2014 REPORT TO THE COMMUNITY

ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

Community Health Plans: Investing in Better Care, Better Health

2014 REPORT TO THE COMMUNITY

Letter from the President

Dear Friends and Colleagues,

Improving health and health care requires us to continually reshape our thinking about everything from how to be healthy to what we need from the health care system. Health care leaders must constantly rethink as well: What is the best way to meet the health care needs of individuals and families?

Fortunately, some of our nation's best health care leaders — those working in ACHP member health plans — are not just thinking about change, they are creating it. They are demonstrating that changing health and health care involves changing both the way they work and the communities in which they live.

How do you change a community? The answer lies in the pages of this report. Like Priority Health, you give consumers clear, comparative information about the quality and cost of care, so they can make informed choices. Like Rocky Mountain Health Plans, you identify needs in your community — homeless children, in their case — and address them. Like Group Health Cooperative, you get out the cardboard and duct tape to build a model clinic designed around consumers' expressed needs.

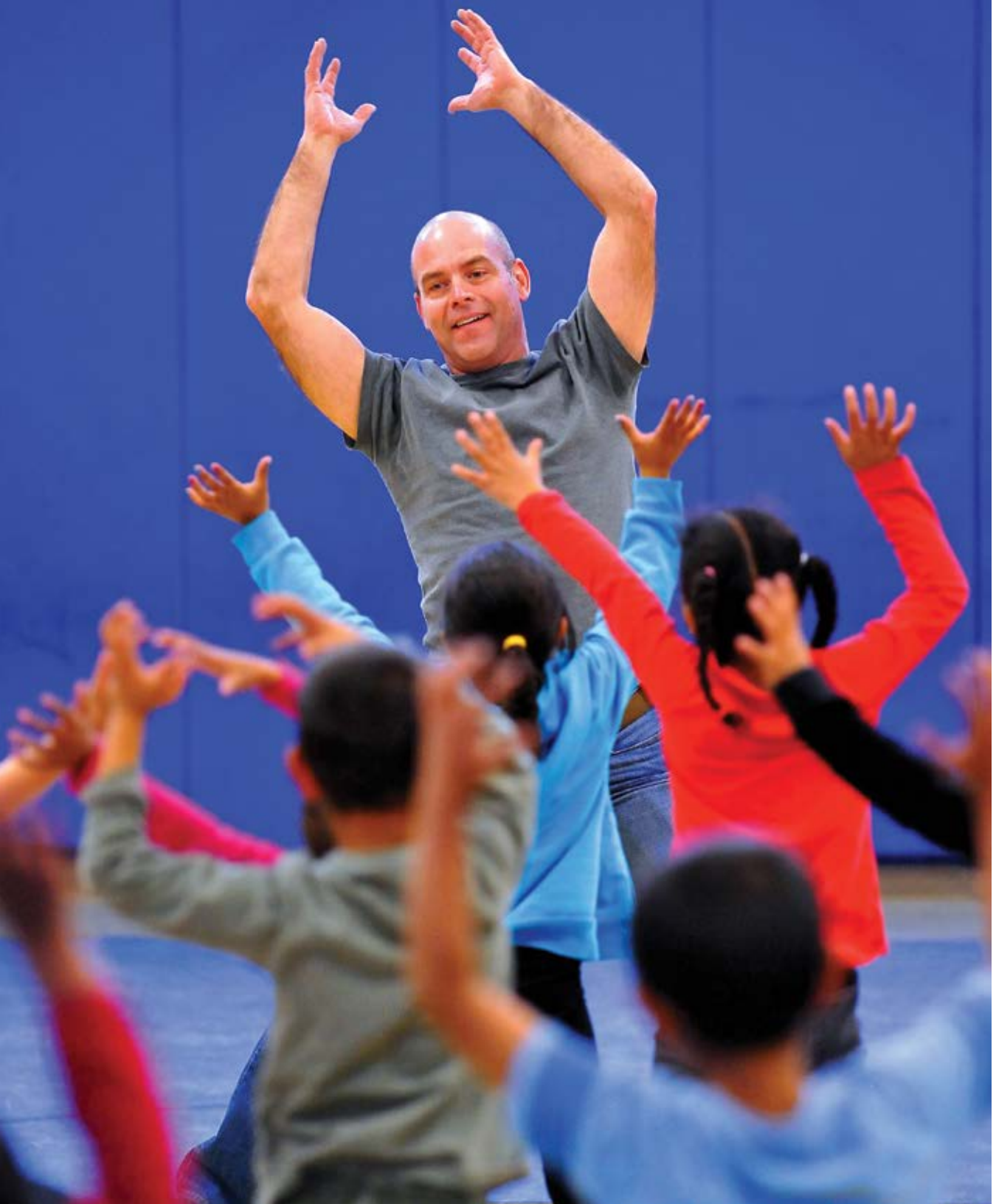
Public policy is an important lever for bringing about change, and ACHP works hard in that arena. But we work just as hard to bring our member health plans together to teach, learn, collaborate and create powerful partnerships that result in important change at the community level.

We know that national change grows from local change. We are proud — and inspired — to present an exciting look at changing communities in this report.

Patricia

Patricia Smith
President and CEO

We have been fortunate that Michael W. Cropp, M.D., president and CEO of Independent Health, has served as our board chair with vision and energy since 2013. As he steps down with our profound gratitude, we welcome Patricia Richards, president and CEO of SelectHealth, to fill the role with her own brand of smart and effective leadership.



Promoting Good Health Through Innovative Partnerships

Community health plans are uniquely situated to work in close partnership with other local organizations to promote good health, and to support strong partnerships among the plan's caregiving teams. Shared goals and commitment to the local community fuel these healthy relationships, resulting in better care and better health.

Designing Care to Reduce Pain Points

GROUP HEALTH COOPERATIVE

Seattle, Washington

By opening in-store clinics in local pharmacies, Group Health is finding new ways to treat patients' pain. Not just the physical kind of pain, but the "pain points" that people sometimes describe when they access care in more traditional settings, such as having to fit into the provider's schedule rather than vice versa, or not knowing what the out-of-pocket costs of a visit will be.

Through a unique collaboration, Group Health and Bartell Drugs, a local chain of pharmacies, have opened three walk-in retail clinics together, the first of their kind in Seattle. These CareClinics are not standalone "docs-in-a-box," says Wellesley Chapman, M.D., medical director of care delivery innovation at Group Health. Rather, he says, "They are an extension of our medical center where people can access care more easily." Patients pay a set price for a clinic visit, and receive a printed visit summary, which is also sent to the patient's primary care physician electronically.

The menu of services includes immunizations and injections — given by the pharmacy staff — or clinical treatment from a nurse practitioner for colds, sinus or urinary tract infections, school or camp physicals and other common needs. A visit costs $75 or a Group Health member's co-pay amount, with a separate flat fee for lab work.

Dr. Chapman says the clinics' physical layout and processes were carefully designed using Lean human-centered design principles after listening to members in focus groups and doing substantial

testing in a prototype clinic built from cardboard. "We ran hundreds of simulations of patient encounters, and it was really interesting to have the pharmacy's retail staff at our design sessions," says Chapman. "They held us to a very high standard of customer service."

For example, the sequence of steps is carefully ordered so that when patients arrive at the clinic they are asked to describe their symptoms only once (repeatedly answering the same questions is a patient "pain point"), and they are not asked for insurance or payment information until it is clear the clinic can actually treat their needs. If not, the clinician helps the patient schedule an appointment at an urgent care center.

Chapman says that CareClinic is getting high marks for both quality of care and patient experience. "Our plan is to grow this model, which is removing both logistical and financial barriers to care."

Supporting Good Health with Zumba and Zucchini

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN

Albany, New York

Where can you shop for groceries, take a fitness class and learn about disease management, all under one roof? Residents of Albany, N.Y., know the answer.

Thanks to an innovative partnership among Capital District Physicians' Health Plan (CDPHP), the YMCA and Hannaford Supermarkets, local residents have access to a comprehensive resource that supports all kinds of healthy habits. The Healthy Living Center, located inside a large, popular Hannaford supermarket, offers a variety of fitness classes and programs focused on nutrition, weight and disease management, senior health and medication safety.

Opened in October 2013, the Healthy Living Center was created by these three well-known, community-based organizations because they share a mission to support good health for local residents. "CDPHP takes seriously our responsibility to support the health, vibrancy and quality of life for the communities we serve," says John Bennett, M.D., president and CEO.

The center is open seven days a week and offers dozens of free classes in the morning, afternoon and evening, including Zumba, spinning and other popular workouts. Nutrition classes focus on healthy cooking, eating and grocery shopping.

The center represents a changing understanding of the role of care providers in the health of communities and individuals. Since clinical care affects only about 20 percent of a person's overall health, the biggest effects on health are outside the doctor's office: physical environment, lifestyle choices and social and economic factors. CDPHP recognizes the value of reaching beyond the traditional role of health care professionals to embed healthy options in the day-to-day life of the community. Putting a fitness and healthy living center inside a grocery store is a powerful example of this philosophy.

In the center's first year, more than 1,600 people registered as members and took part in hundreds of programs. Now classes fill up routinely and membership continues to increase. "The Healthy Living Center is an amazing gift to the community," says one local resident who discovered it while shopping and has become a regular user. "I tell everyone I know about it."

An Innovative Partnership Rewards Healthy Eating

INDEPENDENT HEALTH

Buffalo, New York

For Independent Health members with the health plan's new nutrition benefit, getting the recommended five servings of fruits and vegetables each day is easier and more rewarding than ever. It is not only good for their health, it's good for their wallets as well.

Through an innovative partnership with Tops Friendly Markets, a local grocery chain, Independent Health created a nutrition benefit that works like this: For every $2 a member spends on fresh fruits and vegetables at Tops, the member receives $1 back in the form of a rewards card that can be used for other food purchases at Tops. The accumulated value of the rebates is tracked automatically at the cash register, and rewards cards are distributed quarterly to members who earn the minimum $15 per quarter.

During the first half of 2014, eligible Independent Health members had already earned nearly $240,000 in rewards by purchasing fresh

produce at Tops. More than 1,100 members received a rewards card the first quarter and an additional 1,800 rewards cards were issued the second quarter. Members reported losing weight and saving money.

For example, Independent Health member and employee Brendan Heavey says he lost 13 pounds in his first several months with the benefit, and received a quarterly rewards card worth $124. "Now that I have the nutrition benefit, I eat a lot more vegetables," says Heavey. "The benefit basically gives me a 50 percent discount off the fruits and vegetables I buy."

Independent Health included the nutrition benefit in the majority of its small group and individual plans introduced for 2014. Groups with more than 50 full-time employees may purchase the benefit as a rider, and many do as part of an overall corporate focus on supporting wellness.

"Diet and exercise are key contributors to wellness and good health," says Michael W. Cropp, M.D., president and CEO. "Providing easier access to healthy eating and better nutrition is one of the many tools we offer our members to help them get more engaged in their health and develop fitness and lifestyle behaviors they can sustain."

This is not the first time Independent has led the way with an innovative lifestyle benefit. It was the first health plan in New York to offer gym benefits, and the first to offer financial incentives for personal health engagement. "We like to help our members take charge of their health," says Cropp.

Helping Patients and Families Plan Ahead

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

Madison, Wisconsin

As a former hospice nurse, Lisa Sherven says her ears perked up when she learned about the Wisconsin Medical Society's new initiative to promote advance care planning throughout the state. "This is a personal passion of mine," says Sherven, R.N., B.S.N., quality services manager at Group Health Cooperative of South Central Wisconsin (GHC-SCW). "I saw so many families struggle with this issue. So I asked my organization to participate."

GHC-SCW identified funding for the initiative, and became one of the first health care organizations in the state to join the program, called Honoring Choices Wisconsin. It is a comprehensive program built around the idea that advance care planning is not simply about completing a document: It requires an ongoing conversation. As part of the Honoring Choices program, GHC-SCW now provides trained facilitators to help members start that conversation with their loved ones.

GHC-SCW piloted the program for two years before spreading it organization-wide. The first step was to embed the concept of advance care planning into routine care episodes. Now GHC-SCW clinicians are prompted to check for an advance directive on file when they see patients who are 60 and over and visiting for a physical check-up, a Welcome to Medicare visit or Medicare Wellness visit.

Patients without an advance directive are offered the opportunity to meet with an Honoring Choices facilitator to guide them through the process of having these important conversations and documenting their choices. GHC-SCW currently has 10 trained and certified facilitators on staff.

"It can be hard for people to have these conversations on their own," says Sherven, who serves both as a facilitator and as a trainer of facilitators within her organization and beyond. "We help patients identify what to think about, what to talk about and what to document. We talk about specifics like CPR and tube feeding, and also about things like who has the ability and the willingness to heed their wishes."

Sherven says that currently fewer than 13 percent of GHC-SCW members have an advance directive on file. While Sherven points out this is consistent with national benchmarks and that one goal is to increase that number significantly, she says Honoring Choices is about more than simply filling out a document. "It really is about helping people think about and plan for the kind of care they really want, when they want and need it."

Engaging Consumers in Cost and Quality Choices

PRIORITY HEALTH

Grand Rapids, Michigan

Because Priority Health believes in providing its members with good information that can help them make smart choices, it has always been ahead of the curve on transparency. It was among the first health plans to publish its primary care

quality ratings more than a decade ago. Now it's the first Michigan-based health plan to give members access to information about the cost and quality of the most common health care services before they receive care.

Working with Healthcare Bluebook, a guide to area pricing for health care services, Priority Health developed a customized tool that enables members to see and compare the cost of more than 200 common procedures, including surgeries and lab and imaging tests. The methodology calculates the fair price (based on local and national benchmarks) for the region or network, and considers a number of variables that include Priority Health's contract rate and the distribution of providers performing that service or procedure. For example, a member can quickly see that, depending on the provider and facility, a chest X-ray can cost from $353 to more than $1,200.

"I think of this as engaging consumers in the Triple Aim," says John Fox, M.D., associate vice president of medical affairs. "We want to engage members in improving their outcomes and reducing their costs. All of our strategies converge around this goal."

Priority Health members can see providers coded as green (at or below fair price), yellow (slightly above fair price), red (among the most expensive), or black (provider does not publicly share contracted prices). They can also access quality ratings for providers and facilities. Fox says that currently about 60 percent of Priority Health network providers are publicly sharing their cost data. While Michigan state law does not require hospitals to share price data, this initiative is increasing the pressure for them to do so.

This is just a first step on the road to providing consumers with personalized cost information, says Kim Suarez, vice president of medical operations and customer experience at Priority Health. "What people care about is what it will cost them," she says. "Next year we will roll out integrated benefit and cost information for consumers. Our members will be able to access real-time pricing on what their total costs will be before they receive care, based on which provider, service and facility they select." In addition, the health plan will offer financial incentives to members for choosing cost-effective providers.

"Impacting cost and quality requires using multiple levers," says Fox. "That's what we're trying to do with public data sharing, member-specific cost data and plan design."

Outreach Helps At-Risk Behavioral Care Patients

SCOTT & WHITE HEALTH PLAN

Temple, Texas

Successful health plans must effectively balance caring for populations of patients with caring for patients as individuals. Scott & White Health Plan does both jobs well, and one of the best examples is the way the plan cares for patients with behavioral health needs.

"We recently launched a program to improve adherence to treatment," explains Duke Ruktanonchai, M.D., vice president and medical director for behavioral health. Currently the program targets Medicaid members who are on anti-psychotic medications.

The program relies on a strong working partnership among pharmacy staff, data analysts, behavioral health specialists and primary care physicians. "Each month the pharmacy produces data on people taking anti-psychotic medications who have not refilled their prescriptions," says Ruktanonchai. "Our quality analytics group pulls in other data — such as, has the member been hospitalized or visited the emergency department (ED) for psychiatric reasons — and we stratify the risk for these members with a four-color system."

Red, the highest risk, is for those with chronic mental illness such as schizophrenia or bipolar disorder who have had a recent ED visit or hospitalization. These members are entered into case management. "We send a letter to the member and the provider about the fact that the member has not refilled his or her prescriptions, and I reach out personally to the prescribing physician with the same message." Ruktanonchai says that since most of the prescribing physicians are primary care doctors, this conversation is an opportunity to better integrate behavioral health and primary care.

Patients with lower risk are coded either yellow or green; in both cases the letter still goes out, but the degree of intervention varies. Patients coded white are "unknown," which could mean, for example, that they are on an anti-psychotic medication but they don't have a documented psychiatric diagnosis. "In these cases I contact the prescriber to see what's going on," says Ruktanonchai.

Scott & White used to outsource behavioral health utilization and case management services, but decided to bring them back in-house. "We added the physician-to-physician outreach so it's very hands-on, very individualized and, we think, very effective," says Ruktanonchai.

Investing in Communities

Ask anyone who works for a community health plan and he or she will tell you the defining difference: We are part of the community. We live here, our members are our neighbors. Community health plans are especially invested in supporting the health of the whole community, member and non-member alike.

Seeing and Meeting Unmet Needs in the Community

ROCKY MOUNTAIN HEALTH PLANS
Grand Junction, Colorado

"We are a not-for-profit, local health plan that wants to ensure we are doing the very best for

our neighbors," says Lisa Fenton Free, executive director of the Rocky Mountain Health Plans Foundation. "Serving the community is at the core of our organization. It's who we are. It's what we do."

That mission means that Rocky Mountain Health Plans (RMHP) reinvests at least three to five percent of its annual revenues into other local organizations, programs and services that are dedicated to improving the health and well-being of people of all ages and backgrounds. RMHP touches the lives of nearly as many non-members as it does its own members.

The foundation, funded through private donations and grants, looks for health care needs it can address locally. For example, says Fenton Free, "About six years ago we recognized a growing problem of homeless children and teens in some of our communities. We learned that some schools have teachers or counselors coming to school as early as 5 a.m. to let kids come in and sleep before school starts." So the foundation mobilized RMHP employees and made arrangements with the Mesa County and Denver Public School systems to help.

"At the beginning of the school year, we deliver 1,000 hygiene kits in backpacks to the schools," says Fenton Free. "We collect funds year-round, purchase all the supplies and fill them with toothpaste, toothbrushes, shampoo, bandages, lotion and even quarters for laundry machines. When kids come to school disheveled and in dirty clothes, they get isolated. To help with this, the teachers know they can give one of these backpacks to a child in need."

Fenton Free says this work has raised awareness about the problem of homeless families and children. "Our Denver office also helps make breakfast every month at a teen shelter. They buy, make and serve the food, and they provide supplies like socks and underwear."

Being a local, community-focused health plan allows RMHP to stay close to the real struggles of those in need in the community, says Fenton Free. "You see each other in the grocery store, it keeps the needs real and close. It reminds us of our mission — to serve the whole community — and that not everything can be solved within the standard structure of health benefits. If we don't look at health this way, holistically, then we put a band-aid on the problems."

Fruitful Efforts to Improve Community Health

CAPITAL HEALTH PLAN

Tallahassee, Florida

"Capital Health Plan is a community health plan," says Polly White, senior vice president of marketing and administration. "That means that in addition to our focus on delivery of evidence-based medical care, part of our mission is to serve the wider community."

Capital Health Plan does this in many ways, but two of White's favorite initiatives involve fruit and seniors.

"When we participate in employee benefit fairs or community events such as charity walks, our booth replicates a fruit stand, just like you'd see at a farmers market," says White. "We have apples, oranges, bananas and seasonal fruits like pears, plums and kiwi. People tell us they appreciate the community service."

White says it is one way of helping people fulfill the health plan's tagline: Live Well! "We want people to eat well as part of an overall healthy lifestyle," she says. The fruit stand is a popular stop at fundraising and awareness events such as breast cancer, heart health and Alzheimer's disease community walks.

"We can buy up to 400 cases of fruit a year for these community events," says White. "It is for our whole community, to get people thinking and talking about their health. We love being out and about, interacting with our neighbors."

Another program that Capital Health Plan offers to all community members is *Savvy Senior*, a monthly brown-bag lunch program. Featured speakers make presentations on senior health issues of all kinds. Topics have ranged from eye care to nutrition, from heart health to depression, and everything in between.

"Our auditorium holds 50 people and we have had standing room only for some of the *Savvy Senior* presentations," says White. "Our physicians or other care providers give the talks and answer questions, and the resulting discussions are very interesting. Participants tell us these sessions are helpful and informative."

"We see ourselves as part of the community, as a trusted resource for both members and non-members…Our job is to do the right thing."

–Casey Smith, SelectHealth

"We care about the whole community," says White. "We live and work here, too. Our goal is to improve the health of our community through low-cost, high-impact initiatives that reach out and help everyone live well."

Providing Effective, Affordable Online Care

HEALTHPARTNERS

Minneapolis, Minnesota

Most consumers today are accustomed to going about their daily business online, from banking to shopping to entertainment. But receiving health care online? That's a relatively new phenomenon — one that HealthPartners embraced in 2010 when it launched virtuwell.com. A mobile- and web-based online convenience clinic, virtuwell® is for health plan members and non-members alike and shows high patient satisfaction and clinical effectiveness, as well as significant cost savings.

"At virtuwell, we treat more than 50 common conditions associated with a high degree of diagnostic accuracy, including sinus and bladder infections, acne and pink eye," explains Drew Zinkel, M.D., associate medical director for virtuwell. "Anything that requires a lab test, imaging, or in-person exam is not treated through virtuwell."

With virtuwell, customers experience the same clinical process they would follow in a face-to-face visit, starting with the question, "What do you think you have?" Customers describe their symptoms by answering a series of questions, and also provide information about their medical history, allergies and medications. Sophisticated algorithms and safety protocols help ensure online care is safe for the customer.

Board-certified nurse practitioners review each case to make a diagnosis and create a treatment plan, which includes a prescription when appropriate. The customer receives a text message or email when the plan is ready, usually within 30 minutes. If desired, a customer can also ask to speak to the treating nurse practitioner by phone.

A virtuwell visit costs $45; insurance is accepted and follow-up calls are free. In 2011, virtuwell became the first online care service to be authorized for Medicare coverage, an endorsement of its attention to quality and safety. Data show virtuwell's average cost is $88 lower per episode than comparable care received in a traditional setting, and customers report that a virtuwell visit also saves about 2.5 hours. More than 110,000 cases have been treated since the clinic launched.

"We designed virtuwell to achieve Triple Aim results. Because we deliver clinically effective care at a fraction of the cost and twice the convenience of traditional approaches, we're making a lot of people happy," says Kevin Palattao, vice president for virtuwell. "It's a big space out there, and we think eventually every health plan and employer will want a number of competitive solutions like virtuwell in their provider network."

Helping Consumers Navigate the Market

SELECTHEALTH

Murray, Utah

The U.S. health care landscape is complex, and navigating the ins and outs of insurance coverage and costs can be confounding. Imagine, then, that you're new to the whole process of evaluating and choosing health coverage. This is the case for millions of Americans who gained access to health insurance in 2014 under the Affordable Care Act (ACA).

SelectHealth recognized a growing need for education and information even before the new law took effect. "We started to get a handle on the impact of the new law early on, and spent most of 2013 helping our sales staff for the individual market become ACA experts," says Heidi Castaneda, manager of Small Employer and Individual Plans sales teams. "Subsidies, new marketplaces, cost share reduction plans...these are all new to some consumers. We knew we needed a team of experts to help people understand it all, especially people who may never have had insurance before."

SelectHealth set up a special phone line for ACA-related questions, and promoted it in local media. The plan also created an in-depth but user-friendly section on its website that includes a video, Q&A on a wide range of details and interactive Advanced Premium Tax subsidy estimation tools that help users understand the effect of the new law on their own coverage and costs.

These tools are available to everyone, not just SelectHealth members. "We see ourselves as part of the community, as a trusted resource for both members and non-members," says Casey Smith, supervisor for the Individual Plans sales team. In fact, Smith says there are even times when a sales staff might advise a caller to enroll in a different health plan if that suits his or her needs best. "Our job is to do the right thing," he says.

During the last open enrollment period, the health plan offered more than 100 seminars on

health care reform for the public, Castaneda says, and fielded as many as 800 calls per day. "Some staff would take 100 calls a day during the busiest times," she recalls. The most common questions are about subsidies and penalties for not buying health insurance. "And some people don't even know what to ask, so we start with the basics and walk them through it," says Castaneda. "We like to educate people so they can make good decisions."

Reserving the ED for True Emergencies

PRESBYTERIAN HEALTH PLAN

Albuquerque, New Mexico

When patients visit hospital emergency departments (ED) for non-emergency needs — because they lack access to or knowledge about more appropriate care settings — they contribute to the high cost of health care for everyone. What's more, they can create bottlenecks in busy EDs that should be reserved for true emergencies.

Presbyterian Health Plan has addressed this problem by creating Emergency Department Navigators, nurse practitioners or physician assistants who work right in the ED to assess patients' needs — all patients, not just Presbyterian Health Plan members — and direct them to the most appropriate level of care.

When patients arrive in the ED they receive a medical screening from an ED Navigator to determine their health condition and possible needs. The ED Navigators have access to a broad range of resources and systems, including teleconferencing technology.

Presbyterian's ED Navigator: The Right Care at the Right Place

- There was a ***25 percent overall reduction in ED use*** in the Medicaid population.
- There was a ***40 percent reduction in post-navigation ED use***.
- Only seven percent of patients returned to the ED for non-emergent care following navigation.
- There is a projected plan ***savings of $15 million*** over five years.
- 79 percent of the patients referred out of the ED are seen by a primary care physician or urgent care provider.
- Over ***14,000 patients were navigated in the first two years*** of the program, equivalent to 10 percent of the ED patient volume. That is an average of 23 patients per day across the two EDs that featured navigators.

Presbyterian Health Plan's ED Navigator program ensures members receive the right care for their condition. By diverting patients who are not experiencing an emergency away from the emergency department and toward primary or urgent care, the plan delivers the right care at the best value for its patients.

If the navigator determines that the patient does not need emergency care, he or she directs the patient to the most appropriate clinical setting for treatment. ED Navigators help patients make an appointment to address their acute condition within 12 to 24 hours, and direct them to a primary care physician for ongoing care. They also follow up to make sure that patients keep their appointments.

The program was implemented in 2010, and the results to date are significant. During the program's first two years, more than 14,000 patients — about 10 percent of the ED patient volume — were redirected to a more appropriate level of care. This averages about 23 patients each day. Nearly 80 percent of patients referred out of the ED are seen by a primary care physician or urgent care provider.

In the Medicaid population, the program resulted in a 25 percent overall reduction in ED use, with only about seven percent of patients returning to the ED for non-emergent care following their consultation with an ED Navigator. Presbyterian Health Plan evaluators project a savings of $15 million over five years.

Focusing on Value

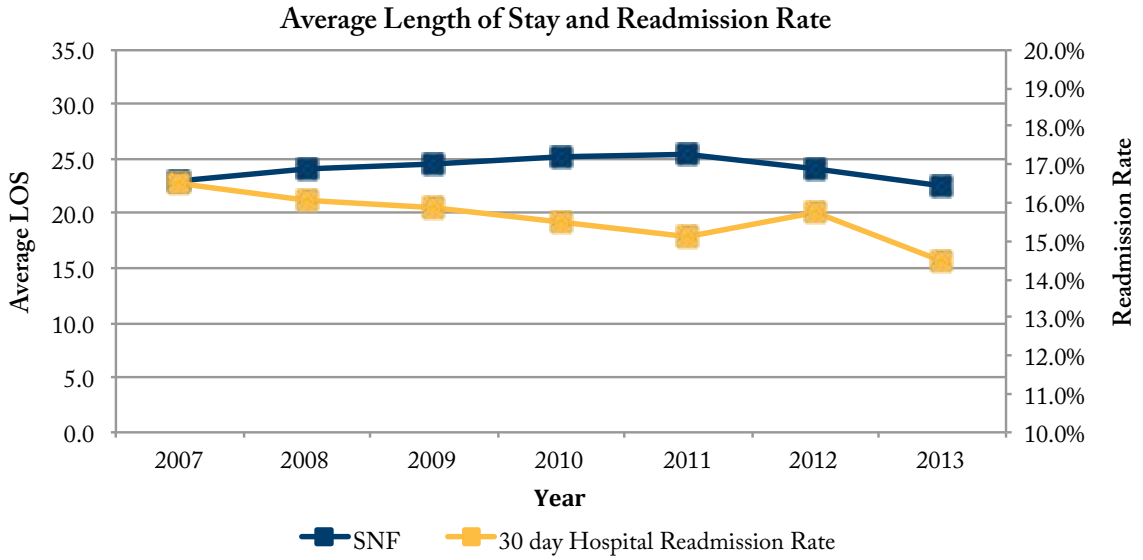
Community health plans work hard every day to increase the value of the health care dollar. Smart use of technology, more effective care processes, better communication and support for patients — all these strategies help community health plans improve care and control costs.

Improving Care, Reducing Readmissions

GEISINGER HEALTH PLAN
Danville, Pennsylvania

Geisinger Health System is widely known for delivering excellent care and for innovative thinking. The organization's leaders are always looking for opportunities for improvement. For

Geisinger's Improvement in Nursing Home Performance



The blue line is the average number of days a patient spends in a nursing home after an acute care episode. The yellow line is the percentage of those patients who need to be readmitted to the hospital within 30 days. Through its efforts with nursing homes, Geisinger has reduced the number of patients readmitted to hospitals, improving quality of care while lowering costs.

example, in 2008 Geisinger began to focus on reducing its high readmission rates and lengths of stay in skilled nursing facilities (SNF). "Like almost every other health system out there, we had about a 30 percent hospital readmission rate from SNFs," says Joann Sciandra, R.N., B.S.N., C.C.M., associate vice president of population management.

"First we needed to understand why patients were being readmitted," says Sciandra. "We did a lot of research and analysis, and learned that, among other things, we could improve the way we work with SNFs." The organization eliminated the three-day acute stay requirement for SNF admission, tightened its approach to rehab and long-term acute care, evaluated opportunities for redesigning care within SNFs, examined its home health relationships and altered its payment models to incorporate quality performance.

Part of the revamp involved creating a network of high-performing SNFs that could more efficiently handle higher volumes of patients. This meant gradually eliminating about 60 SNFs from its network and providing additional training and development for the nursing home care teams in the remaining SNFs. Geisinger also placed advanced care practitioners into high-volume SNFs in close proximity to its network of patient-centered medical homes.

"We have nurse practitioners or physician assistants in many of the SNFs we work with, and their goal is to see the patient within 24 hours of their arrival at the SNF," says Sciandra. "They document all the SNF care in the patient's electronic health record, so when patients return to their medical home, it is a smoother transition of care. They really help maintain continuity of care and communication."

Geisinger provides regular training and development for the nursing home teams, including training on how to recognize early warning signs, better treat acute exacerbations and use care planning tools.

As a result of this comprehensive overhaul, SNF-to-hospital readmissions dropped from 24 percent in 2007 to 14 percent in 2013, and the average length of stay declined by about a day. Geisinger estimates a savings of more than $3.5 million dollars so far as a result of these improvements.

Extending the Delivery System with Technology

KAISER PERMANENTE

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

As the owner of the world's largest private deployment of electronic medical records (EMR),

Kaiser Permanente is a leader in the use of digital technology to extend access to care and improve convenience, quality and affordability. "Health care is really the last industry where we still require the consumers to come to us, no matter what," observes Jo Carol Hiatt, M.D., assistant medical director, Southern California Permanente Medical Group. "We think telehealth will help transform health care and give people more care and support." Kaiser believes that technology can strengthen the connections between patients and providers by improving access and personalizing care.

Kaiser Permanente uses technology in a wide range of ways across its many regions throughout the U.S. Its mobile app, downloaded more than one million times, allows members to securely email providers and manage appointments, view lab results and medical record information and refill prescriptions.

In Kaiser Permanente's California regions, stroke patients are getting appropriate care faster thanks to video consultations between emergency department staff and Permanente neurologists. "The specialist can see the CT scan and talk with the emergency room doctor and the radiologist, even observe a physical exam of the patient, and discuss recommendations over video with the patient and/or companions," says Hiatt.

In San Diego, Kaiser Permanente has launched a small but effective pilot program to provide lactation counseling to new mothers via smartphone or video consultation. "A lactation specialist can observe the mother and baby, and can help get breastfeeding on track," says Hiatt. "When breastfeeding isn't going well, there is a sense of urgency because the baby is crying and the mother is frustrated. This is when new mothers often quit breastfeeding. Getting an at-home consult can make all the difference."

In Kaiser Permanente's Georgia region, some behavioral health care is offered via teleconferencing. "This is the perfect specialty for video technology, because it doesn't involve a physical exam," says Hiatt. "If you can make behavioral health care more accessible and more convenient, and reduce the stigma of going to the doctor's office, then that really serves the patients' needs better."

"Does all this technology save money?" asks Hiatt. "Sometimes it does. But the real payoff is better care and better health. That's what it's really about."

Smaller Network Offers Bigger Value

SECURITY HEALTH PLAN

Marshfield, Wisconsin

The health insurance landscape is confusing for many consumers. Worse, it can also be very expensive. As more people gain access to insurance through the Affordable Care Act, some for the first time, Security Health Plan saw a need for more value-driven options in the marketplace. The products it created as a result of this thinking have been extremely well received.

"We did market research in 2012, and looked specifically at the preferences of consumers who are very price-sensitive," says Marty Anderson, director of marketing for consumer products. "And we created new options to meet their needs and preferences."

Called Security Health Plan Select, this family of insurance options offers comprehensive benefits with a range of deductible and out-of-pocket options and a smaller network of providers than Security's main HMO plan. "Many people understand that paying a lower premium means using a smaller provider network," says Anderson. "They are happy with that trade-off."

Premiums for the Select products are 10 to 15 percent lower than for the HMO plan, and the Select network includes about half of the providers who are part of Security's broader HMO network. The Select provider network still includes Marshfield Clinic, the dominant provider system within Security's service area. "Marshfield Clinic is well known and well respected by consumers," says Anderson. "We wanted to make sure all our members have access to it, especially those in the Select plans."

"These products really offer our members a good value," says Anderson. "They have access to high-quality providers in their communities at a lower cost." Benefit packages are also designed to create value. For example, the Select plan with the highest deductible — $6,350 for an individual — also includes three primary care visits per year covered at 100 percent before the deductible. "We incorporated features our customers told us they want," says Anderson.

The Select products are offered to people who live in nine of the 32 counties that Security serves. "In those counties, eight out of ten enrollees have chosen a Select plan," says Anderson. The health plan's challenge was to create a product for a targeted segment of consumers where price, value and quality overlap. "It's the sweet spot, the middle of the Venn diagram," he says. "And I think we found it with Select."

E-Visits Deliver Quality, Convenience and Access

UPMC HEALTH PLAN

Pittsburgh, Pennsylvania

Having a child sick enough to be hospitalized is one of life's scarier parenting experiences. If that child must be transferred from a familiar local hospital to an urban medical center to receive specialty care, the experience only gets harder. But what if technology could effectively bring that specialty care to the local hospital? UPMC is already doing this and more with telemedicine.

"You can't afford to have specialty expertise in every hospital," says John Lovelace, president of UPMC for You and president of Government Programs & Individual Advantage Products at UPMC Health Plan. "But with telehealth, providers from different institutions in different locations can effectively consult with one another and sometimes save the patient from having to transfer."

Lovelace says that UPMC is already using this scenario to prevent unnecessary pediatric transfers. "About half the children who present in a local emergency department (ED) and get transferred to Children's Hospital of Pittsburgh of UPMC are discharged from the Children's Hospital ED after evaluation. If the specialty expertise had been available to the local ED, much of that stress on the family and the health system could be avoided."

UPMC is also offering consumers e-visits with providers through UPMC AnywhereCare, 24 hours a day, seven days a week, within 30 minutes of initial contact. For just $38 (or less where AnywhereCare is integrated into the patient's health insurance benefits), AnywhereCare asks consumers to describe their symptoms in a clinical questionnaire. A UPMC provider reviews the information, may follow up with more questions by secure messaging or video and provides a diagnosis and treatment plan, which could include a prescription or directions to see a clinician face-to-face.

"A couple of features differentiate AnywhereCare from other telehealth programs," says Alissa Meade, senior director, Strategic Business Development. "If the patient is a UPMC patient, the record of the e-visit is integrated directly into the patient's electronic health record. If not, we send a letter to his or her primary care physician. Also, AnywhereCare was developed with our own doctors, so it's our own platform with our own providers."

National figures show that e-visits with health care providers have increased 400 percent since 2012. "We see this as a powerful way to improve access, timeliness and quality of care," says Lovelace. "Telehealth is an important part of a smart health care strategy."

Improving Every Care Process, Every Day

MARTIN'S POINT HEALTH CARE

Portland, Maine

The busy South Portland Medical Center is open six days a week, with patients coming and going all day. It is hard to imagine staff members fitting in additional work, but for more than a year they have been engaged in an intensive, time-consuming but highly productive project to evaluate and improve every single process that contributes to patient care.

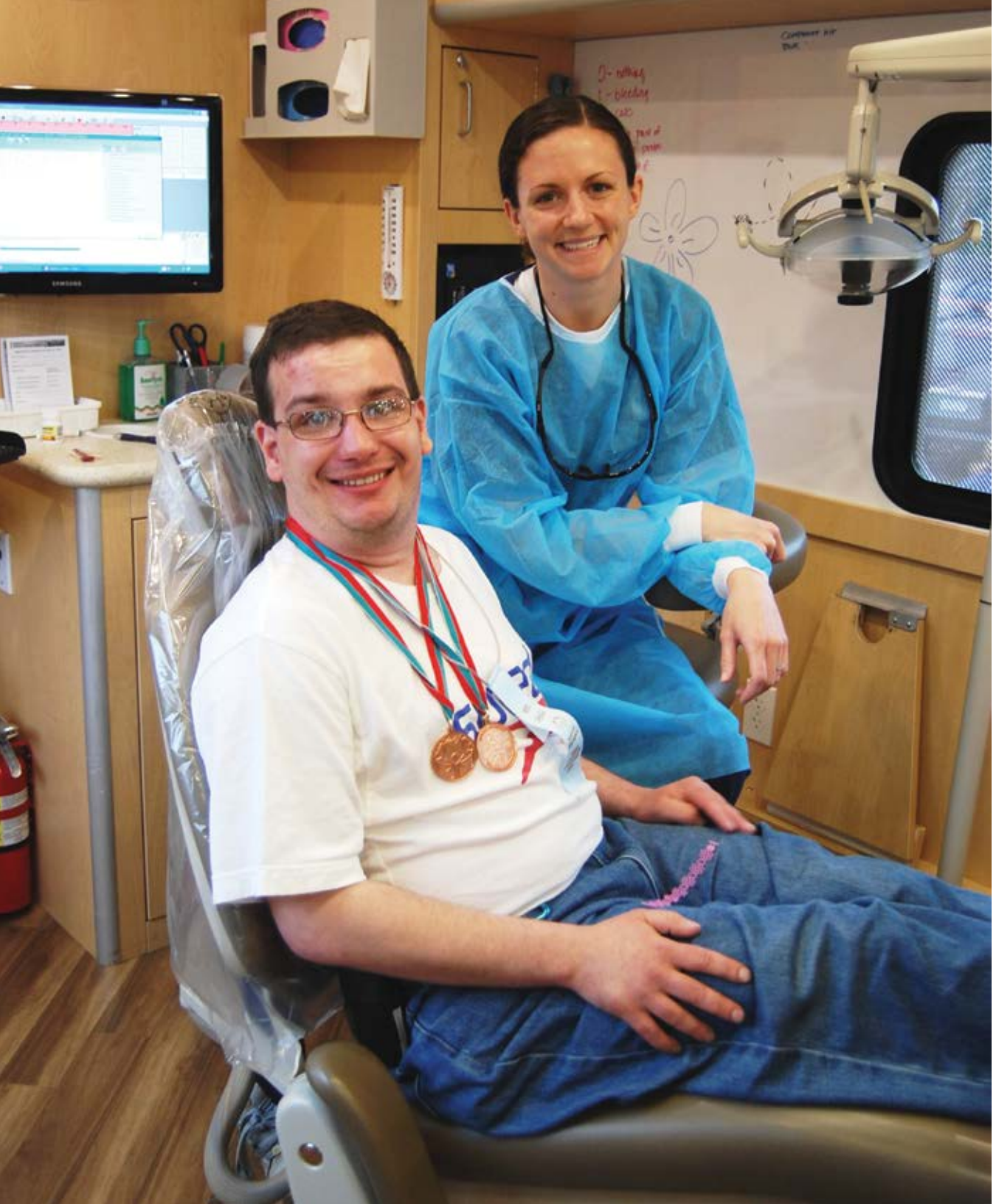
"From the moment a patient calls our office until they are seen and they leave the building we are looking at every single step to find ways to reduce waste," says Practice Administrator Lynn Roberts. Roberts says the initiative, using Lean human-centered design principles, has been challenging but highly effective.

Creating reliable processes that produce reliable results requires standardization. "We have always delivered high-quality care," says Roberts. "But everyone did things in their own way, which means the patient experience was different every time." Roberts says it took about a year to get from "zero standard work" — meaning none of the patient care processes were explicitly standardized — to 80 percent standard work, leaving an appropriate 20 percent for adaptation.

The staff also focused on ensuring that everyone works at the top of his or her training. "Physicians were spending too much time on administrative work when they should spend most of their time using their clinical skills," says Roberts. "We redesigned processes around who could create lab orders, refill prescriptions, fill out forms. We re-routed a lot of documents that used to pile up in providers' in-boxes. They were sifting through hundreds of things they didn't need to see. We cut down their in-box load by about 50 percent."

Roberts believes that the staff members' success at improving processes is due in part to some important foundational work they did together before they embarked on the Lean journey. "I wanted everyone to have the same tools in their toolboxes, so we did some training about basic things like how to talk to each other when things aren't going well, how to focus on fixing processes, not people, and how to accept, and even embrace, different styles of thinking and working."

As all innovators know, it is a continuous journey. The entire staff, including physicians, meets every day for a 15-minute huddle to check in on improvement work and goals. "Without everyone's engagement, you can't move forward," says Roberts. "The huddles keep us engaged on a daily basis."



Engaging Patients

Community health plans know that good health requires patients to be actively engaged in their care. Programs and processes that help patients more easily access care and engage with providers result in better health for individuals and healthier communities.

Rewarding Members for Healthy Behaviors

FALLON HEALTH

Worcester, Massachusetts

Fallon Health leaders wanted to know more about what members and other consumers sought from their health plan. So they partnered with a research firm to host weekly conversations with groups of members and non-members and heard a variety of ideas and suggestions on different topics.

"But there was one concept that kept rising to the top, and we knew we should act on it," says Janis Liepins, vice president of marketing. "People felt they ought to be rewarded for healthy behavior by paying less for health insurance. They drew the parallel to safe driver discounts from auto insurers."

Enter Fallon's "Healthy Health Plan," a new standard benefit introduced in early 2013. The first of its kind in Massachusetts, the Healthy Health Plan provides as much as $200 in cash to adult members who are or become healthy.

The program works like this: Adult health plan members who fill out an online health risk assessment receive $50, and are eligible for an additional $150 depending on the results. Those who are already healthy — with low risk for developing health problems — automatically receive the additional money, along with encouragement to continue their healthy habits.

Members at moderate and high risk receive the balance if they complete a health action plan and begin to act on it. An action plan could include health coaching, wellness workshops, or interactive tools like meal planners and exercise tutorials. Each activity has a point value, and members must earn 150 points to qualify for the additional $150.

Why aren't the cash rewards based on health metrics like weight loss or reduced blood pressure? "Because overwhelmingly our consumers told us they did not want this type of program," says Milissa Obara, director of product management. "They felt it wouldn't be fair to people who have a genetic predisposition to certain health risks." In addition, the resources required to measure, evaluate and report participants' results would be significant, not to mention inconvenient for the participant. "We are trying to make it easier for people to get healthy, and we know that our coaching and wellness programs are really effective," says Obara.

Tailoring Communications to Members' Preferences

TUFTS HEALTH PLAN

Watertown, Massachusetts

As the health care industry shifts to a more member-centric environment, Tufts Health Plan is working to increase understanding on both sides of the relationship. The health plan is trying to better understand the member experience, and working to help members become better consumers of care.

"Health care is complex," says Paul Kasuba, M.D., senior vice president and chief medical officer. "How can we simplify the experience for our members?" To help answer that question, Tufts Health Plan leaders have identified and examined specific touch points throughout the member journey, from selection of coverage all the way through service delivery.

Using this information, they created five composite fictional personas that represent about 85 percent of the health plan's membership. For example, "Jose" is a young, single man who is mostly interested in fitness; "Michelle" is 35, married and expecting her first child; and "Kevin" is 64, an empty nester with chronic back pain.

Tufts Health Plan staff analyzed how the member journey might play out, and how it should play out, for each persona, identifying points where the member experience could be improved. Not surprisingly, a common denominator in every scenario is the need for effective communication, particularly with new members.

Communicating well with customers is not a new concept. But mapping the member experience for each persona, and then testing ideas with focus groups, helped to highlight for Tufts Health Plan leaders the need to segment the market in order to communicate in different ways with different types of consumers.

Younger members such as "Jose" prefer high-tech communication tools like a mobile ID card or a wearable fitness tracker. Young pregnant women are very interested in a treatment cost estimator to help them plan their pregnancy care and expenses. Older members like the idea of a "buddy program" through which they are assigned a specific personal customer service representative who can help them with all their questions.

Tufts Health Plan is also piloting an interactive new member kit. About 15,000 members have received a USB card instead of the traditional paper kit. More than half of those who received one opened it immediately, and the rate of new members who chose a doctor online was far greater than for those who received paper kits.

Reaching At-Risk Patients with Team-Based Care

UCARE

Minneapolis, Minnesota

Asthma can be a challenging condition to live with and treat. Those with poorly managed asthma make frequent visits to emergency departments (ED) for "rescue care," resulting in stress and expense that could ideally be avoided. Effectively

Improving UCare Members' Asthma

- Since the inception of the program, UCare has seen a ***51 percent reduction in emergency department visits*** and a ***27 percent reduction in inpatient admissions*** for members who take part.
- In a member satisfaction survey, ***100 percent of respondents agreed they are better able to manage their asthma*** post-intervention.
- Of those who responded to the survey, ***96 percent indicated they get useful information from the respiratory therapist*** during the home visit and follow-up calls.
- 83 percent both made an appointment with their doctor for a routine asthma care visit and feel they are now able to participate in most activities without asthma-related breathing problems.

Through education and regular interaction, UCare has improved health, lowered costs and enhanced the health care experience for its members with asthma.

managing asthma requires commitment and focus from both caregivers and patients — which is exactly what UCare's asthma management program has achieved. As a result, patients in the program have experienced more than 50 percent fewer ED visits and a 27 percent decline in hospitalizations.

UCare began using a telephone-based asthma coaching program in 2005, through which higher-risk asthma patients received automated voice-response calls, an annual asthma action plan and other services intended to help them manage their health. UCare also reached out to local schools to partner with school nurses around asthma care.

But these efforts weren't enough, leaders realized. Too many patients were still suffering from asthma attacks, landing them in the ED or hospital. So in 2012, UCare introduced a team-based home visiting and case management program for asthma patients found to be at high risk for hospitalization, and a gift-card incentive program for members to participate.

The team includes a respiratory therapist who makes an initial home visit and assessment, the results of which are shared with the patient's pediatrician or primary care physician. The caregivers then work as a team with the patient and family to create and monitor an appropriate action plan.

Because UCare serves a large portion of the Twin Cities' Somali population, the asthma team also includes a Somali community health worker who can help bridge the cultural and language gap. This is thanks to a partnership with Wellshare International, a nonprofit that works with the Somali community.

The program has succeeded at keeping patients healthier and out of the hospital. Nearly all patients surveyed say the program has helped them better manage their condition, and that the respiratory therapist provides useful information. More than 80 percent have made appointments with their doctors for routine asthma care and report having fewer asthma-related problems. And during the program's two years so far, participants' per member/per month costs dropped by more than 13 percent.

Teaching Resilience to Those Who Need It Most

CAREOREGON

Portland, Oregon

Resilience is one of life's most valuable traits, and many psychologists believe it is a quality that can be learned. To help teach and support the ability to meet or rise above challenges, CareOregon has created a Health Resilience Program for members who are medically complex, sometimes resistant to treatment and most in need of support and personal coaching. The program is yielding encouraging results.

To help identify those who might benefit from such a program, CareOregon examines records of members who have had at least one hospital admission or more than six visits to the emergency

department (ED) over the past year. Clinicians can refer those whose high utilization is found to have been inappropriate to the Health Resilience Program.

The program is designed for complex patients with multiple chronic conditions, often including mental health conditions and challenging social issues such as unstable housing, food insecurity or social isolation. More than 60 percent of those in the program have a substance abuse disorder.

If providers identify the need for intervention, CareOregon dispatches a Health Resilience Specialist, a health care worker with a behavioral health background who is tasked with developing close, meaningful partnerships with high-need patients. Specialists are masters-level social workers, often with experience working in the Portland community with the Medicaid population, and they are selected because of their proven ability to engage individuals who are resistant to treatment.

Specialists partner with and guide vulnerable patients through a care planning process that includes identifying personal health goals and lifestyle changes, and ensure that people with mental illness receive the medical attention and emotional support they need. They visit patients in their homes and develop a highly individualized approach to addressing each person's unique set of challenges. This might involve traditional medical assistance, such as accompanying them to a medical appointment, or more non-traditional help, such as helping them move out of a destructive home environment.

The program has enrolled more than 1,100 patients. After two years, enrolled patients have had a 35 percent reduction in their average hospital and ED admission rates. These are tangible measures of a program that is also yielding profound personal results that cannot be so easily quantified.

CareOregon's Health Resilience Specialists partner with and guide vulnerable patients through a care planning process that includes identifying personal health goals and lifestyle changes, and ensure that people with mental illness receive the medical attention and emotional support they need.

Ensuring a Healthy Start for Mothers and Babies

DEAN HEALTH PLAN

Madison, Wisconsin

Low-income women who live in Wisconsin's Dane or Rock counties have a better chance at a healthy pregnancy thanks to an innovative new collaboration between Dean Health Plan and Dean Clinics. "The health plan hires nurse case managers and embeds them in the clinics' Ob/Gyn departments to identify and enroll patients who can benefit from our new medical home program for women with high-risk pregnancies," says Stacy Monahan, government programs education and outreach coordinator. The initiative is available to women enrolled in BadgerCare Plus, a state program for low-income residents.

The nurse case managers collaborate and coordinate with the clinic's care team, and help members make and keep appointments; connect with other medical providers; understand and follow the care plan; find community resources and help coordinate other services; choose a doctor for the new baby; and set up the first appointment after delivery.

"We're very focused on overcoming health disparities," says Monahan, which is why Dean Health Plan has implemented these special medical homes in five clinics. "We've found that almost 80 percent of our Medicaid members are eligible to enroll."

Eligible enrollees must sign up before their 16th week of pregnancy, so nurse case managers comb through appointment schedules at the clinic to identify potential candidates for the program. "If a Medicaid member is coming in to see a doctor about a pregnancy, the nurse case manager will speak with her before or after the appointment to explain the program," says Monahan. In addition, some women are automatically eligible if they meet certain criteria, such as being 18 or younger, homeless, or having a chronic medical or behavioral health condition that might negatively affect the outcome of their pregnancy.

The program includes a home visit — if members consent — and at least 10 prenatal appointments and one post-partum check-up. Nurse case managers keep in close touch with the women throughout their pregnancies by phone, email and text messages.

The program officially began in July 2014, so

the first babies will arrive in early 2015. "We are looking forward to a lot of healthy babies in the new year," says Monahan.

Helping Seniors Stay Fit

NEW WEST HEALTH SERVICES

Helena, Montana

According to a 2014 study, Montana ranks 13th among the 50 states for the amount of physical activity in which its citizens regularly engage. Montanans like to be active, and New West Health Services, which serves Medicare members, is helping to ensure that its members can stay active as long as they like.

New West offers all its enrollees free membership in Silver&Fit®, an exercise and healthy aging program that gives members access to local fitness facilities, or brings fitness programs right into the home. "Members can enroll free of charge," says Ryan O'Connell, director of marketing and sales. "And just like a network of medical providers, Silver&Fit offers a network of gyms and exercise centers that are widely spread throughout the service area, and convenient for most of our members."

Regular exercise is an essential component of healthy aging, and the long Montana winter is not always conducive to outdoor activity for seniors. A gym membership helps members stay active and fit year-round. Silver&Fit members can use all the amenities at their fitness facility, including pools and whirlpools. They can also take fitness classes offered as part of the facility's standard membership package, including tai chi, yoga or exercise classes designed specifically to help boost seniors' strength and balance to prevent falls.

The gym memberships also provide another important benefit for the Medicare population, says O'Connell. "Many of the seniors I talk with say going to the gym is not just about getting some exercise. It is also a really important social time for them." Being socially connected is also associated with healthy aging.

For members who are less mobile or who simply prefer to exercise at home, Silver&Fit provides home-based exercise kits. The kits come in different "flavors," says O'Connell, including strength exercise, yoga or dance. "The kits include training videos, written guides and light equipment such as stretch bands."

Midway through 2014, O'Connell says about 5,000 of New West's 22,500 Medicare members had taken advantage of Silver&Fit memberships. The health plan is working to increase that number. "It's a great benefit," says O'Connell. "It's free to our members, and it supports good health, which is something we want all of our members to enjoy for as long as possible."

Challenge and Inspiration: Reflections from ACHP's Outgoing Board Chair

Michael W. Cropp, M.D., president and chief executive officer of Independent Health in Buffalo, N.Y., stepped down at the end of 2014 after two years as chair of the ACHP Board of Directors. We asked him to share some of his observations as he ended his term.

What do you think are some of the most common challenges currently facing community health plans?

I think one of our biggest challenges is to continually find better and more effective ways to improve the overall health of the communities we serve. As a nation we spend more than $2.5 trillion on health care, and about 75 percent of that cost is related to chronic conditions. A lot of chronic conditions are driven by lifestyle choices, such as smoking or not getting enough exercise. For example, studies show overweight and obesity cost the U.S. $147 billion in 2008 and could add $344 billion to direct health care costs if nothing is done soon. So in order to improve health and reduce costs, we need to continue developing programs and processes that support healthy habits for families and individuals in our communities. Much has been written and debated about health care reform and coverage, but it's really about health, and improving the overall health of our community. This is one area where community health plans are leading the way.

In what ways are community health plans leading the way toward better health?

Because we are locally rooted, community health plans truly understand the needs of the people we serve and how to meet those needs. We are very good at working together with other local organizations to support good health. Here at Independent Health, we have partnered with a local grocery store to offer our members money-back rewards for buying fresh produce, as part of our nutrition benefit. There are innovative examples like this at so many ACHP member health plans.

Are community health plans making a difference beyond the local level?

Absolutely. In fact, I believe the only way things change at the national level is when they start at the local level. ACHP member health plans provide care and coverage for more than 18 million Americans. We are among the best health plans in the nation as assessed by the NCQA. We set the bar for innovation and excellence, and we exert a very strong influence on the health care system throughout the nation. ACHP is highly respected on Capitol Hill as a reliable source of information about effective health policy.

How does ACHP help its member health plans meet the challenges of improving health, access and affordability?

ACHP provides an exceptional forum for its member health plans to work together to share ideas and solutions. Each health plan is distinct, but we all face similar challenges, and ACHP provides unique tools, resources and connections that help us meet those challenges. It is an impressive group of organizations with innovative leaders that don't compete, but readily collaborate so we regularly learn from each other.

What has inspired you during your tenure as ACHP board chair?

I have been continually inspired by the extraordinary dedication and creativity I've seen among the leaders and staff of these outstanding health plans, and at ACHP. This is a remarkable group of leaders who never stop thinking about and working toward better health for their members, and better health care for the nation. It has been my honor to serve as board chair of this important organization.

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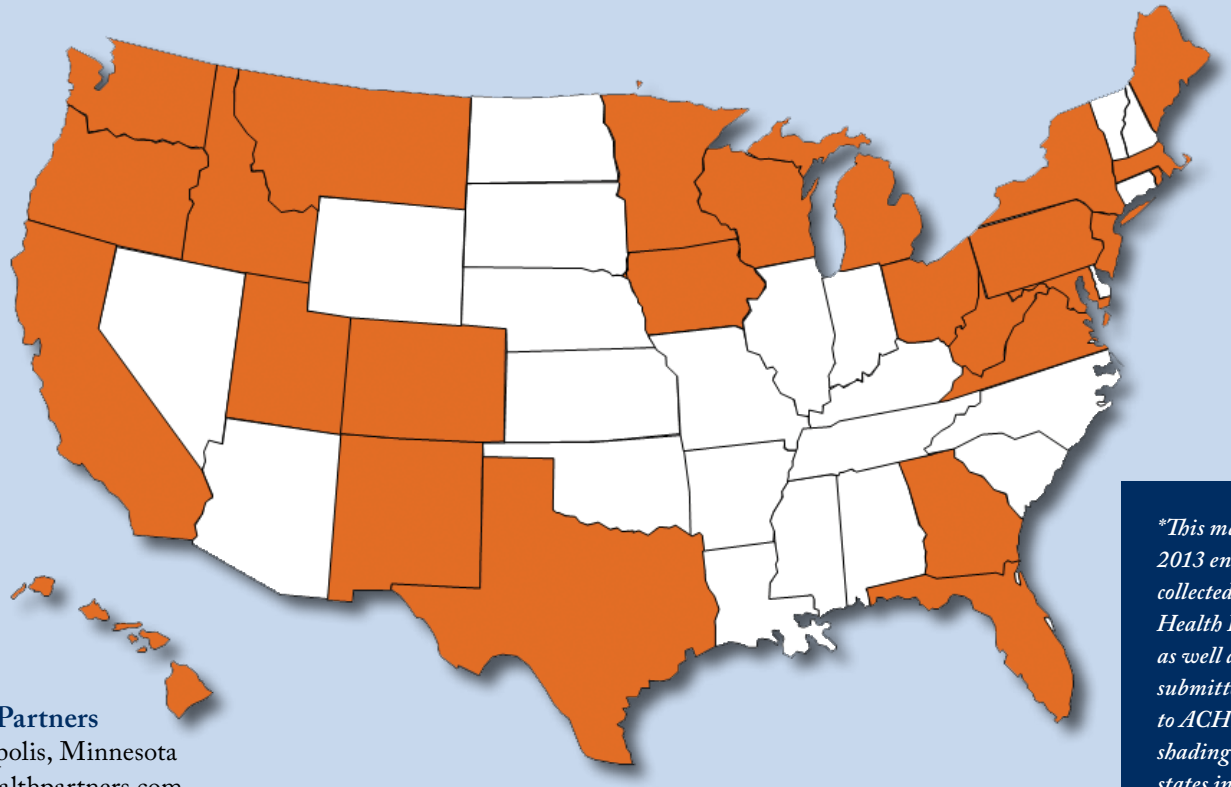
ACHP Members



**This map reflects 2013 enrollment data collected through AIS's Health Plan Directory as well as data submitted by members to ACHP. Orange shading indicates those states in which ACHP member plans do business.*

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 Health
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: Kaiser Foundation Health Plan and The Permanente Federation
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 Year in Review: A Focus on Policy, Programs and Performance

In 2014, our member plans delivered high-quality, affordable, patient-centered, cost-effective health care in communities across the country. In Washington, ACHP advocated for policies that support this work, facilitated networking and learning opportunities and highlighted our members' leadership on the national stage.

ADVOCATED SOUND PUBLIC POLICY

Through our strong relationships on Capitol Hill and in the Administration, ACHP has:

Helped shape Medicare Advantage payment policy

- We successfully advised the Centers for Medicare and Medicaid Services (CMS) to withdraw a proposal that would have limited how diagnoses from Health Risk Assessments are used in calculating risk adjustment payments. This and other steps significantly lowered the potential loss in funding and reductions in benefits that would have followed.
- We continue to lobby for elimination of a cap on Medicare Advantage payment "benchmarks," a move that will restore more than $100 million to member plans to fund additional benefits for Medicare enrollees. Payment rules for 2016 that will be developed during 2015 will require similar vigilance and coordinated ACHP lobbying efforts.

Led the way on Medicare Advantage and quality

- We continue to deliver a strong message to Congress and the Administration in support of the Medicare Advantage Star Ratings and quality incentive payments, estimated to augment funding for Medicare Advantage benefits offered by ACHP plans by $800 million in 2014.
- In more than 75 meetings with members of Congress, committee staff and Administration officials, ACHP has recommended steps to achieve high-quality, affordable care through Medicare Advantage and the use of transparent metrics to drive quality, competition and greater accountability.
- We are lobbying members of Congress to reverse current policy that limits payment for telehealth-based services in the Medicare Advantage basic benefits package.

Navigated the regulatory environment

- In 2014 we submitted 13 formal responses to proposed rules or requests for comment on issues ranging from policy on Medicare payments for hospice services to quality ratings for plans in the exchanges.
- We have been instrumental in convincing the Center for Medicare and Medicaid Innovation to move forward with an initiative allowing greater flexibility for Medicare Advantage plans to implement models that have been successful in their commercial business.

EXPANDED LEARNING & INNOVATION PROGRAMS

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. In 2014 we:

Facilitated innovation in accountable health communities

- Through the ACHP Medical Directors Council, we helped our members focus on four strategic priorities: health system redesign (expanded from delivery system redesign); consumerism; care delivery; and community health (expanded from population health).
- To focus on cost and community, we created collaboratives to dive deeply into pharmacy and behavioral health issues.
- In 2015 we will add another learning collaborative focused on high-cost, high-need populations and we will intensify our focus on service innovation.

Produced informative reports

Our two high-visibility reports are based on work by the pharmacy and behavioral health learning collaboratives:

- ***Dollars and Sense: Putting Specialty Drug Costs in Perspective*** educates key stakeholders about specialty drug costs and provides them the information needed to begin addressing the issue. To highlight the release of the report, ACHP gathered an expert panel of key stakeholders at a Capitol Hill briefing. More than 70 individuals from the Hill and health care organizations joined us in a standing-room only presentation on how the costs of specialty pharmaceuticals are affecting care and costs across the country.
- ***Community Health Plan Strategies for Improving Mental Health*** describes innovative programs at five ACHP member plans to better treat those with mental illness. The report, which features case studies of community health plans using their deep local knowledge to improve care and reduce stigma, was released at a webinar at which representatives of three of the featured plans spoke. The webinar garnered 142 attendees and the online report has been viewed nearly 7,000 times.

DEMONSTRATED DISTINCTIVE VALUE AND PERFORMANCE

Provided powerful tools to boost performance and quality

- ACHP gives member plans access to our premier quality benchmarking tool, the *HealthPlan Performance Gauge*®. This set of custom analytic tools allows plans to precisely dissect their quality rankings and ratings and target improvement areas.
- We help our members understand and achieve exceptional quality performance on the MA Star Ratings and the National Committee for Quality Assurance Health Insurance Plan Rankings. We keep them informed of potential and planned changes to quality measures and ranking/rating methods.

Connected marketplace leaders

- Through new monthly "marketplace issues" calls, in addition to our annual in-person Marketplace Focus meetings, ACHP enables plans to share their experiences with state and federal exchanges and their perspectives on market trends.
- ACHP also launched an initiative to help our members better connect to purchasers through efforts focused on private exchanges, multi-state employers and evaluating potential collaborative opportunities for expanded network access.

COMMUNICATED TO AND ABOUT OUR MEMBERS

- We ensure 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 through consistent messaging, reports, public events, blog posts, social media, our report to the community and op-eds in local newspapers and publications based in Washington, D.C. We ensure that our members are well-informed about ACHP activities as well as events and activities at fellow member plans.

Top-Performing Plans

In the 2014-2015 National Committee for Quality Assurance (NCQA) rankings of all health plans, 9 of the nation's top 10 Medicare plans, 6 of the top 10 plans in the commercial rankings and 3 of the top 10 Medicaid plans are offered by ACHP plans. Sixteen ACHP plans have the top commercial ranking in their state.

NCQA's measurement drives quality improvement that directly affects more than 130 million Americans nationwide. Health plans are ranked based on clinical performance, member satisfaction and NCQA accreditation.

Commercial Plans Top 50

RANK	PLAN
1	Tufts Associated Health Maintenance Organization (HMO/POS)
5	Kaiser Foundation Health Plan of the Northwest (HMO)
6	Tufts Benefit Administrators (PPO)
7	Kaiser Foundation Health Plan of Southern California (HMO)
8	Kaiser Foundation Health Plan of Northern California (HMO)
9	Martin's Point US Family Health Plan (HMO) (ME)
12	Geisinger Health Plan (HMO/POS)
13	Kaiser Foundation Health Plan of the Mid-Atlantic States (HMO)
14	Group Health Cooperative of South Central Wisconsin (HMO)
16	Capital Health Plan (HMO)
18	Kaiser Foundation Health Plan Hawaii (HMO)
19	Kaiser Foundation Health Plan of Georgia (HMO)
20	UPMC Health Plan (HMO)
21	UPMC Benefit Management Services (HMO)
24	Capital District Physicians' Healthcare Network (HMO/POS)
25	Capital District Physicians' Health Plan (HMO)
26	Group Health Plan (HealthPartners) (HMO/POS/PPO)
26	HealthPartners (HMO/POS/PPO)
26	HealthPartners Administrators (HMO/POS/PPO)
29	Kaiser Foundation Health Plan of Colorado (HMO)
32	Independent Health Association (HMO/POS)
34	Fallon Health (HMO/POS)
39	Capital District Physicians' Healthcare Network (self-funded) (PPO)
39	CDPHP Universal Benefits (PPO)
41	Security Health Plan of Wisconsin (HMO/POS)
45	Martin's Point US Family Health Plan (HMO) (MA, NH, NY, PA, VT)
48	Priority Health (HMO/POS)

Medicare Plans Top 25

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	Capital Health Plan (HMO)
5	Kaiser Foundation Health Plan Hawaii (HMO)
6	Kaiser Foundation Health Plan of Colorado (HMO)

8	Kaiser Foundation Health Plan of Georgia (HMO)
9	Kaiser Foundation Health Plan of the Mid-Atlantic States (HMO)
10	Geisinger Health Plan (HMO)
11	Group Health Plan (cost) (HealthPartners) (HMO)
12	Capital District Physicians' Health Plan (HMO)
14	Group Health Cooperative (HMO)
17	Security Health Plan of Wisconsin (HMO/POS)
20	Priority Health (HMO/POS)
21	Martin's Point Generations (HMO/POS)
22	Fallon Health (HMO)
24	Priority Health (PPO)

Medicaid Plans Top 25

RANK	PLAN
1	Network Health (Tufts Health Plan) (HMO)
2	Fallon Health (HMO)
6	Kaiser Foundation Health Plan Hawaii (HMO)
11	Priority Health (HMO)
13	Security Health Plan of Wisconsin (HMO)
15	Capital District Physicians' Health Plan (HMO)
21	UPMC for You (HMO)
22	Independent Health Association (HMO)

Seven members of the Alliance of Community Health Plans (ACHP) earned 5 stars from the Centers for Medicare and Medicaid Services (CMS), the highest score awarded to health plans participating in the Medicare program. Only 11 plans (contracts) in the country received this rating. Overall, 28 Medicare plans (contracts) operated by ACHP members received 5, 4.5 and 4 stars in the Star Ratings released October 10 by CMS; plans offer combined Medicare Advantage (Part C) and prescription drug (Part D) coverage. Additionally, one plan offered by an ACHP member received 5 stars for its stand-alone Medicare plan (Part C). These high-rated plans from ACHP member organizations are available in 18 states and the District of Columbia.

Plans with the Top-Ranking Commercial Plan in their State

Capital District Physicians' Health Plan (NY)

Capital Health Plan (FL)

Geisinger Health Plan (PA)

Group Health Cooperative of South Central Wisconsin (WI)

HealthPartners (MN)

Kaiser Foundation Health Plan of Colorado (CO)

Kaiser Foundation Health Plan of Georgia (GA)

Kaiser Foundation Health Plan Hawaii (HI)

Kaiser Foundation Health Plan of the Mid-Atlantic States (DC, MD, VA)

Kaiser Foundation Health Plan of the Northwest (OR, WA)

Kaiser Foundation Health Plan of Southern California (CA)

Martin's Point Health Care (ME)

Presbyterian Health Plan (NM)

Scott & White Health Plan (TX)

SelectHealth (UT, ID)

Tufts Health Plan (MA, RI)

ACHP plans receiving 5 stars for their combined Medicare Advantage and Part D plans:

Group Health Cooperative

Kaiser Permanente California

Kaiser Permanente Colorado

Kaiser Permanente Hawaii

Kaiser Permanente Mid-Atlantic

Kaiser Permanente Northwest

Martin's Point Health Care

ACHP plan receiving 5 stars for its stand-alone Medicare (Part C) plan

Dean Health Plan

ACHP Staff

Left to right: Jennifer Phillips, Michelle McLean, Betsy Pray, Karlee Averett, Howard Shapiro, Toni Fanelli, Jasmine Jones, Patricia Smith, Alex Orton, Lynne Cuppernull, Michael Ly, Holly Bode, Matthew Fuentes, Sophia Bushong, Chloe Stier, Lindsay Arrington, Stephen Cox and Christine Shen Moreschi.

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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. ACHP's member health plans provide coverage and care for more than 18 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 quality of care, including primary care redesign, payment reforms, 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.

ACHP plans enroll more than 18 million Medicare, Medicaid and commercial members in 29 states and the District of Columbia.

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 member 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.

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

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