Leon F. DeJulius, Jr. (Pa. 90383)
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Attorney for UPMC

Appendix 1

June 27, 2014 Consent Decree

OAG submitted the Consent Decree to the Commonwealth Court as Exhibit B to OAG's Feb. 7, 2019 Petition to Modify.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By KATHLEEN G. KANE, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By MICHAEL CONSEDINE, Insurance Commissioner and PENNSYLVANIA DEPARTMENT OF HEALTH, By MICHAEL WOLF, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. and HIGHMARK, INC., A Nonprofit Corp.; Respondents.	:	No. 334 M.D. 2014

MOTION TO APPROVE CONSENT DECREE WITH RESPONDENT UPMC

1. The Commonwealth of Pennsylvania acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Petitioners), initiated an action by filing a Petition for Review on June 27, 2014, against the Respondent UPMC, the allegations of which are incorporated herein by reference.

2. The Petitioners and Respondent, UPMC, have resolved the allegations in the Petition for Review subject to this Court's approval of the terms and conditions contained in the proposed Consent Decree attached.

WHEREFORE, Petitioners respectfully request that this Honorable Court approve the proposed Consent Decree.

Respectfully submitted

COMMONWEALTH OF PENNSYLVANIA

KATHLEEN G. KANE
Attorney General

Date: 6/27/2014 By: _____

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 42624
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By KATHLEEN G. KANE, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By MICHAEL CONSEDINE, Insurance Commissioner and PENNSYLVANIA DEPARTMENT OF HEALTH, By MICHAEL WOLF, Secretary of Health, Petitioners, v. UPMC , A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. and HIGHMARK, INC., A Nonprofit Corp.; Respondents.	:	No. _____M.D. 2014

CONSENT DECREE

AND NOW, this _____ day of _____, 2014, upon the Motion to Approve Consent Decree with Respondent UPMC filed by the Commonwealth of Pennsylvania, acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Commonwealth or Petitioner), which initiated an action by filing a Petition for Review (Petition) on June 26, 2014, the allegations of which are incorporated herein by reference.

SETTLEMENT TERMS

NOW THEREFORE, for good and valuable consideration, Respondent, UPMC agrees for itself, its successors, assigns, agents, employees, representatives, executors, administrators, personal representatives, heirs and all other persons acting on their behalf, directly or through any corporate or other device, as follows:

I. INTERPRETATIVE PRINCIPLES

A. The Court's Consent Decree shall be interpreted consistently with the Insurance Department's UPE Order in the Highmark/West Penn Allegheny Health System matter, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013), and the 2012 Mediated Agreement and to protect consumers and UPMC'S charitable mission. The outcome of the actions embodied in the Consent Decree shall be incorporated in the Transition Plan to be filed by Highmark by July 31, 2014, as provided under Condition 22 of the UPE order. The Consent Decree is not a contract extension and shall not be characterized as such.

II. DEFINITIONS

A. "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member cost-shares.

B. "Children's Final Order" means the Final Order in the matter of *In Re: Children's Hospital of Pittsburgh and Children's Hospital of Pittsburgh Foundation*, No. 6425 of 2001 (All. Co. 2001).

C. "Emergency Services/ER Services" means medical services provided in a hospital emergency department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

D. "Greater Pittsburgh Area" means the counties of Allegheny, Beaver, Butler, Washington and Westmoreland.

E. "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance or managed-care plans, offered by government, for-profit or non-profit third-party payors, health care providers or any other entity.

F. "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities.

G. "Highmark" means Highmark, Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include UPE and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

H. "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

I. "In-Network" means where a health care provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health

Plan's members. The member shall be charged no more than the co-pay, co-insurance or deductible charged by his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.

J. "Mediated Agreement" means the Mediated Agreement entered into by UPMC and Highmark on May 1, 2012, with assistance of a mediator appointed by the Governor and all agreements implementing the Mediated Agreement.

K. "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

L. "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

M. "Trauma" means medical services that are provided to an individual with a severe, life threatening injury which is likely to produce mortality or permanent disability and which are provided at the designated Trauma Center in a facility that provides specialized medical services and resources to patients suffering from traumatic, serious or critical bodily injuries and which is accredited by the Pennsylvania Trauma Systems Foundation and services needed for appropriate continuity of care.

N. "UPE", also known as Highmark Health, means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. UPE serves as the controlling member of Highmark.

O. "UPE Order" means the Pennsylvania Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).

P. "UPMC" means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at: 200 Lothrop Street, Pittsburgh, PA 15213. Unless otherwise specified, all references to UPMC include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

Q. "UPMC Health Plan" means the Health Plan owned by UPMC which is licensed by the Pennsylvania Department of Insurance.

R. "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, Western Psychiatric Institute and Clinic of UPMC and any other Hospital acquired by UPMC following the entry of the Court's Consent Decree.

S. "Western Pennsylvania" means the 29-county area designated by the Blue Cross Blue Shield Association in which Highmark does business as Highmark Blue Cross Blue Shield.

IV. TERMS

UPMC shall comply with the following terms:

A. **Access**

1. **ER/Trauma Services** - UPMC shall negotiate in good faith to reach an agreement with Highmark on In-Network rates and patient transfer protocols for emergency and trauma services for hospital, physician and appropriate continuity of care services at all UPMC and Allegheny Health Network hospitals by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. This does not mean that Hospitals or physicians rendering emergency or trauma services to a patient are In-Network for purposes or services other than treating the emergency condition for which a patient is admitted or the treating physicians are otherwise In-Network under other terms of this Consent Decree including, but not limited to, the Continuity of Care, Unique/Exception Hospitals or Oncology. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. UPMC shall not Balance Bill consumers until the ER services agreement is resolved.

2. **Vulnerable Populations** – UPMC and Highmark mutually agree that vulnerable populations include: (i) consumers age 65 or older who are eligible or covered by Medicare, Medicare Advantage, (ii) Medigap health plans, (iii) Medicaid and/or (iv) CHIP. With respect to Highmark's covered vulnerable populations, UPMC shall continue to contract with Highmark at in-network rates for all of its hospital, physician and appropriate continuity of care services for CHIP, Highmark Signature 65, Medigap and commercial retiree carve out as long as Highmark

does not make unilateral material changes to these programs. UPMC shall treat all Medicare participating consumers as In- Network regardless of whether they have Medicare as their primary or secondary insurance. UPMC reserves the right to withdraw from these arrangements if Highmark should take the position that it has the authority to revise the rates and fees payable under those arrangements unilaterally and materially.

3. **Local Community Needs** – Where UPMC is the provider of services provided locally that the patient's treating physician believes the patient needs and DOH has determined such services are not available from another source, and member is Out-of-Network, UPMC will not Balance Bill the member, and UPMC and Highmark shall negotiate a payment that shall not be greater than the Out-of-Network rates established by this Consent Decree.

4. **Oncology/Cancer Services**– Highmark subscribers may access, as if In-Network, UPMC services, providers, facilities, and physicians involved in the treatment of cancer, if a patient's treating physician determines that a patient who is diagnosed with cancer should be treated by a UPMC oncologist and the patient agrees to be so treated. In addition, UPMC and Highmark shall negotiate an agreement for treatment of illnesses which result from cancer treatment. These resulting illnesses may include, but not be limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. Moreover, all UPMC joint ventures and physician services

provided at or on behalf of independent hospitals, whether related to oncology or not, shall be In-Network. If UPMC and Highmark do not reach an agreement on rates for cancer treatment and resulting illnesses by July 15, 2014, the parties will be subject to the Dispute Resolution Process set forth in paragraph C(1) below. UPMC shall not Balance Bill consumers until this agreement is resolved. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order.

5. **Unique/Exception Hospitals and Physicians** – UPMC shall negotiate in good faith to reach an agreement with Highmark for hospital, physician services and follow-up care services at Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Venango (Northwest), UPMC/Hamot, UPMC/Altoona, UPMC Horizon and any facility, any physician services, or any other provider services located or delivered outside the Greater Pittsburgh Area currently owned or acquired in the future by UPMC, or with whom UPMC has an agreement to handle provider contracting, such as, but not limited to, the Kane Community Hospital, or any other physician services or facility outside the Greater Pittsburgh Area determined by DOH to be essential to meet local community needs, by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE order. The Children's Final Order will continue in effect.

6. **Out-of-Network Services** – For all other Highmark subscribers whose care is not otherwise governed by other provisions in this Consent Decree, beginning

January 1, 2015, UPMC will provide services to all such subscribers on an Out-of-Network basis. UPMC's reimbursement rates for Out-of-Network services for Highmark subscribers shall be no more than 60% of charges if paid promptly and provided that UPMC informs consumers of such charges before rendering services.

7. **Continuity of Care** – UPMC and Highmark mutually agree that the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In-Network rates. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. While undergoing a continuing course of treatment with UPMC, the services covered In-Network will include all services reasonably related to that treatment, including, but not limited to, testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically appropriate, or disputes the scope of that care, the DOH or its designated representative will review the matter and make a final, non-appealable determination.

8. **Transfer of Services** – If any services covered by this Consent Decree are transferred or consolidated at one or more UPMC Hospitals, the terms of this Consent Decree shall apply to those transferred services where such services are transferred or consolidated.

9. **Referrals and UPMC Transfer of Patients** - (a) UPMC shall not require its physicians to refer patients to a UPMC Hospital in situations where the patient is

covered by a Health Plan that does not participate with such UPMC Hospital or otherwise expresses a preference to be referred to a non-UPMC Hospital; (b) UPMC shall not refuse to transfer a patient, whether for diagnosis or treatment, to a non-UPMC Hospital or health care provider if such transfer is requested by the patient, the patient's representative when such representative is authorized to make care decisions for the patient, or the patient's physician; provided the patient is stable and that the transfer is medically appropriate and legally permissible; (c) When a patient is in need of transfer and is covered by a Health Plan with which the UPMC Hospital does not contract, UPMC shall transfer the patient to the Health Plan's participating non-UPMC facility (provided the patient is stable and that the transfer is medically appropriate and legally permissible) unless, (i) the patient or the patient's representative expresses a contrary preference after having been informed of the financial consequences of such a decision, or (ii) is otherwise approved by the patient's Health Plan.

10. **Safety Net** – UPMC and Highmark mutually agree to establish a one-year safety net beginning January 1, 2015, for any existing UPMC patient and Highmark subscriber (i) who used UPMC physicians and services In-Network during the 2014 calendar year, (ii) who is not in a continuing course of treatment, and (iii) who is unable to find alternative physicians and services in their locality during the one year period. UPMC and Highmark shall hold such consumers harmless if they continue to use such physicians and services prior to January 1, 2016. Rates for the safety net period shall be as set forth under the Dispute Resolution Process

set forth in paragraph C(1) below. The safety net is not a contract extension, and neither Highmark nor UPMC nor their agents shall characterize it as such.

11. **Advertising** – UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.

B. **Monetary Terms**

Consumer Education Fund and Costs – UPMC shall contribute $2 million dollars to the Consumer Education Fund to be used by the OAG, PID or DOH for education and outreach purposes during the transition; and to cover costs, including attorneys' or consultant fees of the OAG, PID and DOH within 60 days of the entry of this Consent Decree.

C. **Miscellaneous Terms**

1. **Dispute Resolution Process** - Where required in this Consent Decree, UPMC and Highmark shall negotiate in good faith. If the parties are unable to reach agreement on any of the issues raised in this Consent Decree by July 15, 2014, or such other date as may be set by OAG, PID and DOH, then the terms or rates shall be subject to the following:

   a. Rates

      i. For the period, January 1, 2015 to December 31, 2015, rates for all In-Network services covered in this Consent Decree, except for those rates currently being arbitrated by UPMC and Highmark, shall revert to the last mutually agreed upon rates or fees by UPMC and Highmark with the applicable medical market basket index (MBI) increase applied January 1, 2015.

ii. For rates currently being arbitrated, in the event that the current arbitration between UPMC and Highmark finds in favor of UPMC, then the rates and fees under the Consent Decree will revert to the rates in effect before April 1, 2014 as of the date of the arbitral award and shall remain in place through December 31, 2015. If as a consequence of the arbitral award, Highmark owes UPMC for underpayments, Highmark shall pay UPMC appropriate interest. If as a consequence of the arbitral award, UPMC owes Highmark for overpayments, UPMC shall pay Highmark appropriate interest. If an arbitral award is not decided before January 1, 2015, Highmark shall increase its payments by one-half the difference between Highmark's April 1, 2014schedule and its rate schedule in effect before April 1, 2014 for the period January 1, 2015 to December 31, 2015.

iii. For the period beginning January 1, 2016 to the expiration of the Consent Decree or the expiration of any agreements between UPMC and Highmark for all In-Network services, whichever is later, the rates shall be the rates mutually agreed to by Highmark and UPMC, or UPMC and Highmark shall engage in a single last best offer binding arbitration to resolve any dispute as to rates after December 31, 2015 as set forth in paragraph C (2) below.

iv. Any agreement or award as to rates and fees will be binding on both UPMC and Highmark, meaning that each will bill and make payments consistent with the agreement or award.

b. Non-Rate Term – Disputed terms set forth in this Consent Decree and unrelated to rate and reimbursement shall be subject to mediation before the OAG, PID and DOH. If mediation does not result in resolution within 30 days or such other time set by the OAG, PID and DOH, UPMC and Highmark shall engage in binding arbitration to resolve the dispute as to terms as set forth in Paragraph C (2) below.

2. **Binding Arbitration**

   a. The Parties will file a joint plan with this court for a single last best offer binding arbitration before independent and neutral parties by August 14, 2014 or seek court intervention to resolve any disputes over such process.

3. **Binding on Successors and Assigns** – The terms of this Consent Decree are binding on UPMC, its directors, officers, managers, employees (in their respective capacities as such) and to its successors and assigns, including, but not limited to, any person or entity to whom UPMC may be sold, leased or otherwise transferred, during the term of the Consent Decree. UPMC shall not permit any substantial part of UPMC to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Consent Decree.

4. **Enforcement** - The OAG, PID and DOH shall have exclusive jurisdiction to enforce the Consent Decree. If the OAG, PID or DOH believe that a violation of the Final Decree has taken place, they shall so advise UPMC and give UPMC 20 days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this

Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Final Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to UPMC for a response within 30 days. If after receiving the response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise UPMC and give UPMC twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Final Decree in this Court. If the complaint involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

5. **Release** –This Consent Decree will release any and all claims the OAG, PID or DOH brought or could have brought against UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited violations of the crimes code, Medicaid fraud laws or tax laws are not released.

6. **Compliance with Other Laws** - The Parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

7. **Notices** – All notices required by this Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand deliver to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to UPMC:

Chief Executive Officer
University of Pittsburgh Medical Center
U.S. Steel Tower
62nd Floor
600 Grant Street
Pittsburgh, PA 15219

Copies to:

General Counsel
University of Pittsburgh Medical Center
U.S. Steel Tower
62nd Floor
600 Grant Street
Pittsburgh, PA 15219

8. **Averment of Truth** – UPMC avers that, to the best of its knowledge, the information it has provided to the OAG, PID and DOH in connection with this Consent Decree is true.

9. **Termination** – This Consent Decree shall expire five (5) years from the date of entry.

10. **Modification** – If the OAG, PID, DOH or UPMC believes that modification of this Consent Decree would be in the public interest, that party shall give notice to the other and the parties shall attempt to agree on a modification. If the parties

agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

11. **Retention of Jurisdiction** – Unless this Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Consent Decree.

12. **No Admission of Liability** – UPMC, desiring to resolve the OAG's, PID's and DOH's concerns without trial or adjudication of any issue of fact or law, has consented to entry of this Consent Decree, which is not an admission of liability by UPMC as to any issue of fact or law and may not be offered or received into evidence in any action as an admission of liability, whether arising before or after the matter referenced herein.

13. **Counterparts** – This Consent Decree may be executed in counterparts.

NOW THEREFORE, without trial or adjudication of the facts or law herein between the parties to this Consent Decree, Respondent agrees to the signing of this Consent Decree and this Court hereby orders that Respondent shall be enjoined from breaching any and all of the aforementioned provisions.

WE HEREBY consent to this Consent Decree and submit the same to this Honorable Court for the making and entry of a Consent Decree, Order or Judgment of the Court on the dates indicated below.

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
KATHLEEN G. KANE
Attorney General

Date: June 27, 2014 By: _____

Date: 6/27/2014 By: _____
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 82620
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

Date: _____ By: _____
MICHAEL F. CONSEDINE, COMMISSIONER
PENNSYLVANIA INSURANCE DEPARTMENT

Date: _____ By: _____
MICHAEL WOLF, SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: _____ By: _____
JAMES D. SCHULTZ, GENERAL COUNSEL

Date: 6/27/14 By: _____
Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
KATHLEEN G. KANE
Attorney General

Date: _____ By: _____

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 82620
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

Date: 6/27/14 By: _____

MICHAEL F. CONSEDINE,
COMMISSIONER
PENNSYLVANIA INSURANCE DEPARTMENT

Date: 6/27/14 By: _____

MICHAEL WOLF
SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: 6/27/14 By: _____

JAMES D. SCHULTZ, GENERAL COUNSEL

Date: _____ By: _____

Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120

Counsel for the Commonwealth of Pennsylvania

BY THE RESPONDENT
UPMC

Date: June 27, 2014 By:

W. Thomas McGough, Jr.
Executive Vice President & Chief Legal Officer
UPMC
U.S. Steel Tower, Suite 6241
600 Grant Street
Pittsburgh, PA 15219

Appendix 2

OAG's Proposed Modified Consent Decree

OAG submitted its Proposed Modified Consent Decree to the Commonwealth Court as Exhibit G to OAG's Feb. 7, 2019 Petition to Modify.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By JESSICA ALTMAN, Insurance Commissioner; And PENNSYLVANIA DEPARTMENT OF HEALTH, By DR. RACHEL LEVINE, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. And HIGHMARK INC., A Nonprofit Corp.; Respondents.	: : : : : : : : : : : : : : : : : :	No. 334 M.D. 2014

MODIFIED CONSENT DECREE

AND NOW, this _____ day of _____, 20___, upon the ***Petition for Supplemental Relief to Modify Consent Decrees*** filed by the Commonwealth of Pennsylvania through its Attorney General, Josh Shapiro, and the record in this case, the Consent Decrees approved by this Court on July 1, 2014 are hereby combined into this single decree and modified as follows:

INTERPRETIVE PRINCIPLES

1. The terms of this Modified Consent Decree are based upon the status of the respondents as charitable institutions committed to public benefit and are intended to promote the public's interest by: enabling open and affordable access to the respondents' health care services and products through negotiated contracts; requiring last best offer arbitration when contract negotiations fail; and, ensuring against the respondents' unjust enrichment by prohibiting excessive and unreasonable charges and billing practices in the rendering of medically necessary health care services.

DEFINITIONS

2.1 "Acquire" means to purchase the whole or the majority of the assets, stock, equity, capital or other interest of a corporation or other business entity or to receive the right or ability to designate or otherwise control the corporation or other business entity.

2.2 "All-or-Nothing" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for all of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.3 "Anti-Tiering or Anti-Steering" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits the Health Plan from placing the Health Care Provider in a tiered Health Plan product for the purpose of steering members to Health Care Providers based on objective price, access, and/or quality criteria determined by the Health Plan, or which requires that the Health Plan place the Health Care Provider in a particular tier in a tiered Health Plan product.

2.4 "Average In-Network Rate" means the average of all of a Health Care Provider's In-Network reimbursement rates for each of its specific health care services provided, including, but not limited to, reimbursement rates for government, commercial and integrated Health Plans.

2.5 "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member Cost-Shares.

2.6 "Cost-Share" or "Cost-Sharing" means any amounts that an individual member of a Health Plan is responsible to pay under the terms of the Health Plan.

2.7 "Credential" or "Credentialing" means the detailed process that reviews physician qualifications and career history, including, but not limited to, their education, training, residency, licenses and any specialty certificates. Credentialing is commonly used in the health care industry to evaluate physicians for privileges and health plan enrollment.

2.8 "Emergency Services/ER Services" means medical services provided in a hospital emergency or trauma department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

2.9 "Exclusive Contract" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits either party from contracting with any other Health Care Provider or Health Plan.

2.10 "Gag Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that restricts the ability of a Health Plan to furnish cost and quality information to its enrollees or insureds.

2.11 "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities but excludes services from for-profit ambulance and air transport providers.

2.12 "Health Care Provider Subsidiary" means a Health Care Provider that is owned or controlled by either of the respondents, and also includes any joint ventures with community hospitals for the provision of cancer care that are controlled by either of the respondents.

2.13 "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance, self-insured, third party administrator or managed-care plans, whether offered by government, for-profit or non-profit third-party payors, Health Care Providers or any other entity.

2.14 "Health Plan Subsidiary" means a Health Plan that is owned or controlled by either of the respondents.

2.15 "Highmark" means Highmark Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include Highmark Health and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.16 "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

2.17 "Inflation Index" means the Medicare Hospital Inpatient PPS market basket index published annually by the Centers for Medicaid and Medicare Services.

2.18 "In-Network" means where a Health Care Provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health Plan's members. The member shall be charged no more than the Cost-Share required

pursuant to his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.

2.19 "Material Contract Terms" means rates, term, termination provisions, the included providers, assignment, claims processes, addition or deletion of services, outlier terms, dispute resolution, auditing rights, and retrospective review.

2.20 "Most Favored Nations Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that allows the Health Plan to receive the benefit of a better payment rate, term or condition that the provider gives to another Health Plan.

2.21 "Must Have" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for one or more of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.22 "Narrow Network Health Plan" means where a Health Plan provides access to a limited and specifically identified set of Health Care Providers who have been selected based upon criteria determined by the Health Plan which shall include cost and quality considerations.

2.23 "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

2.24 "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

2.25 "Provider Based Billing," also known as "Facility Based Billing" and "Hospital Based Billing," means charging a fee for the use of the Health Care Provider's building or facility at which a patient is seen in addition to the fee for physician or professional services.

2.26 "Tiered Insurance Plan" or "Tiered Network" means where a Health Plan provides a network of Health Care Providers in tiers ranked on criteria determined by the Health Plan which shall include cost and quality considerations, and provides members with differing Cost-Share amounts based on the Health Care Provider's tier.

2.27 "Top Tier" or "Preferred Tier" means the lowest Cost-Share Healthcare Providers within a Tiered Insurance Plan or Tiered Network.

2.28 "Unreasonably Terminate" means to terminate an existing contract prior to its expiration date for any reason other than cause.

2.29 "Highmark Health," means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Highmark Health serves as the controlling member of Highmark.

2.30 "UPMC" and the "UPMC Health System," also known as the "University of Pittsburgh Medical Center," means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at 600 Grant Street, Pittsburgh, Pennsylvania 15219. Unless otherwise specified, all references to UPMC include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.31 "UPMC Health Plan" means the Health Plans owned by UPMC which are licensed by the Pennsylvania Department of Insurance or otherwise operating in Pennsylvania.

2.32 "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, UPMC Jameson, UPMC Susquehanna, UPMC Pinnacle, UPMC Cole, Western Psychiatric Institute and Clinic of UPMC and any other Hospital Acquired by UPMC following the entry of the Court's July 1, 2014 Consent Decree or this Modified Consent Decree.

TERMS

3.1 Internal Firewalls – Highmark and UPMC shall implement internal firewalls as described in Appendix 2 by the Pennsylvania Insurance Department in its April 29, 2013 Order as part of Highmark's acquisition of West Penn Allegheny Health System.

3.2 Health Care Provider Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Care Provider Subsidiaries shall negotiate with any Health Plan seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below.

3.3 Health Plan Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Plan Subsidiaries shall negotiate with any credentialed Health Care Provider seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below. Nothing herein shall be construed to require a Health Plan Subsidiary to include a Health

Care Provider in a particular Narrow Network Health Plan, including in any particular tier in a Tiered Insurance Plan or Tiered Network.

3.4 Prohibited Contract Terms – Highmark and UPMC are prohibited from utilizing in any of their Health Care Provider or Health Plan contracts:

3.4.1 Any Anti-Tiering or Anti-Steering practice, term or condition;

3.4.2 Any Gag Clause, practice, term or condition;

3.4.3 Any Most Favored Nation practice, term or condition;

3.4.4 Any Must Have practice, term or condition;

3.4.5 Any Provider-Based Billing practice, term or condition;

3.4.6 Any All-or-Nothing practice, term or condition;

3.4.7 Any Exclusive Contracts practice, term or condition;

3.5 Limitations on Charges for Emergency Services – Highmark's and UPMC 's Health Care Provider Subsidiaries shall limit their charges for all emergency services to their Average In-Network Rates for any patient receiving emergency services on an Out-of-Network basis.

3.6 Limitations on Terminations – Highmark and UPMC shall not Unreasonably Terminate any existing Payor Contract.

3.7 Direct Payments Required – Highmark's and UPMC's Health Plan Subsidiaries shall pay all Health Care Providers directly in lieu of paying through their subscribers for services.

3.8 Non-Discrimination – Highmark and UPMC shall not discriminate in the provision of health care services, the release of medical records, or information about patients based upon the identity or affiliation of a patient's primary care or specialty physician, the patient's Health Plan or the patient's utilization of unrelated third-party Health Care

Providers – provided, however, that this provision shall not be understood to require Highmark and UPMC to provide privileges or credentials to any Health Care Provider who otherwise does not qualify for privileges and credentials.

3.9 Duty to Communicate – Highmark and UPMC shall maintain direct communications concerning any members of their respective health plans that are being treated by the other's provider to ensure that their respective agents, representatives, servants and employees provide consistently accurate information regarding the extent of their participation in a patient's Health Plan, including, but not limited to, the payment terms of the patient's expected out-of-pocket costs.

3.10 Advertising – Highmark and UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.

3.11 Changes to Corporate Governance – Highmark Health and UPMC Health System shall replace a majority of their respective board members who were on their respective boards as of April 1, 2013 by January 1, 2020, with individuals lacking any prior relationship to Highmark Inc. or UPMC, respectively, for the preceding five (5) years.

CONTRACT RESOLUTION (LAST BEST OFFER ARBITRATION)

4.1 Highmark and UPMC shall provide a copy of this Modified Consent Decree to any Health Plan licensed by the Pennsylvania Department of Insurance seeking a services contract or, to any Health Care Provider licensed by the Pennsylvania Department of Health seeking a services contract. Any such Health Plan or Health Care Provider may, at its option, require Highmark or UPMC to participate in the two-step contract resolution provisions of this Modified Consent Decree contained in paragraphs 4.2 through 4.8 by opting in, as set forth in paragraph 4.2, provided that: in the case of Health Care

Providers, the Health Care Provider has identified the specific Health Plan product of either Highmark or UPMC with which the Health Care Provider desires to contract.

4.1.1 First Step - period of good faith negotiations. If no contract is reached during the period;

4.1.2 Second Step - the Health Plan or Health Care Provider may request binding arbitration as outlined in paragraphs 4.3 through 4.8.

4.2 A Health Plan or Health Care Provider must give written notice to Highmark or UPMC of its desire to opt in and utilize the contract resolution provisions of this Modified Consent Decree at least ninety (90) days prior to the expiration of its existing contract with Highmark or UPMC. If a Health Plan or Health Care Provider does not have an existing contract with Highmark or UPMC, the Health Plan or Health Care Provider must give such notice within thirty (30) days after it has notified Highmark or UPMC, in writing, of its interest in a contract. A failure to opt-in to this contract resolution provision is deemed an opt- out for a period of one year.

4.3 As the First Step, a Health Plan or Health Care Provider shall negotiate in good faith toward a contract for Highmark's or UPMC's health care services and/or health plan for at least ninety (90) days. At the conclusion of the ninety (90) day negotiation period, if the negotiations have been unsuccessful, the Health Plan or Health Care Provider may trigger binding arbitration with Highmark or UPMC (hereinafter collectively referred to as the "Arbitration Parties") before an independent body, but must do so, in writing, within thirty (30) days after the conclusion of good faith negotiations:

4.3.1 The arbitration panel will be an independent body made up of five representatives. A representative or his or her employer shall not have been an

officer, director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties:

4.3.1.1 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with less than 100 employees;

4.3.1.2 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with more than 100 employees;

4.3.1.3 The Pennsylvania Health Access Network shall appoint one (1) member;

4.3.1.4 The Health Plan or Health Care Provider shall appoint one (1) member; and

4.3.1.5 Highmark or UPMC, where they are an Arbitration Party, shall appoint one (1) member.

4.3.2 The Arbitration Parties shall each submit to the independent body its last contract offer and a statement of agreed upon contract terms and those Material Contract Terms which remain unresolved. The independent body may reject a request for arbitration if the number of unresolved Material Contract Terms exceeds the number of agreed upon Material Contract Terms and order the Arbitration Parties to engage in another sixty (60) days of negotiation.

4.3.3 The independent body may retain such experts or consultants with expertise in health plan and health care provider contracting issues to aid it in its deliberations, provided that any such experts or consultants shall not have been an officer,

director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties. The cost of such experts or consultants shall be divided equally between the Arbitration Parties.

4.3.4 If, during the course of the negotiation process outlined above, either of the Arbitration Parties fails to propose Material Contract Terms prior to arbitration, the arbitration panel shall impose the proposed terms of the party which did make a proposal with respect to such Material Contract Terms. If both Arbitration Parties submit proposed contracts, the independent body shall inform the Arbitration Parties of any information the independent body believes would be helpful in making a decision. The independent body shall not prohibit the presentation of information by either of the Arbitration Parties for consideration, but must consider the following:

4.3.4.1 The existing contract or contracts, if any, between the Arbitration Parties.

4.3.4.2 The prices paid for comparable services by other Health Plans and/or accepted by other Health Care Providers of similar size and clinical complexity within the community.

4.3.4.3 The criteria required by either Highmark or UPMC concerning the credentialing of Health Care Providers seeking an agreement with either Highmark or UPMC.

4.3.4.4 Whether the Health Care Provider is seeking an agreement in a tiered Health Plan of either Highmark or UPMC; in no event shall either respondent be required to permit a Health Care Provider to participate in a Narrow Network Health Plan, including in a particular tier in either of the respondents' Tiered Insurance Plans or Tiered Networks.

4.3.4.5 Whether a contract between the Arbitration Parties would prevent other Health Care Providers in such Health Plan from meeting quality standards or receiving contracted for compensation.

4.3.4.6 The weighted average rates of other area hospitals of similar size and clinical complexity for all payors, separately for each product line (commercial, Medicare managed care and/or Medicaid managed care) for which the Health Plan or Health Care Provider is seeking an agreement with either Highmark or UPMC.

4.3.4.7 The costs incurred in providing the subject services within the community and the rate of increase or decrease in the median family income for the relevant county(ies) as measured by the United States Department of Labor, Bureau of Labor Statistics.

4.3.4.8 The rate of inflation as measured by the Inflation Index, and (i) the extent to which any price increases under the existing contract between the Health Plan or Health Care Provider and Highmark or UPMC (as applicable) were commensurate with the rate of inflation and (ii) the extent to which the Health Plan's premium increases, if any, were commensurate with the rate of inflation.

4.3.4.9 The rate of increase, if any, in appropriations for Managed Care Organizations participating in Pennsylvania's Medical Assistance program for the Department of Public Welfare, in the case of a Medicaid Managed Care Organization participant in this arbitration process.

4.3.4.10 The actuarial impact of a proposed contract or rates paid by the Health Plan and a comparison of these rates in Pennsylvania with Health Plan or Health Care Provider rates in other parts of the country.

4.3.4.11 The expected patient volume which likely will result from the contract.

4.3.4.12 The independent body shall not consider the extent to which a party is or is not purchasing health plan or health care services from the other party.

4.4 Once the arbitration process has been invoked, the independent body shall set rules for confidentiality, exchange and verification of information and procedures to ensure the fairness for all involved and the confidentiality of the process and outcome. In general, the Arbitration Parties may submit confidential, competitively-sensitive information. Therefore, the independent body should ensure that it and any consultants it retains do not disclose this information to anyone outside the arbitration process.

4.5 The independent body must select the Material Contract Terms proposed by one of the Arbitration Parties. The parties are bound by the decision of the independent body. Any disputed non-Material Contract Terms shall be resolved in favor of the Respondents to this Modified Consent Decree unless the arbitration is between the Respondents in which case the non-Material Contract Terms of the Respondent whose Material Contract Terms are selected shall apply.

4.6 Because of the important interests affected, the independent body shall commence the arbitration process within twenty (20) days after it is triggered by a written request from a Health Plan or Health Care Provider. It shall hold an arbitration hearing, not to exceed three (3) days, within sixty (60) days of the commencement of the arbitration process. The independent body shall render its determination within seven (7) days after the conclusion of the hearing. The Arbitration Parties, by agreement, or the independent body, because of the complexity of the issues involved, may extend any of the time periods in this section, but the arbitration process shall take no more than ninety (90) days from its commencement.

4.7 The Arbitration Parties shall each bear the cost of their respective presentations to the independent body and shall each bear one-half of any other costs associated with the independent review.

4.8 During the above arbitration process:

4.8.1 If the Arbitration Parties have an existing contract, the reimbursement rates set forth in that contract will remain in effect and the reimbursement rates will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.2 If the Arbitration Parties have no contract, the Health Plan shall pay for all services by Highmark or UPMC (as applicable) for which payment has not been made, in an amount equal to the rates in its proposed contract. This amount will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.3 If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are less than the amounts owed under the contract awarded as the result of arbitration, the Health Plan shall pay interest on the difference. If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are greater than the amounts owed under the contract awarded as the result of arbitration, the Health Care Provider shall reimburse the excess and pay interest on the difference. For purposes of calculating interest due under this paragraph, the interest rate shall be the U.S. prime lending rate offered by PNC Bank or its successor as of the date of the independent body's decision on arbitration.

MISCELLANEOUS TERMS

5. Binding on Successors and Assigns – The terms of this Consent Decree are binding on Highmark and UPMC, their directors, officers, managers, employees (in their respective capacities as such) and to their successors and assigns, including, but not limited to, any person or entity to whom Highmark or UPMC may be sold, leased or otherwise transferred, during the term of this Modified Consent Decree. Highmark and UPMC shall not permit any of their substantial parts to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Modified Consent Decree.

6. Enforcement – The OAG, PID and DOH shall have exclusive jurisdiction to enforce this Modified Consent Decree. If the OAG, PID or DOH believe that a violation of this Modified Consent Decree has taken place, they shall so advise Highmark and UPMC and give the offending respondent twenty (20) days to cure the violation. If after that time the violation has not been cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this Modified Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Modified Consent Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to Highmark or UPMC for a response within thirty (30) days. If after receiving the response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise Highmark or UPMC and give the offending party twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in this Court. If the complaint

involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

7. Release – This Modified Consent Decree releases any and all claims the OAG, PID or DOH brought or could have brought against Highmark or UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing nonprofit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Modified Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited to violations of the crimes code, Medicaid fraud laws or tax laws are not released.

8. Compliance with Other Laws – The parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with the obligations of Highmark and UPMC under the laws governing nonprofit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

9. Notices – All notices required by this Modified Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand deliver to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Charitable Trusts and Organizations Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Health Care Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Antitrust Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to Highmark

Chief Executive Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

Copies to:

Executive Vice President and Chief Legal Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

If to UPMC:

Chief Executive Officer
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

Copies to:

General Counsel
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

10. Averment of Truth – Highmark and UPMC aver that, to the best of their knowledge, the information they have provided to the OAG, PID and DOH in connection with this Modified Consent Decree is true.

11. Termination – This Consent Decree shall remain in full force and effect until further order of the Court.

12. Modification – If either the OAG, PID, DOH, Highmark or UPMC believes that further modification of this Modified Consent Decree would be in the public interest, that party shall give notice to the other parties and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for further modification and shall bear the burden of persuasion that the requested modification is in the public interest.

13. Retention of Jurisdiction – Unless this Modified Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Modified Consent Decree.

BY THE COURT:

_____

, J.

Appendix 3

Commonwealth Court's
March 12, 2019 Scheduling Order II

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Commonwealth of Pennsylvania, By Josh Shapiro, Attorney General; Pennsylvania Department of Insurance, By Jessica K. Altman, Insurance Commissioner and Pennsylvania Department of Health, By Rachel Levine, Secretary of Health, Petitioners	:	
v.	:	No. 334 M.D. 2014
UPMC, A Nonprofit Corp.; UPE, a/k/a Highmark Health, A Nonprofit Corp. and Highmark, Inc., A Nonprofit Corp., Respondents	:	

SCHEDULING ORDER II

AND NOW, this 12th day of March, 2019, after status/scheduling conference with counsel on March 7, 2019, it is **ORDERED and DECREED** that this Court's Scheduling Order I dated February 25, 2019 shall be supplemented as follows:

1) Consistent with Pa. R.C.P. No. 213(b), in the absence of objection, in recognition of the public interest in and potentially far-reaching impact of the litigation, and in further recognition of the need for some resolution of a portion of this litigation before June 30, 2019, Count I of the Commonwealth's Petition to Modify is severed from the other Counts of the Petition, and shall be litigated separately and expeditiously, as more fully set forth below; any dispositive orders pertaining to Count I of the Petition to Modify shall be deemed to include permission to appeal from this Court ("lower court") pursuant to Pa.R.A.P. 1311, and contain the statement prescribed by 42 Pa. C.S. §702(b), without further application by the parties; and

2) Respondent UPMC shall have until the close of business on Monday, March 18, 2019, to file a reply brief in support of its Motion to Dismiss or Preliminary Objections; and

3) All interrogatories, requests for production, and requests for admissions shall be answered within 30 days after service. All documents being produced shall be produced as expeditiously as possible on a rolling basis with production commencing at the time the written responses are served; and

In the event litigation on Count I of the Petition to Modify goes forward after the Court decides Respondent UPMC's Motion to Dismiss or Preliminary Objections:

4) Respondent UPMC shall file an Answer to Count I of Commonwealth's Petition to Modify within 10 days of this Court's decision on the Motion to Dismiss or Preliminary Objections; and

5) Any new petitions to intervene shall be filed no later than the close of business on March 26, 2019; and

6) Petitioners shall be limited to a total of 15 depositions, and Respondent UPMC shall be limited initially to a total of 15 depositions, but for each deposition sought by Respondents Highmark (not to exceed 15), Respondent UPMC will be entitled to an additional deposition, the intention being that each "side" will be allowed an equal number of depositions; and

7) Any expert witness who will testify at any trial or fact-finding hearing shall prepare a signed expert report stating the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. All expert reports shall be served no later than the close of business on Monday, May 6, 2019; and

8) By the close of business on Monday, May 13, 2019, the parties shall file and serve pretrial memoranda consistent with the requirements of Pa. R.C.P. No. 212.2; a pretrial conference shall be held in Courtroom 3002 of the Pennsylvania Judicial Center, Third Floor, Harrisburg, Pennsylvania, commencing at 11:00 a.m. prevailing time on Monday, May 20, 2019; and

9) If needed, a non-jury trial on Count I of the Commonwealth's Petition to Modify shall commence Wednesday, May 29, 2019, in Courtroom 3002 of the Pennsylvania Judicial Center, at 10:00 a.m. prevailing time. The Commonwealth, as the moving party, shall arrange for court reporting services for the trial. The parties shall appear with exhibits

pre-marked and with sufficient copies for opposing counsel and the Court. The parties should be prepared to file proposed findings of fact and conclusions of law within five business days of the close of the record.

ROBERT SIMPSON, Judge

Certified from the Record

MAR 13 2019

And Order Exit

Appendix 4

"FAQs for End of Consent Decree Between Highmark and UPMC," posted to the website of the Pennsylvania Insurance Department and available at:

https://www.insurance.pa.gov/Companies/Documents/FAQ%20for%20End%20of%20Consent%20Decree%20Final.pdf

UPMC submitted this document to the Commonwealth Court as Exhibit L to UPMC's Feb. 21, 2019 Motion to Dismiss.

Highlighting added for the Court's convenience.

FAQs for End of Consent Decree Between Highmark and UPMC:

1. **What is the Highmark/UPMC Consent Decree?**

   In 2012, UPMC announced it would no longer continue to contract with Highmark following Highmark's proposed affiliation with health care provider Allegheny Health Network (AHN). In 2014, Highmark and UPMC each entered into a Consent Decree with the Office of Attorney General, the Insurance Department and the Department of Health to provide clarity and certainty for consumers concerning in-network access for Highmark members to UPMC providers. The Consent Decree allowed for access to certain unique or exception UPMC hospitals and providers and for certain groups of people (such as seniors) to continue receiving in-network treatment until the expiration of the Decrees on **June 30, 2019**.

2. **Who does the ending of the Consent Decree impact?**

   The ending of the Consent Decree will primarily impact current Highmark insureds in the Greater Pittsburgh and Erie areas who: (a) are in a continuing course of treatment with a UPMC provider; or (b) who are currently in or will seek oncology treatment from a UPMC provider; and/or (c) have Medicare Advantage plans.

   These insureds will now need to decide to either:

   - keep their Highmark insurance and start seeing a new in-network doctor,
   - to continue seeing their UPMC doctor and change their insurance plan to one where UPMC providers are in-network
   - or continue seeing their UPMC doctor and consider options for paying out-of-network provider costs.

   Insureds do not necessarily have to choose between in-network access to AHN and in-network access to UPMC. Both commercial and Medicare Advantage plans that provide in-network access to both AHN and UPMC are offered by several national insurance companies.

3. **Why is the Commonwealth allowing this to happen?**

   The Commonwealth cannot force an insurance company and a provider to contract at in-network rates with each other.

   Governor Wolf has dedicated significant efforts and will continue to diligently work to protect consumers by overseeing the implementation of the Consent Decree and through the consummation of the January 2018 agreement, to ensure access for Highmark's commercial insureds who require critical, unique services.

4. **What is in-network access, and why is it important?**

   In-network access is when an insurance company has a contract with a health care provider to provide services to enrollees for a negotiated rate. The health care provider agrees to accept the negotiated rate, together with any cost sharing by the enrollee (such as a copayment, coinsurance or deductible), as payment in full. Consequently, the patient does not receive a bill for the charges that exceed the insurers' payment. For many patients, it is often significantly less expensive for an insured to seek treatment from an in-network provider. However, each plan is different.

   Some health insurance plans only pay for services when an enrollee visits an in-network provider unless it is an emergency (such as exclusive provider organizations (EPOs) and health maintenance organizations (HMOs)). If you have a traditional HMO and choose to seek non-emergency care from an out-of-network provider, you will pay the entire cost. Other health insurance plans will pay at least some of the costs even if the member visits an out-of-network provider (point of service (POS) and preferred provider organizations (PPOs)). However, if you receive care from an out-of-network provider you will pay more of the cost than if you saw an in-network provider, and your provider may ask you to pay the difference between the actual cost of the service and the amount paid by your insurance company. This is called balance billing. Note that balance billing is up to the providers' discretion and prohibited for Medicare beneficiaries.

5. **How can I find out if the doctors and hospitals I want to use are in-network for a health plan I am considering?**

   The best way to find out if a provider you would like to visit is in-network would be to consult the website of the health plan in which you are considering enrollment. Additionally, you can reach out to the provider directly to confirm their network status with the health plan you are considering.

6. **Is there a transition period for care if my hospital/provider is not in-network?**

   Yes, the transition period is through **June 30, 2019**. Highmark insureds in the Greater Pittsburgh region and Erie will not have in-network access to any UPMC facility beyond this date, except for the exceptions clarified in Question 9.

7. **What is the impact to me if I am a Highmark member and I receive care from an out-of-network UPMC provider for non-emergency services?**

   With respect to in-network access to UPMC providers for Highmark members, the Consent Decree allows certain populations to take until June 30, 2019, to transition to a provider who is in-network with Highmark, explore out-of-network benefits, or change their health insurance coverage during the open enrollment period.

The end of the Consent Decree is almost here. If you have marketplace coverage or are enrolled in a Medicare Advantage plan, you will need to make decisions about your 2019 insurance coverage during open enrollment season. Since the Consent Decree ends mid-year 2019, the plan you select may or may not have access to most UPMC hospitals and/or physicians for the entire 2019 year.

People in the Greater Pittsburgh and Erie area who are planning on enrolling in a Highmark insurance plan must take into account which providers are in-network with Highmark insurance. Their UPMC provider may not be on that list for the entire year (there are a few exceptions listed in later questions), and so if they plan on staying with their Highmark insurance they may choose to switch providers. If they enroll in a Highmark insurance plan and try to continue seeing their UPMC provider, they will be required to pay higher out-of-pocket costs and may be subject to balance billing (if they are not a Medicare beneficiary).

It is important to understand your insurance plan's out-of-network coverage, if applicable. Your financial responsibility may be impacted by utilizing an out-of-network provider.

8. **I have group coverage from a Blue Cross Blue Shield (BCBS) company other than Highmark, am I affected by this?**

   Yes, if you have a plan that utilizes a network of providers and seek treatment in Highmark's service area the rules for in-network access will be the same as outlined in question 7. The BlueCard program is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while travelling or living in another BCBS Plan's service area. If you have group coverage from a BCBS company other than Highmark and seek treatment in Highmark's service area, you will be able to access providers that are in-network with Highmark. If you choose to see an out-of-network provider and your plan has an out-of-network benefit, you will be required to follow the provider and insurance plan's out-of-network process.

9. **Are there any specific UPMC services or hospitals that are still in-network if I have Highmark commercial insurance?**

   Yes, there are UPMC hospitals that will remain in-network in 2019 for Highmark insurance plans.

   In January of this year, Highmark and UPMC announced an agreement to continue access to UPMC providers for Highmark members with commercial coverage needing access to critical, unique services, including certain transplant services. This agreement also affects cancer patients and areas where there are not many other feasible options for access to non-UPMC providers. These exceptions are listed below.

Please be aware that these exceptions may not apply to certain "no UPMC" Highmark insurance plans, such as My Direct Blue and Community Blue Medicare HMO/PPO, which are designed to be out-of-network for all UPMC providers (although My Direct Blue is in-network at UPMC Children's Hospital of Pittsburgh). You should check with Highmark to see if your coverage is a "no UPMC" plan in which you would not have in-network access under these exceptions.

The following specialty services by UPMC will remain in-network for Highmark insureds after June 30, 2019, even if the hospitals would otherwise be considered out-of-Network: UPMC Center for Assistive Technology, UPMC Center of Excellence for Treatment of Cystic Fibrosis, and services unique to UPMC in the region, such as living-donor liver transplants, lung transplants, heart-lung transplants and small bowel transplants. These specialty transplants are also in-network services for other Blue Cross and Blue Shield members accessing UPMC through the Blue Card program in accordance with Blue Card rules and the members specific benefit plan design.

As always, it is best to check with your insurer on the status of a provider from which you wish to receive care prior to obtaining services from the provider.

Pursuant to a term sheet agreed to by the parties to allow access following the Consent Decree expiration, Highmark's commercial enrollees have the following access to UPMC facilities:

UPMC hospitals in the greater Pittsburgh area continuing to contract with Highmark insurance at in-network rates:

Greater Pittsburgh Area Hospitals	In-Network	Out-of-Network
UPMC Children's Hospital of Pittsburgh	✔	
UPMC Magee-Womens Hospital		✘
UPMC East		✘
UPMC McKeesport		✘
UPMC Mercy		✘
UPMC Montefiore		✘
UPMC Passavant (both campuses)		✘
UPMC Presbyterian		✘
UPMC St. Margaret		✘
UPMC Shadyside		✘
UPMC Hillman Cancer Center at UPMC Shadyside		✘
UPMC Western Psychiatric Hospital	✔	

In Western PA, UPMC hospitals continuing to contract with Highmark insurance at in-network rates:

Western PA Hospitals	In-Network	Out-of-Network
UPMC Altoona	✔	
UPMC Bedford	✔	
UPMC Hamot		✖
UPMC Horizon (both campuses)	✔	
UPMC Jameson	✔	
UPMC Kane	✔	
UPMC Northwest	✔	

In Central and Eastern PA, UPMC hospitals continuing to contract with Highmark insurance at In-network rates:

Central and Eastern PA Hospitals (After 6/30/19)	In-Network	Out-of-Network
UPMC Cole	✔	
UPMC Pinnacle Carlisle	✔	
UPMC Pinnacle Community Osteopathic in Harrisburg	✔	
UPMC Pinnacle Hanover	✔	
UPMC Pinnacle Harrisburg	✔	
UPMC Pinnacle Lancaster	✔	
UPMC Pinnacle Lititz	✔	
UPMC Pinnacle Memorial in York	✔	
UPMC Pinnacle West Shore in Mechanicsburg	✔	
UPMC Susquehanna Divine Providence in Williamsport	✔	
UPMC Susquehanna Lock Haven	✔	
UPMC Susquehanna Muncy Valley	✔	
UPMC Susquehanna Soldiers & Sailors in Wellsboro	✔	
UPMC Susquehanna Sunbury	✔	
UPMC Susquehanna Williamsport Regional	✔	
UPMC Chautauqua WCA in Jamestown, NY (via Blue Card program)	✔	

In the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark at In-network rates until 2021:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Beaver	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Washington	Medical Oncology Center
Excela Arnold Palmer Medical Oncology, Mt. Pleasant	Medical Oncology Center

Excela Arnold Palmer Medical Oncology, North Huntingdon	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Sewickley	Medical Oncology Center
Heritage Valley Radiation Oncology at UPMC West	Radiation Oncology Center
UPMC/St. Clair Hospital Cancer Center	Radiation Oncology Center
Heritage Valley Radiation Oncology Beaver	Radiation Oncology Center
Washington Health System Radiation Oncology	Radiation Oncology Center
Butler Health System Medical and Radiation Oncology	Medical & Radiation Oncology Centers
Excela Arnold Palmer Cancer Center	Medical & Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2021:

The Regional Cancer Center, Erie	Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2024:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Johnstown	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Uniontown	Medical Oncology Center
Grove City Medical Oncology (limited Med Oncology services)	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Greenville	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Windber	Medical Oncology Center
John P. Murtha Regional Cancer Center	Radiation Oncology Center
Uniontown Hospital Radiation Oncology, Robert E. Eberly Pavilion	Radiation Oncology Center
Jameson Radiation Oncology	Radiation Oncology Center
UPMC Cancer Center at UPMC Altoona	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Horizon	Medical & Radiation Oncology Centers

10. Are there any specific Allegheny Health Network (AHN) services or hospitals that are still in-network if I have UPMC insurance?

The Consent Decree specifically involves Highmark insurance and UPMC providers. Although the Consent Decrees do not speak to the UPMC Health Plan and access to AHN, that is still something consumers should consider during open enrollment. Therefore, if you have UPMC Health Plan, you should go to the UPMC Health Plan's website and look to see which providers are listed as in-network. Provider directories are subject to change, so it is important to check the health plan's website periodically for the most up-to-date information.

11. What facilities are considered in-network with each plan?

Insurance companies and providers negotiate contracts that determine network access for individual insurance plans. For the most up-to-date information on which facilities are considered in-network for each health plan, the consumer should go to the insurance company's website and check the provider directory, as they are subject to change.

12. I like my Primary Care Physician (PCP), can I just self-pay and continue to see him/her?

Yes, if you choose to keep both your PCP and your health insurance plan, you may continue to see your UPMC provider on an out-of-network basis. However, you should consider in advance your financial costs. If you choose to self-pay for your office visit you will likely also be personally responsible for any additional costs as a result of that visit, such as lab tests or procedures recommended by your provider.

13. What about providers (PCPs, specialists)? Both UPMC and Highmark's websites suggest contacting the provider directly. Can we trust that the in-network provider listing is correct on the plan's website?

It is the responsibility of the insurance company to have the most accurate information on its website, and that includes the listing of in-network providers.

If you notice incorrect listings on the company's website, please reach out to the Pennsylvania Insurance Department's Bureau of Consumer Services. Its contact information can be found below:

Toll-free: 1-877-881-6388
Fax: (717) 787-8585
TTY/TDD: (717) 783-3898

File a complaint by visiting this website: https://www.insurance.pa.gov/Consumers/File%20a%20Complaint/Pages/default.aspx

It is always best to check with your insurer on the status of a provider from which you wish to receive care prior to obtaining services from that provider. Should you have questions after reviewing their website, please contact the customer service number on the back on your insurance card.

14. **What if I have a Highmark PPO product, or a Highmark Medicare Advantage PPO product (such as Freedom Blue), or a Highmark HMO POS product (such as Security Blue) can I still go to an out-of-network facility?**

    Yes, if you have a Highmark commercial PPO plan, a Highmark Freedom Blue or Security Blue plan, you may still go to an out-of-network provider; you should refer to your plan's benefits for in and out-of-network coverage.

    For commercial plans, you may be accountable for the difference between UPMC's charge and the insurance plan's allowed amount payment, after your cost sharing. Please see Question 4 for more information on balance bills.

    For some services in Medicare plans, like physician visits, there may be no difference in cost-sharing for in or out-of-network. For other services, you may pay less for using a provider in Highmark's network. Medicare providers cannot require members to pay a copay or cost-sharing amount that exceeds the in or out-of-network payment stipulated by their plan. Note that emergent and urgent care is always covered as in-network coverage per federal regulations.

    UPMC has stated that after June 30, 2019, it intends to require patients with out-of-network insurance products to pay in advance for all nonemergent services. For more information regarding this pre-pay policy, call Highmark at the number on the back of your ID card or UPMC at 1-800-533-8762.

Information specific to traditional Medicare, Medicare Supplement, and Medicare Advantage Enrollees

15. **If I have traditional Medicare along with Medicare supplemental insurance, am I affected by this?**

    Consumers with Medicare supplemental insurance (also called Medigap) have access to all providers who accept Medicare, including UPMC.

Currently, most Medicare supplemental policies do not have networks. Therefore, there is no concept of in-network or out-of-network associated with those Medicare supplemental policies.

You should always review your providers' network status and your plan's network benefits before purchasing a plan.

16. If I have Medicare Advantage, am I affected by this?

There are certain UPMC services and hospitals that will continue to be in-network, as described further below. You should always check with your insurance company and/or your doctor before scheduling a visit to confirm their network status with your insurance.

17. What if Highmark Medicare Advantage subscribers find out that their provider is not in-network after all enrollment periods have ended? Will they have a Special Enrollment Period?

A Special Enrollment Period (SEP) is granted only on an exception basis and on terms set by the federal Centers for Medicare and Medicaid Services.

18. Are there any specific UPMC services or hospitals that are still in-network if I have a Highmark Medicare Advantage plan?

Most UPMC providers and hospitals in Greater Pittsburgh and Erie will be out-of-network for Highmark Medicare Advantage members after June 30, 2019. However, there are certain UPMC services and hospitals that will continue to be in-network, as described further below.

Please be aware that these exceptions may not apply to certain "no UPMC" Highmark insurance plans, such as My Direct Blue and Community Blue Medicare HMO/PPO, which are designed to be out-of-network for all UPMC providers (although My Direct Blue is in-network at UPMC Children's Hospital of Pittsburgh). You should check with Highmark to see if your coverage is a "no UPMC" plan, in which case you would not have in-network access under these exceptions.

As always, it is best to check with your provider and with your insurer on the status of a provider in which you wish to receive care prior to obtaining services from that provider.

For further questions about Medicare Advantage products, please contact the Medicare Services Center at 1-800-MEDICARE. For Pennsylvanians seeking assistance with Medicare coverage, you can contact the toll-free APPRISE helpline at 1-800-783-7067.

Pursuant to ongoing contracts between the parties, Highmark's Medicare Advantage enrollees have the following access to UPMC facilities:

UPMC hospitals in the greater Pittsburgh area continuing to contract with Highmark insurance at in-network rates:

Greater Pittsburgh Area Hospitals	In-Network	Out-of-Network
UPMC Children's Hospital of Pittsburgh	✔	
UPMC Magee-Womens Hospital		✘
UPMC East		✘
UPMC McKeesport		✘
UPMC Mercy		✘
UPMC Montefiore		✘
UPMC Passavant (both campuses)		✘
UPMC Presbyterian		✘
UPMC St. Margaret		✘
UPMC Shadyside		✘
UPMC Hillman Cancer Center at UPMC Shadyside		✘
UPMC Western Psychiatric Hospital	✔	

In Western PA, UPMC hospitals continuing to contract with Highmark insurance at in-network rates:

Western PA Hospitals	In-Network	Out-of-Network
UPMC Altoona	✔	
UPMC Bedford	✔	
UPMC Hamot		✘
UPMC Horizon (both campuses)	✔	
UPMC Jameson	✔	
UPMC Kane	✔	
UPMC Northwest	✔	

In Central and Eastern PA, UPMC hospitals continuing to contract with Highmark insurance at In-network rates:

Central and Eastern PA Hospitals (After 6/30/19)	In-Network	Out-of-Network
UPMC Cole	✔	
UPMC Pinnacle Carlisle	✔	
UPMC Pinnacle Community Osteopathic in Harrisburg	✔	
UPMC Pinnacle Hanover	✔	
UPMC Pinnacle Harrisburg	✔	
UPMC Pinnacle Lancaster	✔	

UPMC Pinnacle Lititz	✔	
UPMC Pinnacle Memorial in York	✔	
UPMC Pinnacle West Shore in Mechanicsburg	✔	
UPMC Susquehanna Divine Providence in Williamsport	✔	
UPMC Susquehanna Lock Haven	✔	
UPMC Susquehanna Muncy Valley	✔	
UPMC Susquehanna Soldiers & Sailors in Wellsboro	✔	
UPMC Susquehanna Sunbury	✔	
UPMC Susquehanna Williamsport Regional	✔	

In the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark at In-network rates until 2021:

CANCER CENTERS	CENTER TYPE
Excela Arnold Palmer Medical Oncology, Mt. Pleasant	Medical Oncology Center
Excela Arnold Palmer Medical Oncology, North Huntingdon	Medical Oncology Center
Heritage Valley Radiation Oncology at UPMC West	Radiation Oncology Center
UPMC/St. Clair Hospital Cancer Center	Radiation Oncology Center
Heritage Valley Radiation Oncology Beaver	Radiation Oncology Center
Washington Health System Radiation Oncology	Radiation Oncology Center
Butler Health System Medical and Radiation Oncology	Medical & Radiation Oncology Centers
Excela Arnold Palmer Cancer Center	Medical & Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2021:

The Regional Cancer Center, Erie	Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2024:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Johnstown	Medical Oncology Center

Grove City Medical Oncology (limited Med Oncology services)	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Greenville	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Windber	Medical Oncology Center
John P. Murtha Regional Cancer Center	Radiation Oncology Center
Uniontown Hospital Radiation Oncology, Robert E. Eberly Pavilion	Radiation Oncology Center
Jameson Radiation Oncology	Radiation Oncology Center
UPMC Cancer Center at UPMC Altoona	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Horizon	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Northwest	Medical & Radiation Oncology Centers

19. Where can I ask more questions or file a complaint?

If you have questions or wish to file a complaint, there are various options for you to obtain assistance.

- If you are a Highmark health plan member with questions about your coverage, call the Member Service phone number on the back of your insurance card.
- Speak to your provider.
- If you wish to file a complaint, you can contact the Pennsylvania Insurance Department at the following:

  1209 Strawberry Square
  Harrisburg, PA 17120
  Toll-free: 1-877-881-6388
  Fax: (717) 787-8585
  tty/tdd: (717) 783-3898
  A complaint form can be accessed from the Insurance Department's website: www.insurance.pa.gov

Please note that the answers to these FAQs describe the current status as of the time of this posting. The Pennsylvania Insurance Department will update the information when and if new information becomes available.

Appendix 5

Excerpts of October 10, 2014 testimony by Executive Deputy Attorney General James A. Donahue, III, to the Pennsylvania House Democratic Policy Committee.

UPMC submitted a link to video of Mr. Donahue's testimony (available at **https://wdrv.it/39aa0b6df**) to the Commonwealth Court as Exhibit G to UPMC's Feb. 21, 2019 Motion to Dismiss.

Highlighting added for the Court's convenience.

UPMC LIFE CHANGING MEDICINE

PENNSYLVANIA HOUSE OF REPRESENTATIVES
DEMOCRATIC POLICY COMMITTEE HEARING
AT POINT PARK UNIVERSITY
October 10, 2014

Rep. DeLuca

Good Morning everyone. Let me first of all thank Point Park for having us here, this is a beautiful facility here and I want to thank them for hosting this group today for us for this very important policy hearing regarding the Consent Decree with Highmark and UPMC. I also want to recognize Paul Costa who is a board member with Point Park and Paul you're doing a heck of a job here at Point Park, I just seen a big, a lot of money just came in, somebody just donated a lot of money so that means it's really moving ahead. I want to welcome everyone here today this morning to this democratic policy committee meeting on the impending Highmark/UPMC transition and their Consent Decree with the commonwealth. And I want to thank all of our testifiers for appearing here today. Everyone in this room is aware of the long standing dispute between Highmark and UPMC as well as the highly publicized break up that will begin January 1, 2015. Many of us hope for a different outcome and pushed hard to get a new contract. Several members of the General Assembly including Representative Frankel and myself introduced legislation to force a contract through binding arbitration. Unfortunately the republican majority in the legislator refused to bring that legislation up to the vote. As a result, Highmark and UPMC will be ending their contractual relationship at least in regards to the core UPMC facilities in the greater Pittsburgh area. Ladies and gentleman the past is the past. Now we need to start looking forward and do our best to inform the residents of Western Pennsylvania, particularly Highmark cardholders about the specifics of the Consent Decree. While we did not get a new contract, the Department of Health, Insurance Department and the Attorney General's office were able to get both parties to agree to sign a Consent Decree. These Consent Decrees contain some of the provisions that we in the House of democratic caucus fought so hard for. These are documents that will be governing the future of Highmark and UPMC's relationship and that is our focus here today.

We will be joined today by independent representatives of the Western Pennsylvania medical community as well as representatives from UPMC and Highmark. As I stated previously, the Consent Decrees were ultimately the work of three government agencies, The Department of Health, the Insurance Department and the Attorney General's office. While we invited all three agencies involved in the Consent Decrees to appear here, only the Attorney General's office was willing to come and testify. The Corbett administration declined an invitation on this important subject. It would have been helpful to hear from the Insurance Department and the Department of Health since they are the government regulators with prime oversight over both UPMC and Highmark. Testimony from the Department of Health would have been particularly useful given that it is the agency that will hear appeals on (inaudible) of medical treatment under the Consent Decree. However, I want to thank the Attorney General's office for testifying today. While the Attorney General's office is not an expert on the healthcare of insurance practices, its representatives will be able to speak to the enforcement of aspects of the Consent Decree. Again I would like to thank all the members who are participating here today and before I turn it over to Representative Frankel, I would like to have the members and the staff introduce themselves starting from my left.

Representative Chris Sainato, I represent the 9th Legislative District which is in Lawrence, County.

I'm Representative Harry Readshaw, 36th Legislative District, Allegheny County

Shawn Brennan I'm with Representative DeLuca's staff on the House Insurance Committee.

Alan Cohen with Chairman DeLuca, House Insurance Committee.

Chairman DeLuca of the Insurance Committee.

Representative Dan Frankel

Ann Kafricky from Representative Frankel's office

So I just wanted to give you a perspective from both physicians and patients. Over the last number of years thousands of patients that used to either see myself or many of my colleagues, not necessarily just at Allegheny Health Network, had to transition away from our practices to UPMC physician practices for exactly the same reason that this product is being introduced. So my whole point is this is not a unique product, there has been a UPMC Health Plan Medicare Advantage product that's been in existence. Our patients have had to transition out over many years and we've actually facilitated that access because we have to, right. And I just want to make the point that it's been in existence and we, many of us, physicians and patients, have had to deal with this over a period of time.

Rep. DeLuca

Doctor, I don't doubt it's been in existence, but according to the three individuals on that panel they are taking you to court with this product because they disagree with you, okay? John Brennan, do you have a question?

John Brennan

One of the Chairman's biggest issues has been transparency with the Consent Decree and there has been some back and forth regarding the list of physicians that are going to be in network starting next year. Now you talked a bit about the new tool your Network 2015, is that going to clarify for anyone going on there that there are certain physicians that they are say practicing at Altoona, they'll be in network then but when they are primarily they are at say Presbyterian they will not be? Is that going to be clear?

Thomas Fitzpatrick

Yes, the tool was created in cooperation with UPMC. We had exchanged lists of doctors and we had agreed upon a footnote that is prevalent on the website so there are certain physicians on the – your Network 2015 site that have an asterisk but then call to the member to look at that footnote. That again was agreed upon between the two organizations that clearly spells out that these physicians are only in network when they are practicing at in network facilities, and it lists all of those exceptions that I just laid out. So again we want to be as clear as possible, we want to eliminate as much confusion as possible. And again we welcome you know the opportunity to clarify. Our position going in with respect to physicians was we believed that they should be either always in or always out, and we had communicated this to the state, to UPMC and we knew that there was an opportunity for this confusion. So we will do everything that we can, again taking you know updates and working in cooperation with UPMC to update the site and make sure that it is as accurate as possible.

John Brennan

Thank you.
Rep. DeLuca

Thank you gentlemen, I want to thank you for your time in taking the questions and thank you very much and we look forward to working with you and UPMC in the future. Thank you very much. Our next individual to testify will be the James Donahue with the Executive Deputy Attorney General, Pennsylvania Office of Attorney General. James? I want to thank you for coming and I want to thank Attorney General Kane for permitting you to come to testify here at this meeting today. Thank you very much.

James Donahue III

You are welcome, Chairman DeLuca. Chairman DeLuca, member of the Committee thank you for the opportunity to talk to you today about our efforts regarding the disputes between UPMC and Highmark and the Consent Decree we entered into with them on June 27, 2014. I will address three main points today. First is how we came to the Decree as the appropriate resolution of the dispute between Highmark and UPMC, the underlying principles under

the Decree and how the Decree is going so far. UPMC's announcement in 2011 that it would no longer contract with Highmark for a full range of services raised tremendous concern in Western Pennsylvania. The simple question we faced was could we force UPMC and Highmark to contract with each other? We concluded that we could not for several reasons. First, there is no statutory basis to make UPMC and Highmark contract with each other. There is an act, Act 94, which limits certain special corporations, health, hospital plan corporations from terminating hospital contracts; but ultimately those contracts can expire. Second, the disputes that we see here that exist between Highmark and UPMC are similar to although less publicly known than disputes between health plans and hospitals around the country. These disputes over how, what the terms of contracts are go on every day and there are very vigorous and acrimonious disputes going on with many hospital systems and many health plans throughout the Commonwealth. If we forced a resolution in this case we really could not avoid trying to force a similar resolution in all those other situations and that is just simply an unworkable method of dealing with these problems. Third, the contracting process involves two parties willingly coming to an agreement. By us trying to force the parties to enter into an agreement we would be putting our finger on the scale so to speak and having effects that we aren't quite sure what those effects would be. And in particular we wouldn't be sure about what the price effects that we would impose would be. In contract negotiations one of the key things is that each party has the ability to walk away from the negotiations. That ability to walk away forces each side to be reasonable in most circumstances, putting our finger on the scale in favor of one side or the other changes that dynamic in ways that are unpredictable. And one of the key things here in most contract negotiations is price, and price is at the heart of the dispute between Highmark and UPMC, and there is no mechanism in Pennsylvania for resolving this price dispute. Other states like Maryland have such a mechanism for resolving price disputes between hospitals and health plans, but we don't have that statutory tool here.

So we looked at the core issues and we had two nonprofit corporations that had certain unique assets that were not available anywhere else. In addition consumers could suffer dramatic consequences if they only had access to healthcare on an out of network basis. So we looked to do two things, protect those who were vulnerable and who would be objects of charity; and to ensure that consumers who had Highmark insurance would not be out of network when they absolutely had to seek care from UPMC. So the principles that guided us were these. First, that UPMC and Highmark had to have a contract with each other, in those circumstances when contact between the two was unavoidable, specifically Highmark subscribers had to be treated on an in network basis when they had to do things like go to the ER. Second, we had to protect the most vulnerable members of the community, the poor, the elderly and children. The Consent Decree we, with the Departments of Insurance and Health, entered into achieves these goals. Vulnerable populations, children, the poor and elderly have access to UPMC assets. Consumers who need emergency room care, cancer care or services where UPMC is the only provider such as the case in Bedford or with Western Psychiatric Institute have in network access. The Consent Decree means that some consumers who have been using UPMC and have Highmark insurance will need to switch their doctor, if they do not fall within one of the protected categories. We believe that the categories we protected address the circumstances where an access to UPMC is most important.

The Consent Decrees are admittedly very complicated and I know here are a lot of questions. Consequently I can't say things have gone as smoothly as we would have liked. One of the things that has come up has been this new Medicare Advantage plan that Highmark has launched recently that has a very narrow network that excludes UPMC hospitals. We are going to make a filing with the Commonwealth Court later today seeking an injunction to make that plan comply with the Consent Decree. We have a couple of problems with what Highmark has done. One is, as has been pointed out earlier today, immediately after the Consent Decree was signed they took out advertising throughout Western Pennsylvania saying that all seniors will have access to UPMC. Secondly, we have a vulnerable population provision which specifically says seniors will have access to UPMC. And thirdly, there is some broad protections for ER, oncology and the exception hospitals that are included in the Consent Decree that aren't being followed either. You know we are not happy about this. You know as Highmark has indicated they have – they believe they have good reasons for doing what they are doing, and we expect that they will fight our efforts vigorously. And I also want to be clear is our effort is not to remove a zero dollar product from the market, our effort will be to make sure that zero dollar product complies with the Consent Decree.

Appendix 6

July 5, 2018, Pittsburgh Post-Gazette article, "A year away, end of UPMC-Highmark agreement has lost its sting," by Steve Twedt.

Highlighting added for the Court's convenience.

post-gazette.com
Pittsburgh Post-Gazette

A year away, end of UPMC-Highmark agreement has lost its sting

July 5, 2018 7:15 AM

By Steve Twedt / Pittsburgh Post-Gazette

After 2,615 days — nearly twice as long as that more widely known civil war fought in the 1860s — UPMC and Highmark will officially go their separate ways on July 1, 2019.

The question is: Who will notice?

"A lot of the transition work has already been done. We believe we have prepared our members," said Tom Fitzpatrick, Highmark senior vice president, last week. "We expect this is going to be a non-event."

"I think both sides have moved beyond the point where Highmark says there has to be a contract," offered UPMC spokesman Paul Wood. "The market has pretty much adapted."

One year out, the pending Highmark-UPMC split does not appear as scary as it did on May 2, 2012, when then-Gov. Tom Corbett pushed the two parties to extend their in-network contract another two years.

Or even in June 2014 when state officials stepped in again, steering Highmark and UPMC to sign two near-identical five-year consent decrees spelling out how these two health giants who'd dominated the Pittsburgh health insurance market (Highmark) and ran most of the hospitals (UPMC) would break up.

The two sides talk weekly now — an improvement from the consent decree negotiations during which Highmark and UPMC officials did not sit in the same room as state officials shuttle-mediated the agreements.

The conversations today are all business, sorting out the remaining details of the divorce.

"I don't think there will be a peaceful co-existence, unfortunately," said Mr. Fitzpatrick.

Still, it could have been so much worse.

Predictions the past seven years have swung from the dire to the disbelieving: Some foresaw hundreds of patients wrenched from longtime, suddenly-out-of-network doctors while others remained certain the two would reach some last-minute agreement.

Robert Morris University professor and former hospital administrator Stephen Foreman includes himself in the latter group.

"I figured these people would stop fighting, and, boy, that sure hasn't happened," he said last week. "Instead they've taken the fight statewide."

But most people appear to have made their choices by now, whether it involved changing doctors and hospital networks or changing health insurance plans. Locally, the fight now is for subscribers' hearts, minds and premiums.

The two organizations' strategies could hardly be more different: Highmark emphasizes its "value-based" care, bringing medical services into the community so people get the right care in the right venue at the right time.

"We're pretty tenacious competitors," said Mr. Fitzpatrick. "We're going to win on the field."

UPMC, meanwhile, offers its global reputation for cutting-edge research and medical care, and some of the lowest cost individual marketplace plans anywhere.

Mr. Wood said increased competition among insurers in the commercial and government plan sectors, too, has helped keep insurance costs here in check. "We went from one of the most highly concentrated and least competitive markets in the nation to one that's probably one of the more competitive and pro-consumer markets in the nation, offering some extremely low-cost health plans."

Each side already has its individual victories to declare.

"Virtually every employer is offering their employees a way to get to UPMC, either by offering UPMC Health Plan alongside of Highmark, or offering a national insurer alongside with Highmark, or replacing Highmark with UPMC Health Plan or a national insurer," said Mr. Wood.

"We're seeing that across the board."

Mr. Fitzpatrick, though, said Highmark enjoys 94-95 percent subscriber retention rates, "higher than they've ever been."

Its provider arm is finding its financial footing, too.

In December 2011, the auditing firm KPMG raised doubts that the core hospitals now comprising Allegheny Health Network, known then as West Penn Allegheny Health System, could survive. After multiple financial infusions from Highmark Health, AHN recently reported a positive $1.5 million operating income in the first quarter this year.

Over the next five years, UPMC plans to spend $2 billion to build three world-class specialty hospitals inside Pittsburgh city limits while AHN dots the region with a network of five neighborhood hospitals, part of its $700 million plans for construction, expansion and renovation throughout its network.

Those plans cement the roles of both entities as critically important players to the region, providing both access to care and thousands of jobs. "We can't afford to have either one go under," said Mr. Foreman, a health care administration professor at RMU.

But he does worry about the attached cost, both for construction and as a result of having two systems offering duplicative services, sometimes within blocks of each other.

"They've invested so much money in this competition," he said. "The thing I'm worried about is the sort of collective effect over time. Are we going to continue to see the capital investment we're seeing?"

At some point, he said, that's bound to be reflected in higher premiums for consumers.

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Appendix 7

February 2, 2019, Modern Healthcare article, "CFO Karen Hanlon says Highmark is moving past the UPMC conflict," by Tara Bannow.

Highlighting added for the Court's convenience.

Modern Healthcare

February 02, 2019 12:00 AM

Q&A: CFO Karen Hanlon says Highmark is moving past the UPMC conflict

TARA BANNOW

Highmark Health CFO Karen Hanlon

Highmark Health CFO Karen Hanlon says the integrated delivery system is focused on expanding some of its value-based initiatives.

For nearly a decade, Highmark Health and UPMC were embroiled in a high-stakes, high-profile dispute over market power in Western Pennsylvania. Their fractured marriage comes to an end June 30. Highmark Health Chief Financial Officer **Karen Hanlon** told Modern Healthcare finance reporter Tara Bannow at the J.P. Morgan Healthcare .Conference in San Francisco last month that the issue is already in the "rear view mirror." Instead, she's focused on furthering Highmark's evolution toward value-based care delivery, finding ways to bring down the cost of drugs and transitioning to her newly created role of chief operating officer. The following is an edited transcript.

MH: When you look at 2019, what are your biggest financial goals? What are your top strategic priorities?

Hanlon: We are both payer and provider. We cover about 5 million insured lives. We own Allegheny Health Network. We have an interest in Penn State Health. So

it's really about continuing to advance that integrative model and move further down the path around our value-based care activities.

If we do that, the financials will take care of themselves. It's about continuing to find ways to increase quality and lower cost.

MH: Do you have specific targeted ways that you plan on doing that?

Hanlon: We have an entire clinical transformation effort that's being led by Dr. Tony Farah, chief medical officer at Highmark Health. He's working in partnership with our health plan people and our provider people, including at Penn State Health, on a wide array of activities.

At the beginning of last year, or the end of 2017, they rolled out an enhanced complex-care model, which takes the highest-acuity cases—they have at least six health conditions—and more proactively engages with them around managing their care.

We'll keep expanding that to more of the population, because honestly, we started with six or more conditions just because we could only manage a certain number of people.

We have an entire set of efforts around something called Right Care, which involves clinically approved best practices around efficient delivery of care. They continue to look at those and roll them out broadly across all of Allegheny Health Network.

MH: What are you doing in terms of working to lower premiums for your members?

Hanlon: We make sure that our care transformation activities are showing the results that we expect them to show, and then, assuming they're reducing costs, we pass that right through in pricing to the customer.

The benefit of being a not-for-profit is it's part of the mission, right? It's part of what we're trying to do.

> “It's really about continuing to advance that integrative care model and move further down the path around our value-based care activities.”

MH: You've entered into valued-based drug-pricing contracts. Do you see that growing?

Hanlon: We do. Pharmacy in general, we've got to figure out how to deal with it, as a healthcare system. So I do expect that will continue.

MH: Can you name a specific disease that you might target, or a drug?

Hanlon: I don't want to name a specific one because there are a few that we're working on right now within our pharmacy group. It's the criteria that you'd expect: the highest-cost items where you're not sure of efficacy and if you're going to pay for it, you better get the outcome that was supposed to have been delivered.

Allegheny Health Network just joined Civica Rx. We're trying to do more through Allegheny Health Network on that side as well. Certainly the shortages are a part of it, but the cost is, too.

MH: What will joining Civica mean for you?

Hanlon: Allegheny Health Network will be one of the founding members. There will be input into what generics should be considered for rollout within Civica.

MH: Do you feel like issues with UPMC have created an image problem with patients or members?

Hanlon: In Western Pennsylvania, because it's a very local issue. Once you move outside of Western Pennsylvania people don't talk about it so much.

It's just something we have to balance because our businesses go well beyond Western Pennsylvania. In that part of the state, I think consumers have been hearing about it for six years. They are ready for this next stage and to not have to be hearing about the end of the contract between two parties. And we're ready to go.

For us, that's really kind of in the rearview mirror. We've built up Allegheny Health Network and it has been competing effectively. We're seeing the results that we want to see. They have refreshed assets, they have new assets. We're ready for it to compete.

MH: How does being an integrated system position you to address the trends in consumerism?

Hanlon: When you think about the real delivery of care and the data around it and the insights and improving care through the data—whether it's a video visit or an in-person visit—I don't think there's anything that differentiates us just because we're an integrated system. But we've dealt with the payment mechanism of it.

From a consumer standpoint, what we're talking about is making care as accessible as possible, as high-quality as possible, and at an affordable cost. On accessibility, the video visits are huge.

MH: Lastly, one of the things that seems to happen at the J.P. Morgan conference is that people are almost using it like a recruiting event. Do you view it that way?

Hanlon: I don't. But as I say that, I'm transitioning from the CFO role to the COO role, and I can't fully transition until I replace myself.

MH: So you don't have a specific effective date?

Hanlon: Right. We've been recruiting. The announcement was made in July and I've been doing a little bit of both jobs, but we need to recruit a CFO. I have actually had a number of discussions since I've been here (at the J.P. Morgan

conference) about, “Hey, we're looking for somebody,” and people have given me names, they're sending me emails, so I laugh and say, “No it's not recruiting,” but it has been a little bit for me.

On the clinical side, and we see it at Allegheny, the systems that declare their commitment to quality, their commitment to the patient, their commitment being clinician-led … have physicians who want to come work there because they feel that it's an environment where their opinions are going to be heard, that they're going to be valued, their ideas will be embraced. It does make a difference.

Inline Play
