ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

2013 REPORT TO THE COMMUNITY

INVESTING

PARTNERING

IMPROVING

Local COMMITMENT, *National* LEADERSHIP

IN THIS REPORT

Many thanks to ACHP member health plans for supplying photos for this report.

LETTER FROM THE PRESIDENT

Dear Friends and Colleagues,

As more Americans gain access to health insurance, the discussion will inevitably shift from a focus on coverage to a focus on care and — most important of all — a focus on health. ACHP member health plans are more than ready for that conversation.

They are ready because they have been leading the way in designing new outcomes-oriented payment arrangements that increase accountability and create incentives for delivering the right care at the right time in the right place. They have been creating new patient-centric models of care that lead to better outcomes. And they have been promoting transparency for providers and patients alike, to help both groups make better decisions.

This report presents examples of the innovative programs and partnerships ACHP member health plans have created to drive better care, better outcomes and lower costs. Working at the local level, these health plans pilot new ideas and creative strategies to address today's challenges and then share and spread their lessons and successes. And as they do, the implications for public policy become clear. This is how local commitment fuels national leadership.

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Patricia

Patricia Smith
President and CEO

ACHP member health plans are working with schools, towns and community organizations to improve health and well-being not just for their members, but for all those who live in the communities they serve.

Investing in the Health of the Community

Bringing Health and Wellness to Campus

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN
Madison, Wisconsin

When Madison College in Wisconsin launched a campaign in 2012 to promote a "Healthy and Well Campus," leaders there knew that one big component of getting healthy and staying well was missing: a campus clinic. The college offered no on-site health care.

So college officials began to talk with leaders at Group Health Cooperative of South Central Wisconsin (GHC-SCW) about how they could address this. The result of those conversations opened in August 2013 — a medical clinic inside a newly constructed Health Education Center on the college's Truax campus. The Madison College Community Clinic, run and staffed by GHC-SCW, offers health and wellness services to Madison College students, full-time employees and retirees.

The clinic is open 40 hours a week and provides primary care, lab and X-ray services, wellness consultations and clinical health education classes. At full capacity, it will serve nearly 9,000 patients per year. Beginning in 2014, the clinic will expand to become a regular GHC-SCW clinic for its members and surrounding businesses.

"In addition to running the clinic, we are working with the college on wellness activities," says Debra Lafler, GHC-SCW's wellness coordinator. "They have a fitness and recreation center, they have student services and now they have the clinic, but they were all working in silos. We encouraged the college to bring people together from these different areas and develop a strategic plan for building a healthy and well campus together." Lafler is working with college staff to develop health and wellness classes and activities.

GHC-SCW Chief Executive Officer Kevin Hayden says this collaboration is a good example of how institutional partners can work together for the good of the community. "Not only can we provide high-quality health care on campus, we can help enrich the current wellness programming to improve the overall health of the college. Anything we can do to contribute to Madison College's success is our way of stepping up to the plate to be a good community partner and corporate citizen," he says.

The partnership creates benefits that will accrue well into the future: Housed in the college's Health Education Center where students are trained, the clinic provides a great opportunity for the next generation of nurses and health care professionals to learn from a local leader in providing high-quality care.

Powering Up for Better Health

HEALTHPARTNERS
Minneapolis, Minnesota

They say it takes a village to raise a child. By spearheading a community-wide youth health initiative involving community leaders from across many sectors, HealthPartners in Minnesota is successfully demonstrating that it also takes a village to raise a *healthy* child.

PowerUp is a comprehensive community initiative focused on childhood obesity prevention in the St. Croix River Valley. Launched in 2012, it is a joint effort by HealthPartners and Lakeview Health, part of the HealthPartners family of organizations. *PowerUp* is just one example of the health system's focus on improving community health, which is part of its strategic business plan. The program is designed to involve the entire community in making it easy, fun and popular for children to eat well and stay active.

"Everyone is at the table," says Donna Zimmerman, senior vice president of government and community relations. "Public health, public schools, businesses, grocers — it is really a multi-stakeholder effort, and led by the local community." While keeping the messages fun and engaging, the underlying strategy of the initiative is more complex, categorized into four levels of action: Environment and Policy; Community Engagement; Programs and Interventions; and Clinical Interventions. The initial focus has been on developing strong partnerships; the full initiative will be rolled out over several years.

Already, however, *PowerUp* has made significant strides. "The local school board issued a *PowerUp* proclamation and committed in its strategic plan to improve student wellness," says Zimmerman. "They've changed concession offerings at football games. They've opened gyms on Friday nights for family physical activity. After-school programs and even local food shelves are offering more healthy options."

PowerUp resources are shared widely throughout the community, including with local restaurants. A new bakery in Stillwater asked for guidance from *PowerUp* about how to increase its healthy choices. The *PowerUp* website is full of tips, ideas and guidance, and gets lots of visits. One parent posted this message on the site: "Because of *PowerUp* we have better eating habits and life skills at home. Our daughters make sure we have four colors on our plates at mealtime."

"This is about promoting a culture change," says Zimmerman. "And one of the most important roles our health plan and clinics can play is to create community engagement. We are invested in this community for the long-term, and we know we can make a positive difference."

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>
> **DONNA ZIMMERMAN**
> Senior Vice President of Government and Community Relations, HealthPartners

Investing in the Future

NEW WEST HEALTH SERVICES

Helena, Montana

Perhaps because it is large in size but small in population, Montana naturally fosters a sense of community. At New West Health Services, that sense of community is strong. "We are Montanans serving Montanans," says Leon Lamoreaux, president and chief executive officer. The health plan, which serves the Medicare population exclusively, demonstrates its commitment to the communities it serves in a wide range of ways.

To its more than 19,000 members, New West offers high-quality, affordable options for care. "We work closely with our providers to see that our members get the care and services they need. We sponsor a program where physicians visit members in their homes to perform comprehensive evaluations and assessments. We've conducted almost 1,700 in-home assessments for our members and identified problems and challenges that we could help to address," says Lamoreaux. "We check medications, make sure there is food available and survey the home for hazards and fall risks. These in-home health assessments are key to ensuring that our members receive comprehensive care, especially for those who see multiple physicians with lots of in-home care instructions and expectations."

What makes New West a special community asset is that it regularly reaches out beyond its own membership to offer support to all seniors. "A rising tide lifts all boats," says Lamoreaux, "so if we can help seniors outside our membership, all the better." The health plan sponsors the statewide Senior Olympics, a retired senior volunteer program, a walk to end Alzheimer's disease and another to raise awareness about mental health issues.

But perhaps the most unexpected community contribution from this health plan that serves mostly older members are the scholarships it awards to Montana college students studying for health care careers. Now in its sixth year, the program has awarded scholarships to more than 60 students. "These are very deserving students, and represent the future of health care. We hope they'll choose to stay in Montana when they are ready to enter their field," says Lamoreaux.

In 2013 New West received a four-star rating from the Centers for Medicare and Medicaid Services and membership also grew by 69 percent over the previous year. Clearly the health plan is doing a lot of things right. "We do well by doing good," says Lamoreaux. "That's part of our philosophy and our mission."

Gaining Ground on Losing Weight

SCOTT & WHITE HEALTH PLAN

Temple, Texas

The toll that obesity takes on the health of Americans is by now well known, and initiatives to address it are widespread. While much of the focus is on curbing childhood obesity — working to influence the habits of the next generation — considerable work is also being done by the nation's health plans to help adults lose weight. One such program being piloted at Scott & White Health Plan is helping members achieve their weight loss goals through medical supervision, education and behavioral modification. This is more likely to result in long-term maintenance of healthy weight.

The weight management program involves starting with a high-protein/low-carbohydrate diet. Patients come to the program either with a referral from their primary care provider or through one of the health plan's disease management programs for conditions such as diabetes.

All patients are screened and cleared by their physicians first, and meet monthly with a clinical pharmacist. Taniyah Dawson, Pharm.D, manages the program, which has four phases. "The first intervention we assign to the patients is self-monitoring. Patients are instructed to keep a diet log on paper or through a phone app," she explains. "This is typically an eye-opening experience, since many people don't realize how many calories they eat every day."

During the first week, patients begin to use meal-replacements (liquid nutritional supplements that substitute for a solid food meal) and are instructed not to exercise. "The body needs time to adapt to the lower-calorie intake," says Dawson. The next two phases involve adding regular exercise regimens and changing behaviors that were identified through their diet readiness survey. Once patients have

reached their goal weight, grocery meals are slowly added back into the diet. “Weight loss varies but the average person will lose two to five pounds per week. The structure of our program begins to create healthier habits for people, so they can maintain the weight loss when they reach their goal.”

Having a clinical pharmacist run the program is an example of the health plan’s innovative style and eye on cost-effective care. “Many physicians’ schedules do not permit them to manage an intense weight loss program and adjust chronic medications,” says Dawson. “Our clinical pharmacists are residency trained and are able to adjust medications if needed while working under a collaborative practice agreement.”

Building Healthier Communities

SECURITY HEALTH PLAN
Marshfield, Wisconsin

Security Health Plan is dedicated to improving and maintaining the health of its members and the communities it serves. Leaders know that to truly affect health, much of their work must take place outside the doctor’s office. “We know that health is impacted about 20 percent by clinical care, and the rest of the influence occurs outside the clinical setting,” says Jay Shrader, M.H.A., wellness and health promotion manager. “Behavior is a huge influence on overall health, and health behavior is often determined by education,

NATIONAL LEADERSHIP MEANS...

Working to Align Physician Payment

ACHP member plans are ahead of the curve when it comes to implementing innovative, patient-centered payment policies. In May, Patrick Courneya, M.D., medical director for HealthPartners in Minneapolis, testified before the U.S. House Ways and Means Subcommittee on Health to explain his organization’s transition into a system of care that holds physicians accountable to quality and performance standards. In June, Thomas Foels, M.D., chief medical officer at Independent Health in Buffalo, provided testimony at a hearing of the U.S. House Energy and Commerce Subcommittee on Health. Dr. Foels illustrated how Independent Health has pioneered local efforts in quality improvement, primary care redesign and implementation of alternative payment systems to help achieve the Triple Aim of improved health, better care and lower costs through programs like The Primary Connection. The ACHP report *Moving Beyond Fee-For-Service: A Path to Payment Reform From Community Health Plans* highlights how seven member health plans have instituted physician payment models that promote value rather than volume. On September 17, ACHP released the paper at a well-attended webinar featuring three member plan directors: Ray Roth, M.D., of Geisinger Health Plan; Dr. Courneya, of HealthPartners; and Paul Kasuba, M.D., of Tufts Health Plan.

health literacy, social and economic factors and the physical environment."

In 2011 Security Health Plan launched a comprehensive community benefits and prevention program designed to influence the health of its members and communities outside the exam room. The program has two components — community benefit programs and charitable contributions — and three main priorities: children's health, health literacy and behavioral health.

These priority areas were chosen after completion of a regional community health needs assessment. "We asked communities what their priorities are for health and what they are trying to accomplish," Shrader says. "We met with stakeholders, looked at data, evaluated our capacity and whether their goals fit with our mission and developed measures to evaluate our impact. We are strong believers in measuring outcomes."

Security Health Plan allocated $150,000 for Healthy Community mini-grants to implement community projects or enhance existing programs. In addition to grants, the health plan is also a strong believer in partnerships. Shrader says that he and his colleagues especially like to roll up their sleeves and get involved in community programs. "We are not just a sponsor, we are a partner. We want to work together, to help design initiatives and programs, to solve problems."

Being a community health plan has everything to do with this desire to get personally involved in improving health, says Shrader. "Our staff is embedded in our community," he says. "We are involved in numerous community boards and committees. We are coaches and neighbors and volunteers. Security is a small health plan with a big investment in our communities, and I can't think of a better organization to drive toward the goal of better health for everyone."

Reaching Out to the Underserved

PRESBYTERIAN HEALTH PLAN
Albuquerque, New Mexico

In 2012 the state of New Mexico decided to reform and streamline its Medicaid program to improve service and efficiency, shrinking the list of contractors from seven to four. Presbyterian Health Plan was selected to be one of those four, beating out several national carriers. "In fact," says Mary Eden, vice president of government programs, "we were the top-scoring health plan in the RFP process."

The state's new Medicaid program, Centennial Care, kicks off on January 1, 2014. It is organized around four components: a comprehensive service delivery system, personal responsibility, payment reform and administrative simplification. Previously, different organizations provided physical health, behavioral health and long-term services and support for Medicaid recipients, and under the new model each of the four plans will provide the comprehensive list of services to all populations. Contractors will be at risk for all services, and members will be required to pay modest co-payments for things like inappropriate ER use or using brand-name medications when generics are available.

In addition to streamlining the Medicaid program, the state is also looking to expand Medicaid, holding outreach events around the state to tell people about Centennial Care. Medicaid currently covers one in four New Mexicans, but after the expansion that figure is expected to be one in three. "We are working very hard to prepare for this. The transition period will continue six months from go-live," says Eden, because members will be shifting out of plans that will no longer offer Medicaid coverage into a new system.

Eden feels that Presbyterian is especially well suited to take on the expanded Medicaid role because it is the only one of the four contractors that is part of an integrated health system. "We appreciate the provider's perspective," she says. "We ensure that our administrative processes are not overly burdensome to providers, and that is really important."

"The stakes are high," says Eden. "We are from this community, and our statewide survey shows that we are the most trusted health care organization. We have to do right by our customers." The health plan's experience helps. "We know the community and they know us. We can speak to the nuances of New Mexico and the challenges to a state that is disproportionately low-income, that has many underserved markets and communities. We care, and our members know that."

Partnering with Providers and Community Services

Creative collaborations and strategic alliances among health plans, providers and other stakeholders are resulting in better care and support for patients in the doctor's office and at home.

Bridging Medical and Behavioral Health

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN
Albany, New York

Capital District Physicians' Health Plan (CDPHP®) calls its medical home model of integrated care Enhanced Primary Care. No matter what you call it, the health plan is successfully demonstrating that integrated, coordinated care is better for patients, providers and health plans alike.

"We have embedded behavioral health case managers in primary care practices to work closely with the medical staff and help facilitate behavioral health care," explains Robert Holtz, M.A., M.B.A., L.M.H.C., vice president of behavioral health services. "The ultimate goal is medical integration: to coordinate care for people with multiple needs and doctors." Behavioral health case managers often work closely with medical case managers to achieve this integration.

Primary care providers can refer patients to the behavioral health case manager, or the case manager might identify patients who would benefit from care coordination. This can occur through predictive modeling or by looking at patient data on emergency department (ED) visits or hospitalizations. Case managers triage cases to determine which ones can be positively affected by referral to behavioral health professionals, meet directly with patients to create care plans and self-management goals and provide coaching and follow-up for patients as needed.

Enabling patients to meet easily in-person with a behavioral health professional is the first step toward building a therapeutic relationship, says Holtz, who specialized in addiction during his 20 years as a mental health counselor prior to taking on his current role. "Relationships enable us to have more buy-in from our patients."

CDPHP currently employs three behavioral health case managers who split their time among seven primary care practices. Among 161 members from one practice who were referred to behavioral health case management, 21 percent worked with both behavioral and medical case managers. Comparative cost data before and after the behavioral health intervention shows a

total savings for that practice of more than $200,000, the result of 102 fewer hospital admissions and ED visits.

What's more, says Holtz, primary care providers are pleased with the arrangement. A survey among the physicians who work with embedded behavioral case managers showed overall satisfaction of 2.9 on a 3-point scale; time saving of 30 minutes to six hours per week; an estimated 50 to 100 percent improvement in care coordination; and unanimous agreement to recommend the model to others.

Supporting the Most Complex Patients

FALLON COMMUNITY HEALTH PLAN
Worcester, Massachusetts

In September 2013 Fallon Community Health Plan (FCHP) became the nation's first health plan to enroll members in a new program for adults between the ages of 21 and 64 who are dually eligible for both Medicare and Medicaid.

Fallon Total Care, a wholly-owned subsidiary of FCHP, is an integrated approach to coordinating behavioral and medical care with community support, providing members with more benefits than Medicare and Medicaid combined.

"This is a population with complex needs," says Patrick Hughes, president and CEO of FCHP. The fragmented care typically received is not only a quality issue, it is also costly. "This plan is designed to improve the quality of care, the member's experience of care and to bring down the cost."

> "We have partnered with a lot of services this [dual-eligible] population needs, like adult day health centers, home services and transportation. The goal is to provide support that helps our members achieve or maintain better health and live independently."
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> **MARY RITTER**
> President, Fallon Total Care

In this "member-centric" model of care, each member is supported by a navigator who serves as an advocate, coordinator and a single point of contact within an interdisciplinary care team that includes health professionals and community-based support.

To develop an individualized care plan, a nurse and navigator visit each member's home to perform a thorough medical assessment and talk with the member about his or her needs and priorities. The care plan usually includes more than traditional health care. "Food security is often an issue," says Mary Ritter, president of Fallon Total Care, "so we might arrange for Meals on Wheels to be delivered." A pharmacist also performs a thorough medication review and reconciliation, especially important for people who take multiple medications prescribed by different providers.

Ritter says this initiative requires a robust network of professionals that goes beyond the traditional provider network. "We have partnered with a lot of services this population needs, like adult day health centers, home services and transportation. The goal is to provide support that helps our members achieve or maintain better health and live independently."

As the program unfolds, Ritter says FCHP will use more than 100 measures to gauge its effect, with a goal of providing the right care in the right setting, reducing unnecessary emergency room visits. Measures include short-term goals such as the percent of enrollees with an in-person assessment for care planning purposes completed within 90 days of enrollment, and longer-term measures such as results of a member quality-of-life survey. Ritter is excited about the possibilities this initiative represents,

and not just for this specific population. "Really," she asks, "isn't this how all health care should be delivered?"

Delivering Home-Based Primary Care

PRIORITY HEALTH
Grand Rapids, Michigan

At 82, Florence lives alone with her cat Abby. She also lives with congestive heart failure, diabetes, coronary artery disease and some dementia. Her niece looks after her, but the complexity of her aunt's needs makes that challenging. As a result, Florence is in and out of the ER and the hospital frequently.

This is just the sort of patient for whom Priority Health created its new *Home-Based Primary Care* (HBPC) program, which provides chronically ill patients support where they need it the most — at home.

HBPC provides each patient who qualifies for the program with a primary care team that includes a physician, nurse practitioner, registered nurse case manager and social worker. Patients receive a complete health assessment; around-the-clock medical support; a patient-specific plan of care that evolves as needs change; a nurse care manager to monitor patient care; occupational, physical, respiratory and speech therapy; and education about medications, telemonitoring procedures and health emergency preparedness.

NATIONAL LEADERSHIP MEANS...

Strengthening Primary Care

Revitalizing and growing primary care is one critical component of achieving sustainable health care reform and helping reduce the medical cost trend. In April, ACHP published its report, *Strengthening Primary Care for Patients*, which describes efforts undertaken by 17 of its member organizations to improve the U.S. health care system by transforming primary care. It focuses on key components of primary care redesign, such as having the right infrastructure and transparency of information, as well as the potential for improved patient care. The report has been shared with legislators and members of the Administration.

"This initiative grew out of a deep dive into our Medicare data," says Mary Cooley, R.N., B.S.N., M.S., C.C.M., director of care management. "We had a segment of our population whose conditions were poorly managed despite our best efforts. These are people who just cannot reliably access the traditional system of care. And through our visits, we have found people living with incredible challenges, who might have been considered 'non-compliant' when maybe they simply have no transportation, or lack the cognitive processing or supportive care that would enable them to manage a complex treatment regimen."

Telemonitoring technology is an important part of this initiative, with devices in patients' homes that can measure and automatically report weight, blood pressure, blood glucose levels and general well-being. "We even have a small device that asks the patient questions every morning, and soon we'll be starting videoconferencing," says Cooley.

It is too early to measure the overall effect of HBPC because the program is still relatively new, but Cooley says that early data shows about a 50 percent reduction in utilization and 20 percent reduction in cost of care for this population. As for Florence, her HBPC team is currently creating a plan of care to meet her needs, keeping her at home as long and as safely as possible.

Helping Doctors Care for the Whole Patient

ROCKY MOUNTAIN HEALTH PLANS
Grand Junction, Colorado

In the 1980s and '90s state Medicaid programs and private health plans began to "carve out" behavioral health care, contracting with behavioral health networks that operate under

separate financing and care management agreements. But data show that 40 to 80 percent of patients with mental health, behavioral health or substance abuse disorders receive care and prescriptions from a primary care provider. Further, since patient behavior drives a far larger share of future outcomes and costs than the health care itself, there is a growing consensus that it makes sense to integrate the two disciplines more closely, rather than keep them separate.

Leaders at Rocky Mountain Health Plans (RMHP) agree, and they have embarked on a bold program to create a sustainable model that integrates behavioral health and primary care. This innovative pilot program, which provides a global behavioral health payment to providers of comprehensive primary care, is a collaborative endeavor including RMHP, the Collaborative Family Healthcare Association and the University of Colorado Denver Department of Family Medicine, with evaluation funding support from the Colorado Health Foundation.

The idea behind the pilot is simple: Change how care is paid for, empower primary care groups to support the whole patient and address behavior as a key driver in patient health. The pilot initiative involves comparing the changes in cost and outcomes in three integrated practices reimbursed with a global behavioral health payment mechanism to three control sites that are also integrated but use traditional payment models.

Patrick Gordon, associate vice president with RMHP, says that meaningful change to the way care is delivered will not happen without payment reform. Research shows that the additional expense of providing mental/behavioral health services in primary care is offset by the reduction in associated health care costs. Integrated care can offer better access to treatment and better outcomes, but traditional fee-for-service reimbursement is at odds with this model.

To assess the effect of the initiative, RMHP and its partners will measure patient activation; practice experiences in clinical process and culture change; the impact of the model upon intermediate health outcomes and risks, such as depression, anxiety and substance use; emergency department utilization; and other cost drivers.

Committing to Integrated Care

KAISER PERMANENTE
Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington and Washington, D.C.

An emphasis on prevention is in Kaiser Permanente's very DNA, says Raymond Baxter, Ph.D., senior vice president for community benefit, research and health policy. "Kaiser Permanente began in the shipyards and industrial areas where workplace safety was a big issue, and it made people very aware of how the environment outside of health care can influence health," he says.

The very latest manifestation of this philosophy is called *Total Health*, and it is the health plan's ambitious commitment to help its members, its workforce, their families and surrounding communities achieve a state of complete physical, mental and social well-being. How? By promoting and integrating clinical, educational, environmental and social actions that improve health.

"We are pushing against the limits of conventional medicine," says Baxter. "There are forces in the home, school, workplace and community that are still undermining people's health. We can deliver the most effective care possible, and people can still come back in poorer health the next time we see them. If we are going to make the next step in improving and maintaining health, we have to be engaged outside our walls on a scale that no care delivery system has been."

Total Health requires Kaiser Permanente to deploy all its assets, says Baxter, from clinical care and prevention to research, from community health initiatives to shaping public policy. The *Total Health* portfolio includes focus areas, beginning with schools and workforce wellness; core clinical capabilities, such as the KP Integrated Care Model and proven behavior change strategies; and population strategies, such as *Every Body Walk!*, a comprehensive, national public awareness campaign aimed at getting people up and moving every day.

Baxter is clear that promoting broad and meaningful change requires a multi-dimensional approach by a multi-faceted

consortium of partners. "We have a lot of experience with what it takes to mount a powerful community health intervention," he says. "But we can't do everything, and there are other people and organizations that have skills we don't have. The care delivery system has tended to stay away from issues like housing, for example, because we think that's not our job. But we have to recognize the importance of stable housing to health and well-being, and if we can connect our members with those resources, that's an important thing for us to do."

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RAYMOND BAXTER, PH.D.
Senior Vice President for Community Benefit, Research and Health Policy, Kaiser Permanente

Empowering Primary Care Physicians to Improve Care

INDEPENDENT HEALTH
Buffalo, New York

In the summer of 2012, Independent Health launched an innovative initiative to significantly redesign and improve the delivery of health care. That effort, called *The Primary Connection*, is paying off in higher-quality care and lower costs.

The Primary Connection is an alliance between the health plan and more than 25 pioneering primary care practices, built on patient-centered medical home principles. It features the use of Practice Care Coordinators (PCC), registered nurses employed by Independent Health who work onsite at each primary care practice as extended case managers. Working collaboratively with the office practice to optimize a member's care, the PCC plans, coordinates and evaluates available care options and services to develop an individualized care plan. In addition, a resource bank of pharmacists, behavioral therapists, nutritionists, dieticians and practice management consultants is shared by the practices.

A reimbursement model based on pay-for-value and quality care rather than full reliance on fee-for-service promotes efficient, effective care delivery. Independent Health provides each practice with data and analytics to help physicians identify opportunities for improvement and work toward better outcomes for patients.

Donald Robinson, M.D., one of *The Primary Connection*'s architects and chair of its Leadership Council, explains that data give primary care physicians unusual leverage with specialists. "Transparency of a cardiologist's quality, cost and patient satisfaction data, for example, allows the primary care physician to engage in an active dialogue about improvement opportunities with their referral specialists. Subsequent referrals are then based on known performance criteria, rather than simply subjective experiences." One of the key benefits of this model, says Robinson, is that it empowers primary care physicians to play a key role in improving the health care system.

Even with improved quality measures for diabetic, asthma and cardiac patients, and an estimated savings of $1.4 million in medical costs during *The Primary Connection*'s first six months, Independent Health's chief medical officer, Thomas Foels, M.D., says it is too soon to measure its true effect on health and costs. "Transformational work doesn't happen in a day. Like a newly planted seed, it must be

NATIONAL LEADERSHIP MEANS...

Promoting Quality and Efficiency

In 2013 ACHP member plans comprised a remarkably disproportionate share of the nation's highest-quality health plans, according to NCQA health insurance plan rankings and the CMS Medicare Advantage Star Ratings. While ACHP member plans enroll nearly 17 million Americans across the country in commercial, Medicare and Medicaid products, this represents less than 7 percent of the total insured population in the United States. Nonetheless, more than half of the top 25 Medicare, Medicaid and commercial plans ranked by NCQA were ACHP member plans. Additionally, more than 20 percent of the 4-, 4.5-, and 5-star Medicare Advantage plans are ACHP member plans.

The Medicare Star Ratings program – which serves as the basis for paying for value in the Medicare program and which ACHP has been instrumental in developing and supporting – has already had an impact on the quality of care that MA enrollees receive. Quality incentive payments are improving quality across the board, with overall scores increasing in all MA plans, not just ACHP member plans. ACHP has talked with CMS and the Administration about ways to encourage consumers to enroll in high-quality, high-value health plans.

nurtured and given time to grow. We won't really understand the results for another two to four years."

Collaborating Across Borders and Boundaries

SELECTHEALTH
Murray, Utah

Utah-based SelectHealth has embarked on a unique partnership with St. Luke's Health System in Idaho to use shared accountability to drive down costs and improve health outcomes.

Supported by BrightPath, an Idaho-based network of physicians and health care facilities, the partnership will transition away from traditional fee-for-service reimbursement to a "pay-for-value" model that aligns incentives for the health plan, St. Luke's, the physician network and patients — to control costs while also improving health.

SelectHealth is owned by Intermountain Health Care, and shared accountability is part of Intermountain's strategic vision, says Stephen Barlow, M.D., chief medical officer and vice president at SelectHealth. "Intermountain set a corporate goal for fully insured large group premium rates to be no more than CPI plus one percent," he says. The Consumer Price Index is an economic indicator that measures changes in prices and, therefore, inflation. Barlow estimates that over recent years large-group premium rates have been around CPI

plus four percent.

"So how do you put the delivery system on a financial diet and maintain the infrastructure and the quality?" asks Barlow. "How do you create a model that doesn't penalize providers financially for doing the right thing? How do you transition from the current fee-for-service financial structure to a structure where the delivery system takes risks?"

This challenge is shared by health systems throughout the nation, says Barlow, and in addition to new reimbursement models the answer also involves redesigning care delivery and boosting patient engagement. "Cutting down unnecessary ER use is a good example of something that is better for the system and better for the patient," he says. "So we're piloting community-based care managers who visit high-risk patients at home to assess their needs and provide more support."

Patients can share in accountability when they are well-educated about care and treatment options and when financial incentives are tied to benefit and provider choices. "We are working to standardize patient education materials across our many entities, and we've launched a shared decision-making initiative to involve patients more fully in treatment choices," explains Barlow.

About the pioneering aspect of the alliance, Barlow says, "There is no blueprint for this. We know what the current problems are, and where we want to end up. What we're really focused on now is getting there."

Partnering to Deliver Comprehensive Care

MARTIN'S POINT HEALTH CARE
Portland, Maine

It's a bit of a catch-22: Patients who could benefit from home-based health services only qualify if they are officially classified as "home-bound." But staying engaged in life outside the home is important, especially for seniors, so many people resist this label. As a result, they don't get the support they need, which often leads to further decline, emergency room visits and hospitalizations.

At Martin's Point Health Care, leaders thought there might be a better way. "We removed that huge barrier of requiring that people be home-bound," says Anne Davis, director of health management, describing the home health program the health plan is piloting for congestive heart failure patients. Working in partnership with a local home health care vendor, Martin's Point is bringing daily monitoring and care to the homes of those who are not home-bound but are still at high risk for ER visits or hospitalizations.

"For the most part, congestive heart failure patients can avoid those hospital visits and admissions with the help of a home health nurse who can help manage their health and facilitate better communication with their primary care physician and cardiologist," says Ellen Harrison, vice president of medical management.

The home health nurses are specially trained in the care of heart failure patients, and use guidelines with standing orders from physicians that allow nurses to assess the patient and the home, close some gaps in care, order lab work and provide patient education. Telehealth devices such as scales and blood pressure monitors send daily data to clinical care managers for evaluation.

The program also involves collaborating with support services in the community, says Davis. "We identify resources such as Meals on Wheels or transportation services that can make a big difference in how well patients do at home," she says.

The program will ramp up slowly, says Harrison, so the plan can learn what works best before making it more broadly available. "We already know that it is really important to do your homework up front and identify folks who can benefit the most from this model," she says. The health plan estimates that there are about 300 potential patients in the pilot area who could be helped by the program.

Better health care, better health and lower costs: ACHP health plans are leading the way toward these important goals with programs that reduce hospital readmissions, deliver more integrated care and support patient decision-making.

Improving Quality and Affordability

Helping Physicians and Patients Choose Wisely

CAPITAL HEALTH PLAN
Tallahassee, Florida

It is commonly said that it takes about 17 years for new evidence about best medical practice to make its way into everyday use in doctors' offices. Capital Health Plan is engaged in a focused effort to shorten that timeframe. As a result, health plan members are reaping two benefits: improved quality of care, and reduced waste through the elimination of unnecessary care.

"There are a lot of procedures and therapies that are done by habit, but the evidence no longer supports them," says Nancy Van Vessem, M.D., chief medical officer. So Capital Health Plan has embraced a national effort called *Choosing Wisely*, a joint initiative of the American Board of Internal Medicine Foundation and *Consumer Reports* designed to educate both patients and physicians about tests and procedures that are often done unnecessarily.

Choosing Wisely asks professional medical organizations to identify five common tests or treatments in their field that should be questioned and carefully considered by doctors and patients. For example, the American College of Obstetricians and Gynecologists recommends that average-risk women not get an annual Pap test, because it offers no advantages over testing at three-year intervals. The American Academy of Pediatrics advises that computed tomography (CT) scans are not necessary in the routine evaluation of abdominal pain, and unnecessarily increase the lifetime risk for cancer due to excess radiation exposure. And the American Academy of Family Physicians says that imaging for lower back pain within the first six weeks does not improve outcomes, but does increase costs.

To date, 54 specialty societies have published such lists, and 17 consumer groups have joined the effort. The lists include hundreds of tests and treatments that are done too often, and in many cases can cause harm.

The physicians from the health plan's Quality Improvement Committee sent the relevant recommendations to their physician colleagues in various specialties, and asked for feedback. "The lists help us start important conversations, which is the point," says Van

Vessem. So far, she says, the health plan is beginning to see appropriate reductions in tests and procedures that are no longer recommended for certain types of patients.

"Of course physicians and patients need to make choices that are appropriate for each individual," she adds, "but it is important that they base those decisions on evidence about what is actually likely to help the patient."

Integrating Dental and Medical Care

CAREOREGON
Portland, Oregon

In an initiative designed to provide more comprehensive care to an often-vulnerable, low-income population, CareOregon has begun to integrate dental care and medical care for safety-net members of the Coordinated Care Organizations (CCOs) with which it works. CCOs are part of Oregon's reinvented Medicaid program, designed to support new models of care that are more patient-centered and team-focused.

"We have operationalized a dental plan for 35,000 members so far," says Mike Plunkett, D.D.S., M.P.H., dental director. "It is unique nationally because it is not an ancillary business—it is integrated into the medical plan, with functional integration in claims, customer service, provider service and all the other things health plans do."

Plunkett says CareOregon's leaders expect the integrated medical and dental care model to improve health and save money. "In the past, about seven percent of kids up to age five enrolled in CareOregon received dental care in the hospital," explains Plunkett. "Across the state, about 20 percent to 40 percent of low-acuity ED cases are dental related. Maternal oral health and periodontal health of pregnant mothers is linked to birth outcomes, and a good predictor of the child's oral health."

To address this, CareOregon implemented a system of enrollment reports for all zero-to-two-year-old patients and pregnant mothers. To complement the system, it also set up community screening exams for babies, and gave dental education to mothers in their prenatal care visits. The baby community screening exams have seen a utilization rate as high as 35 percent.

In addition, says Plunkett, CareOregon is looking at ways to expand the responsibilities and influence of dental hygienists. "They are incredibly valuable members of the medical team. They are steeped in prevention, they go into schools, Head Start programs and other community-based organizations, and they also do clinical care in an office environment,"

he observes. “Why not extend their reach to include smoking cessation, nutrition or teen pregnancy counseling?” A global care budget that includes both dental and medical care creates incentives for dental hygienists to work at the top of their license, beyond the typical scope of dental practice. This can help to reduce emergency department utilization and lower overall costs.

Dental care will be incorporated into all 15 of the state’s CCOs by July 2014, and CareOregon will work with its CCO partners to develop payment models linked to outcomes, says Plunkett.

“A global care budget that includes both dental and medical care creates incentives for dental hygienists to work at the top of their license, beyond the typical scope of dental practice. This can help to reduce emergency department utilization and lower overall costs.”

MIKE PLUNKETT, D.D.S., M.P.H.
Dental Director, CareOregon

Strengthening the Medical Neighborhood

GEISINGER HEALTH PLAN
Danville, Pennsylvania

Doctors sometimes refer to them as “curbside consults” — when a primary care physician might grab a few minutes of a specialist’s time to ask advice about a patient’s test results or symptoms. Geisinger Health Plan has elevated the curbside consult to a formal process that is resulting in better and more convenient care for patients, reduced testing and better access to specialists for patients who require a face-to-face visit. This is part of Geisinger’s broader strategy to strengthen “the medical neighborhood” and better integrate primary and specialty care.

Called *Ask A Doc*, the pilot program was launched in 2012, focusing on rheumatology. “This is one way we are linking specialty care more directly into the medical home,” says Chief Administrative Officer Janet Tomcavage, R.N., M.S.N. Through the program, a primary care physician can request a telephone consult with a specialist by completing a request in the patient’s electronic health record (EHR). “They can request a consult immediately, within four to six hours, or within 24 hours. The two doctors get on the phone and review the patient’s case and test results. Together they design a coordinated care plan.” They also may decide that the patient should see the specialist in person.

Unlike most curbside consults, after this conversation a formal summary of the consult and the care plan is placed in the patient’s EHR. Tomcavage says that soon there will be a mechanism for sharing this information directly with patients as well.

The pilot has resulted in a reduced need for specialty referrals and a reduction in testing, because primary care physicians are able to more reliably access specialty expertise. This has opened up more specialty appointments for patients who really do need to be seen directly by a specialist. “Everyone has benefitted from this, and it also appears to help reduce costs,” says Tomcavage. It is too soon to formally quantify the financial impact, but overall the physicians participating in the pilot have been very positive about its outcomes.

For the pilot, Geisinger Health Plan seeded grant money to compensate both primary care and specialty physicians for the time they spend consulting about a patient. Now leaders are building a payment model to use when the pilot spreads to more specialties in 2014. “These consults are important,” explains Tomcavage. “This is the kind of collaboration that will improve outcomes and patient satisfaction.”

NATIONAL LEADERSHIP MEANS...

Supporting Innovative Benefit Design

In meetings in the spring and fall with CMS, plan leaders from ACHP and senior CMS officials discussed the importance of implementing flexible benefit structures and relying on high-performing provider networks to improve the quality and efficiency of care for Medicare beneficiaries. Several of ACHP's members offer innovative benefit designs in their commercial products, including Tufts Health Plan in Watertown, Mass., which provides incentives to beneficiaries to choose high-quality, efficient providers.

Assessing More than Medical Needs

GROUP HEALTH COOPERATIVE
Seattle, Washington

Seattle-based Group Health Cooperative has been working hard to reduce hospital readmissions among its Medicare members, and that hard work is paying off. "Our readmission rate for Medicare has dropped from about 15 percent to close to 13 percent," says Thomas Paulson, M.D., chief medical operating officer of the Health Plan Division. But that's not all. "Our admission rate has also dropped from about 260 per thousand to 225 per thousand. So that's a double win."

Paulson sums up the lesson simply: "The best way to prevent a readmission is to prevent an admission." But as most health system professionals know, preventing admissions and readmissions is anything but simple.

Group Health's care transitions program is intended to do both. "It is designed to redirect people who might seek care in an emergency department for non-emergency care," says Paulson, "and help them access care in a more appropriate setting. And it is also focused on assessing the risk for readmission of hospitalized patients prior to discharge, and lining up follow-up visits and post-discharge education accordingly, so they are not readmitted."

Darcy Iwen, program manager for Network Services, says that clinical staff use a risk

assessment grid to help determine which level of intervention a hospitalized patient should receive. "This helps us target our interventions to the higher-risk population," she says. The highest-risk patients should have a follow-up visit within seven days of discharge — with the appointment scheduled before they leave the hospital — and receive post-discharge phone calls from a care manager to check on their recovery and from a pharmacist to review medications.

Paulson explains that keeping Medicare patients out of the hospital means assessing more than just their medical needs. "You have to spend the time to do a deep, thorough assessment of the social determinants that impact their lives," he says. "Who is at home with them? What are their transportation options? What are their food sources? All these things impact their recovery post-discharge. That follow-up phone call from the case manager is so important, because some patients just can't take in all the information prior to discharge. They are much more receptive to learning about self-care when they are back in their home environment."

Helping Consumers Make Informed Choices

TUFTS HEALTH PLAN
Watertown, Massachusetts

Health care has long been a uniquely mysterious commercial transaction for most Americans. The prevalence of third-party payers, the challenges of measuring quality and the fragmented nature of our health care system all combine to make it nearly impossible for consumers to assess the cost or value of the care they receive.

Tufts Health Plan's leaders have been working to change that. "We think that transparency is an important way to bring value to the marketplace," says Paul Kasuba, M.D., chief medical officer. "Transparency drives change for both providers and members because it informs decisions."

While Tufts Health Plan leaders believe that transparency around cost and quality is important and appropriate, in Massachusetts it is also mandated by state law. In 2012, the state legislature passed Chapter 224, which — among other things — mandates public disclosure of certain health care cost and quality information.

Employers want tools that drive their employees to choose high-quality, high-value providers, says Kasuba. And health plan members are increasingly hungry for cost and quality information as well, because they have more skin in the game than ever before. "Seven years ago, when health care reform came to Massachusetts, the majority of our members were in traditional co-pay-type plans. Since then we've seen a substantial shift to limited or tiered products and higher deductibles. Now members want to make choices based on their own perception of value."

In response, Tufts Health Plan has created a secure portion of its website where members can access quality information that enables side-by-side comparisons of hospitals' performance on a number of dimensions, and cost information through the health plan's Treatment Cost Estimator. This tool enables users to estimate the total cost of care for specific treatments, procedures and conditions, as well as their out-of-pocket costs and the difference between in-network and out-of-network costs.

Kasuba thinks that access to this type of data will drive down costs. "Employers and consumers are making choices based on this information and that is driving premium reductions in the market," he says. "Offering our members cost and quality data enables them to be smarter consumers of health care. And that's good for everyone."

Keeping Patients Healthy and Home

UCARE
Minneapolis, Minnesota

In health care, technology advances have largely involved improving medical and surgical devices and diagnostic and imaging tools. But increasingly, medical technology is entering the home, giving patients ways to monitor and maintain their health, and communicate with a clinician, without visiting their doctor.

At UCare, congestive heart failure patients are benefiting from some smart technology called

a Telescale® that helps them manage their health and stay out of the hospital whenever possible. "Our patients call it a talking scale," says Russell Kuzel, M.D., M.M.M., senior vice president and chief medical officer. It's a weight-scale that plugs into a wall outlet and a telephone, and connects to a toll-free phone number that is managed by a nurse. Because even a slight weight gain can be a sign of trouble for congestive heart failure patients, they step on the scale each day. Not only does the scale record and transmit the patient's weight, but it also asks him or her a series of questions.

"The scale asks questions related to the symptoms of heart failure, such as 'Are you more short of breath today?' It uses branch logic, so if the patient answers 'yes' it triggers a deeper set of questions that explores that symptom further," says Kuzel.

The nurse follows up with any patient who appears to be experiencing cardiac issues. "If the nurse thinks there are sufficient criteria to warrant attention from a primary care physician, then the patient will either get a same-day appointment or a change in treatment — such as a change in medication — directed by their physician," Kuzel explains.

The scale is adaptable to patients who speak languages other than English, and there is a non-weighing telemonitoring device available for people who cannot stand.

Kuzel says the program has resulted in about a 40 percent reduction in inpatient admissions in the target population, and 26 percent reduction in ER visits. Patient satisfaction with the program is quite high, says Kuzel, with more than 90 percent of users saying it is neither intrusive nor burdensome. Importantly, most have also learned to recognize weight gain as an important sign of potential problems, and welcome the nurse's attention and advice.

Using Data and Dialogue to Reduce Variation

UPMC HEALTH PLAN
Pittsburgh, Pennsylvania

As an integrated delivery and finance system, UPMC is able to bring together leaders from across its system to examine and address opportunities for improvement. UPMC Health Plan leaders thought orthopedic surgery, and specifically hip and knee replacements, represented one such opportunity.

"We looked at variations in care for hip and knee replacements," says Stephen Perkins, M.D., vice president of medical affairs. Data showed considerable variation across the system, with different orthopedic groups using different techniques and devices for the same types of patients. "We started talking about using bundled payments as a way to improve quality and reduce variation," he says. Bundled payments cover whole episodes of care rather than each service separately.

Analysts looked at the overall cost of care for these procedures, Perkins explained, including pre- and post-surgical services such as imaging and lab work, blood utilization and physical therapy services. "There was a big variation in the operating room services per surgeon, such as length of OR time, types of dressings and pain management techniques," says Perkins.

Perkins says the beauty of being an integrated system is that it promotes cross-system dialogue. "We started with our own orthopedic surgeons, and some selected private surgeons who do all their surgery at our facilities," he explains. "We provided them with their own data *and* data on the other surgeons, and brought everyone together to talk about it." In addition to variations in practice and cost, the data included information about readmission rates, infection rates, member satisfaction and patient expectations.

As a result of these conversations, the health plan designed bundled payments for pre- and post-hospital services, while continuing to pay traditional DRG-based payments for hospital services. While the health system has only recently begun to use this financial model, Perkins says it has already led to decreased variation. "We believe this will continue to improve quality and contain costs," he states. "Just getting a lower cost doesn't help unless our outcomes include patient improvement and high satisfaction."

While Perkins says it was a little challenging to open this dialogue with the physicians, "Now they look forward to the data. It has been a very rewarding collaboration."

LETTER FROM THE BOARD CHAIR

Dear Friends and Colleagues,

I have said many times the most sustainable solutions to transform our country's health care system will come from local efforts. This requires a collective responsibility, wide-ranging partnerships and renewed collaboration among the many health care stakeholders. And no one is in better position to lead this effort than the community-based member plans of ACHP.

Local pioneering efforts to empower physicians and engage consumers and employers are resulting in improved health, better care and lower cost trends.

This report highlights the many innovative ways community health plans are promoting value, leading by example and offering practical strategies that control costs while simultaneously improving health care quality and customer satisfaction. Our work may be at the local level, but our impact is national in scope.

Payment reform is at the forefront of the work of ACHP member plans, developing alternative approaches to physician reimbursement that drive improved quality and affordability. Another area of leadership is working to revitalize and grow primary care by empowering primary care physicians to expand their influence and provide more patient-centered care. Innovative product designs, productive new partnerships and data transparency are all promoting efficient, effective care delivery.

Local Commitment, National Leadership: That is the theme of this report, and it is the reality of the work being done every day by community-based health plans and ACHP. I am proud to be a part of both.

Michael W. Cropp, M.D.
President and Chief Executive Officer, Independent Health
Chair, ACHP Board of Directors

In 2013, our member plans worked in communities across the country to deliver high-quality, affordable, patient-centered, cost-effective health care. In Washington, ACHP advocated for policies that support the work of our members, facilitated multiple networking and learning opportunities and highlighted the excellent work of our members on the national stage.

Advocated Sound Public Policy

REVERSAL OF SIGNIFICANT MEDICARE ADVANTAGE PAYMENT REDUCTIONS

ACHP continues to successfully draw on our relationships on Capitol Hill and in the Administration to achieve lobbying goals. With support we generated from key members of Congress, ACHP played a significant role in convincing the Centers for Medicare and Medicaid Services to change the 2014 Medicare Advantage Update from -2.3 percent to +3.5 percent by assuming a Sustainable Growth Rate (SGR) "fix" in the estimate and making other adjustments. This greatly reduced the potential loss in funding for Medicare Advantage and reductions in the services that our plans provide.

NATIONAL LEADERSHIP ON PAYMENT REFORM AND QUALITY

In more than 75 meetings with members of Congress, committee staff and Administration officials, ACHP is educating and providing recommendations on achieving high-quality, affordable care through Medicare physician payment reform and use of transparent metrics to drive quality, competition and greater accountability. Pending legislation to replace the Medicare SGR formula for physician payment reflects ACHP payment models that we highlighted in these meetings and in a paper on this subject.

HELPING OUR PLANS PREPARE FOR EXCHANGES

ACHP provides our members with a forum to address operational and regulatory issues related to exchange implementation and monitors the potential impact of exchanges on the business of ACHP member organizations.

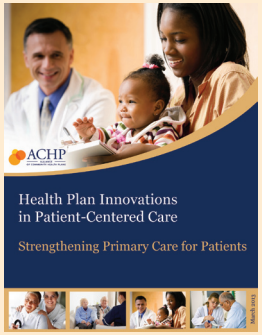
Expanded Learning & Innovation Programs

LEADING IMPROVEMENTS AND INNOVATION IN ACCOUNTABLE HEALTH COMMUNITIES AND THE SYSTEMS THAT SUPPORT THEM

ACHP facilitates collaboration and learning among our members around the goals of improving health and lowering costs at the organization and community level, emphasizing rapid learning for performance improvement. The learning agenda of the ACHP Medical Directors Council, including the work of collaboratives created specifically to dive deeply into pharmacy and behavioral health issues, reflects our intensified attention to the issues of cost and community. Our strategic priority areas for 2013 into 2014 are delivery system redesign (expanded from primary care); payment reform; greater transparency; focus on high-cost populations and areas; and community health (expanded from population health).

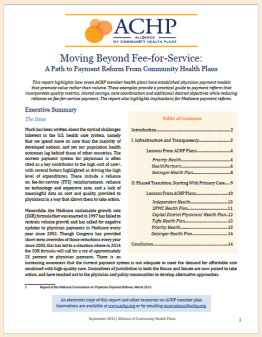
ACHP Publications

Two well-received reports showcase how ACHP plans deliver value to patients.



Strengthening Primary Care for Patients, ACHP's third report in a series on Health Plan Innovations in Patient-Centered Care, profiles 17 ACHP member organizations that increased quality care, improved patient and/or provider experience and lowered costs. Many did all three, demonstrating that health plans and provider groups do not have to sacrifice quality and patient experience for cost.

To highlight the release of the report, ACHP gathered a panel of health care and delivery system transformation experts at the Kaiser Permanente Center for Total Health in Washington, D.C., to discuss health plan and community efforts to implement patient-centered reforms and improve the care experience for both patients and providers.



Moving Beyond Fee-For-Service: A Path to Payment Reform From Community Health Plans describes the specific approaches seven ACHP member plans undertook to build the capacity, trust and incentives for payment reform. The report, meant to serve as an illustrative guide for policy makers and others looking to implement physician payment reform, was released as part of a well-attended webinar and has been a resource in the current Medicare payment reform debate in Congress.

Demonstrated Distinctive Value and Performance

WORKING WITH OUR PLANS TO ENHANCE PERFORMANCE AND QUALITY

ACHP supports our members in understanding and achieving exceptional quality performance on the Medicare Advantage Star Ratings and the National Committee for Quality Assurance (NCQA) Health Insurance Plan Rankings. These include access to ACHP's premier quality benchmarking tool, the HealthPlan Performance Gauge®, custom analytic tools that allow individual plans to precisely dissect their quality rankings and ratings and target improvement areas and keeping our members informed of potential and planned changes to quality measures and ranking/rating methods.

CONNECTING MARKETPLACE LEADERS

ACHP has expanded its efforts to connect marketplace leaders across ACHP organizations. In addition to our annual Marketplace Focus Meetings, ACHP is holding monthly "marketplace issues" calls in which ACHP plans have been sharing their early exchange experiences and other perspectives on market trends.

Communicated to and About our Members

We are focused on ensuring that thought leaders and key stakeholders know about the unique leadership, innovation, quality of care and commitment to community that our plans provide. We raise the visibility of ACHP and our member plans to external audiences in a number of important ways, including consistent messaging, reports, public events, blog posts, social media, our annual report to the community and op-eds in local newspapers and publications based in Washington, D.C. Regular internal communications ensure that our members are well-informed about ACHP activities as well as events and activities at other member plans.

In the 2013–2014 National Committee for Quality Assurance (NCQA) rankings of health plans, all 10 of the nation's top ten Medicare plans, 5 of the top ten plans in the commercial rankings and 5 of the top ten plans in the Medicaid rankings are offered by ACHP members.

TOP 50 COMMERCIAL PLANS

RANK	PLAN
2	Kaiser Foundation Health Plan of the Northwest (HMO)
6	Tufts Associated Health Maintenance Organization (HMO)
7	Kaiser Foundation Health Plan of Northern California (HMO)
8	Tufts Benefit Administrators (PPO)
10	Kaiser Foundation Health Plan of Ohio (HMO)*
11	UPMC Health Plan (HMO)
12	UPMC Benefit Management Services (HMO)
13	Kaiser Foundation Health Plan of Colorado (HMO)
15	Capital Health Plan (HMO)
16	Kaiser Foundation Health Plan of the Mid-Atlantic States (HMO)
17	Kaiser Foundation Health Plan of Southern California (HMO)
18	Capital District Physicians' Healthcare Network (HMO)
19	Capital District Physicians' Health Plan (HMO)
20	Kaiser Foundation Health Plan of Georgia (HMO)
21	Group Health Cooperative of South Central Wisconsin (HMO)
22	Geisinger Health Plan (HMO)
25	Kaiser Foundation Health Plan Hawaii (HMO)
26	CDPHP Universal Benefits (PPO)
26	Capital District Physicians' Healthcare Network (Self-Funded) (PPO)
30	HealthPartners (HMO/PPO)
31	Independent Health Association (HMO)
34	Fallon Community Health Plan (HMO)
41	Priority Health (HMO)
45	Security Health Plan of Wisconsin (HMO)
48	UPMC Health Network (PPO)
48	UPMC Benefit Management Services (PPO)

TOP 20 MEDICARE PLANS

RANK	PLAN
1	Kaiser Foundation Health Plan of Southern California (HMO)
2	Kaiser Foundation Health Plan of Northern California (HMO)
3	Kaiser Foundation Health Plan of the Northwest (HMO)
4	Kaiser Foundation Health Plan of Colorado (HMO)
5	Kaiser Foundation Health Plan Hawaii (HMO)
6	Capital Health Plan (HMO)
7	Geisinger Health Plan (HMO)
8	Kaiser Foundation Health Plan of the Mid-Atlantic States (HMO)
9	Capital District Physicians' Health Plan (HMO)
10	Security Health Plan of Wisconsin (HMO)
11	Kaiser Foundation Health Plan of Ohio (HMO)*
12	Group Health Cooperative (HMO)
12	Priority Health (HMO)
14	Group Health Plan (Cost) (HealthPartners) (HMO)
15	Fallon Community Health Plan (HMO)
16	Kaiser Foundation Health Plan of Georgia (HMO)

TOP 20 MEDICAID PLANS

RANK	PLAN
1	Fallon Community Health Plan (HMO)
2	Kaiser Foundation Health Plan Hawaii (HMO)
3	Network Health (Tufts) (HMO)
5	Priority Health (HMO)
9	Capital District Physicians' Health Plan (HMO)
12	Security Health Plan of Wisconsin (HMO)
15	UPMC For You (HMO)
20	Independent Health Association (HMO)

**Member prior to October 1, 2013.*

Seven members of the Alliance of Community Health Plans (ACHP) received 5 stars from the Centers for Medicare and Medicaid Services (CMS) for their combined Medicare Advantage and prescription drug (Part D) programs, the highest score awarded to health plans participating in the Medicare program. Only 11 plans (contracts) in the country received the 5-star rating for their combined Medicare Advantage and Part D offerings. An additional two plans offered by ACHP members received 5 stars for their Medicare Part-C only plans.

5-STAR PLANS

(combined Medicare Advantage and Part D plans)

Group Health Cooperative (HMO)
Kaiser Permanente California
Kaiser Permanente Colorado
Kaiser Permanente Georgia
Kaiser Permanente Hawaii
Kaiser Permanente Mid-Atlantic
Kaiser Permanente Northwest

5-STAR PLANS

(Medicare Part C-only plans)

Dean Health Plan
Kaiser Permanente

4.5-STAR PLANS

(combined Medicare Advantage and Part D plans)

Capital Health Plan
Capital District Physicians' Health Plan (HMO)
Capital District Physicians' Health Plan (PPO)
Fallon Community Health Plan (HMO)
Geisinger Health Plan (HMO)
Geisinger Health Plan (PPO)
HealthPartners – Group Health Plan
HealthPartners (MSHO)
Independent Health (HMO)
Independent Health (PPO)
Martin's Point Health Care
Priority Health (HMO)
Priority Health (PPO)
Scott & White Health Plan
Security Health Plan
Tufts Health Plan
UCare Minnesota

Overall, 33 Medicare plans (contracts) operated by ACHP members received 5, 4.5 and 4 stars in the combined 2014 Medicare Advantage and Medicare Part D Star Ratings. Eight ACHP members increased their star ratings from last year.

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Capital District Physicians' Health Plan
Albany, New York
www.cdphp.com

Capital Health Plan
Tallahassee, Florida
www.capitalhealth.com

CareOregon
Portland, Oregon
www.careoregon.org

Dean Health Plan*
Madison, Wisconsin
www.deancare.com

Fallon Community Health Plan
Worcester, Massachusetts
www.fchp.org

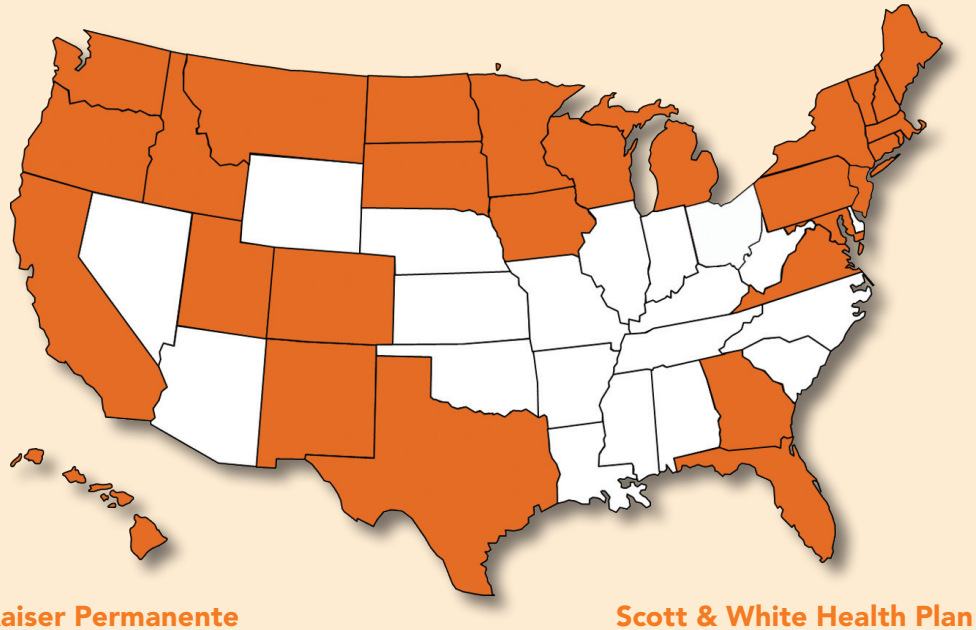
Geisinger Health Plan
Danville, Pennsylvania
www.thehealthplan.com

Group Health Cooperative
Seattle, Washington
www.ghc.org

Group Health Cooperative of South Central Wisconsin
Madison, Wisconsin
www.ghcscw.com

HealthPartners
Minneapolis, Minnesota
www.healthpartners.com

Independent Health
Buffalo, New York
www.independenthealth.com



Kaiser Permanente
Oakland, California
www.kp.org

Martin's Point Health Care
Portland, Maine
www.martinspoint.org

New West Health Services
Helena, Montana
www.newwestmedicare.com

Presbyterian Health Plan
Albuquerque, New Mexico
www.phs.org

Priority Health
Grand Rapids, Michigan
www.priorityhealth.com

Rocky Mountain Health Plans
Grand Junction, Colorado
www.rmhp.org

Scott & White Health Plan
Temple, Texas
www.swhp.org

Security Health Plan
Marshfield, Wisconsin
www.securityhealth.org

SelectHealth
Murray, Utah
www.selecthealth.org

Tufts Health Plan
Watertown, Massachusetts
www.tuftshealthplan.com

UCare
Minneapolis, Minnesota
www.ucare.org

UPMC Health Plan
Pittsburgh, Pennsylvania
www.upmchealthplan.com

**ACHP welcomed Dean Health Plan as a new member as of October 1, 2013.*

ABOUT ACHP

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. The community-based and regional health plans and provider organizations from across the country that make up ACHP's membership provide coverage and care for approximately 17 million Americans. These 23 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care, including patient care coordination, patient-centered medical homes, accountable health care delivery and use of information technology.

OUR MISSION

ACHP and its members improve the health of the communities we serve and actively lead the transformation of health care to promote high-quality, affordable care and superior consumer experience.

We realize our mission by:

- Providing a forum to solve our members' most pressing challenges
- Advocating for better health and health care
- Developing quantitative and qualitative tools to improve performance and meet marketplace challenges
- Building the evidence base for health care improvement

ACHP MEMBERS ARE

- Not-for-profit health plans or subsidiaries of not-for-profit health systems, or provider groups associated with health plans. Member organizations are located primarily in mid-sized and smaller markets and have deep roots in their communities.
- National leaders in health care quality that annually rank among the top-performing health plans in the nation.
- Innovators in delivering affordable, coordinated, multidisciplinary care, and pioneers in the use of electronic health records.
- Role models for other health plans in innovating to achieve the industry's Triple Aim – better health, better care, at a lower cost.

The Alliance of Community Health Plans was founded in 1984 as The HMO Group to help independent health maintenance organizations identify and share best practices. The group changed its name, appointed new leadership and moved from New Jersey to Washington, D.C., in 2001. ACHP continues to help high-performing health plans and provider groups improve coverage and care and to advocate for policies that improve health and health care quality and affordability.

ACHP is committed to protecting our natural resources. This publication is printed on recycled paper with soy-based ink.
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