

HEALTH CARE 2030

ACHP's Roadmap to Reform



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Executive Summary

America's health care system has needed repair for years. But the COVID-19 pandemic thrust an unforgiving spotlight on the system's shortcomings and the urgent need for change.

Our hospital-based acute care system is expensive, inconvenient and inefficient. Chronic conditions are on the rise, and life expectancy has declined in America. Differences in health outcomes are determined primarily by zip code, limiting the wellbeing and economic opportunity of entire communities. Inappropriate, low-value interventions drive up costs and put patients at risk. And the fragmented, fee-for-service system rewards clinicians for doing *more* things to *more* people *more* often.

Scientific innovation has led to life-saving advances, but taken as a whole the system is underperforming. The pandemic gives new urgency to population health investments and a value-driven approach that puts patients first. Private sector solutions give us the opportunity to make vast improvements without extreme disruption or added cost.

In this report, the Alliance of Community Health Plans (ACHP) lays out nonpartisan, practical changes for immediate and long-lasting improvement. ACHP's vision for the next decade of reform promotes a system focused on health and healthier communities – one that safely delivers care where and when patients want it; one in which evidence guides decision making; one in which quality and outcomes are paramount; and one in which data is both secure and accessible. Greater investment in primary care, prevention, telehealth, mental health and screening for unmet social needs offers a proven path forward at this critical juncture.

The strategies tested and perfected by ACHP member companies nationwide are the basis for **Health Care 2030: ACHP's Roadmap to Reform**. The roadmap prescribes a clear path to refashioning an industry from the current *sick* care model to one that's designed for *wellbeing*. And because ACHP member companies are built on a collaborative model that brings together health plans, clinical teams and the community, our solutions advance the interests of individuals, not Wall Street investors. Decades of on-the-ground experience give ACHP members the ability not only to create a roadmap for others to follow, but also to take our own advice, lead by example and provide an evidence-based framework that transcends politics.

As part of the 10-year plan, ACHP member organizations commit to addressing areas that offer the most significant opportunities for health improvement and greater value. These areas include **reducing the prevalence of chronic disease** and implementing real solutions to **improve health care affordability**.

Fully realized, the roadmap moves the country toward a system that enhances the health of individuals and communities. Together, these improvements will shape the system for long-term sustainability and a healthier nation.

HEALTH CARE 2030: ACHP'S ROADMAP TO REFORM



- 1. Advance the Payer-Provider-Aligned Model to Promote Health** by fostering close collaboration that produces better health outcomes and spurs innovation.



- 2. Complete the Journey From Volume to Value** by designing incentives around quality of care and outcomes instead of quantity of services.



- 3. Put Communities First** by providing consumers personalized information, easy-to-use tools and nurturing partnerships that empower individuals and communities.

America's health care system must work for every individual and every community. Unfortunately, it continues to fall woefully short. ACHP has developed a 10-year roadmap to deliver better care more efficiently and effectively.

THREE OVERARCHING AIMS TO IMPROVE THE HEALTH OF COMMUNITIES AND THE NATION

1. Advance the Payer-Provider-Aligned Model to Promote Health



! The Problem

The nation's \$3.6 trillion fragmented health care system — or more accurately, sick care system — suffers from misaligned incentives and fails to meet individuals where they are with the services they need when they need them.

ACHP member companies are built around a unique approach to health care, putting the patient at the center with health plans and clinical teams collaborating to improve outcomes and reduce costs. Core to the payer-provider model is the mission to provide high-quality, coordinated coverage and care. This approach aligns incentives to deliver the right care at the right time in the right place.

Support for a robust primary care system with access to behavioral health services is vital to improving the health of individuals and communities. The partnership between payers and providers strongly impacts the success of these efforts.¹

An advanced primary care system must focus on prevention, management of chronic conditions and the delivery of appropriate, high-value care. Studies have demonstrated that health systems offering comprehensive primary care have superior patient outcomes, fewer health inequities and lower overall costs. However, the United States spends on average just five to seven percent of total health care spending on primary care, less than half of other industrialized nations.²



STRENGTHENING PRIMARY CARE

- Invest in high-value primary care payment models that ensure support for comprehensive, coordinated, team-based primary care with proven results.
- Make home-based options available for patients who are chronically ill, struggling with behavioral health or in need of palliative care.
- Compensate primary care providers to connect their patients with community-based services that help address social needs, manage chronic conditions and address acute care.

¹ Accelerating Adoption of Evidence-Based Care: Payer-Provider Relationships. Alliance of Community Health Plans. November 14, 2018. <http://bit.ly/Evidence-Based-Care-FN>.

² Investing in Primary Care: A State Level Analysis. The Patient-Centered Primary Care Collaborative and the Robert Graham Center. July 2019. <http://bit.ly/PCPCC-Primary-Care-FN>.

The **COVID-19** pandemic **flipped the telehealth switch** almost overnight.

Critical to advancing primary care and the payer-provider model is meeting consumers where they are with the services they need. Telehealth is fundamental to that success. ACHP has long promoted virtual care as a tool for improving care coordination, improving access and reducing costs. Broad flexibilities temporarily provided by federal regulators during the COVID-19 pandemic flipped the telehealth switch almost overnight, resulting in usage surging to nearly three times its previous levels.

89%

WITH AN 89% APPROVAL RATING³
in a national poll, telehealth is no longer optional.

Given consumer enthusiasm and the potential savings inherent in telehealth, policymakers have a rare opportunity to sustain the momentum created during the pandemic.

SUPPORTING TELEHEALTH EXPANSION

- Expand coverage and reimbursement outside of site-of-service requirements, allowing care to be delivered in the home, the office or other community setting.
- Increase the types of health professionals eligible to deliver telehealth to include non-physicians, alternative practice providers and primary care teams.
- Form a comprehensive approach to universal access to telehealth services across all federal health programs, especially for populations with greater social needs and without access to reliable internet.

To continue the gains of the payer-provider-aligned model, all medical professionals must be empowered to practice to the top of their license. Tapping nurse practitioners, physician assistants and a range of alternative practice providers – free of outdated network adequacy standards – will feed the virtuous cycle of greater access, improved health and lower cost.



PAYER/PROVIDER PARTNERSHIP SPURS INNOVATION

Security Health Plan's long-standing collaboration with Marshfield Clinic Health System spurred an innovative, comprehensive, team-based approach to recovery care that is reducing costs and improving health in Wisconsin. The payer-provider relationship fostered alignment of financial incentives, a collaborative leadership strategy and the infrastructure needed to launch the Home Recovery Care program. More than 150 traditionally inpatient conditions (e.g., congestive heart failure, chronic obstructive pulmonary disease, pneumonia, cellulitis and deep vein thrombosis) are now safely and cost-effectively treated at home. The program has enabled Marshfield and Security to reduce costs by 17 to 30 percent compared to a typical hospital admission. Even better, the efforts have produced a 55 percent reduction in readmissions, a 38 percent reduction in average length of a hospital stay and patient satisfaction has continued at about a 98 percent level. Launching this program would not have been possible without the willing partnership between health plan and health system.

³ "Shifting Consumer Health Care Behavior." The Alliance of Community Health Plans. May 21, 2020. <http://bit.ly/Consumer-Behavior-FN>

2. Complete the Journey From Volume to Value



! The Problem

The American health system is addicted to fee-for-service medicine. As long as clinicians are rewarded for the number of procedures delivered, rather than the best patient outcome, health care will remain inefficient, unaffordable and unsustainable.

In order to fully transition to a system focused on higher quality care at a lower cost, evidence-based approaches that prioritize health outcomes must be promoted and rewarded. Baby steps such as pilot programs and bonus payments have not achieved this goal.

As the COVID-19 crisis demonstrated, the fee-for-service model failed providers struggling for survival when the volume of services plummeted overnight. By contrast, provider groups and delivery systems partnering in value-based contracts maintained economic stability, even during the lockdowns, and were positioned to focus on delivering appropriate care to patients, largely through telehealth.



Time and again, research shows that when we pay for care differently, quality and outcomes improve, resulting in greater value for our health dollars. A recent study published in the *Journal of the American Medical Association* found that the health care system wastes up to \$101.2 billion a year in overtreatment or low-value care and up to \$78.2 billion a year for failing to coordinate care.⁴

With the United States spending more on health care per capita than any industrialized nation, it is incumbent on everyone to substantially reduce low-value, unnecessary and often dangerous care and spend our limited resources wisely. It is time our health system rewarded value not volume, quality not quantity.

Providers and health plans serving Medicare Advantage (MA) have proven how a value-based, patient-centered approach with set payments drives quality and efficiency. In contrast to the fragmented, fee-for-service Medicare program, MA emphasizes value, offering highly coordinated care and more benefits at a lower cost to both taxpayer and beneficiary. MA keeps seniors healthier and out of the hospital and emergency rooms — two of the most expensive and medically dangerous entry points in the health system.⁵



MAXIMIZING ACCESS TO HIGH-QUALITY, VALUE-BASED COVERAGE

- Expand seamless conversion to high-quality payers to create convenience and continuity of care as individuals move through federal insurance programs (e.g., from Medicaid to an Exchange plan, Exchange plan to a Medicare Advantage plan, etc.)
- Enroll seniors entering the Medicare program in top quality-rated Medicare Advantage plans where available.
- Increase enrollment and marketing opportunities for health plans that offer promising new approaches to managing chronic conditions.

⁴ Dhruva SS, Redberg RF. "A Successful but Underused Strategy for Reducing Low-Value Care: Stop Paying for It." *JAMA Intern Med.* 2020;180(4):532. February 10, 2010. <http://bit.ly/JAMA-Reduce-Low-Value-Care-FN>.

⁵ "Medicare Advantage: Savings for Seniors and the Nation." The Alliance of Community Health Plans. Sept. 27, 2020. <http://bit.ly/MA-Savings-FN>

REMOVING BARRIERS TO COMPETITIVE DRUG PRICING

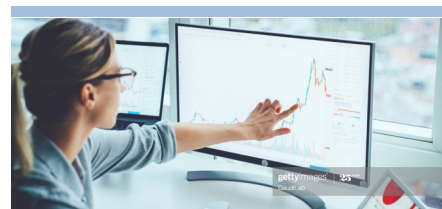
- Reform the anti-kickback statute and Medicaid price reporting to recognize and encourage value-based contracting for prescription drugs.
- Reform intellectual property laws used to block lower-cost biosimilar drugs from entering the market; promote FDA approval and clinical adoption of more biosimilars.
- Curtail patent abuses by empowering the Federal Trade Commission to crack down on anti-competitive behavior and requiring drug manufacturers to provide rationale for increasing list prices.

Holding health plans accountable for providing high-quality coverage and improving health outcomes is essential in the transition to value-based care. Accountability begins by streamlining and simplifying quality measurement that guides purchasers and providers in making smart choices. A 21st century quality measure approach includes standardized metrics for all federal health care programs — Medicare, Medicaid, Exchanges and the Federal Employees Health Benefits Program.

To inject value into the prescription drug market and help manage costs for the consumer, health plans are testing outcomes-based contracting. Under the approach, consumers and health plans pay only for drugs that perform as promised. The arrangements can lower spending for health plans by holding drug makers accountable: if the therapies don't work, drug makers don't get paid.

Yet outcomes-based contracting is still in its infancy and drug prices are busting family and health plan budgets today. In fact, a recent study from GoodRx found drug prices grew faster than any other medical service or good, increasing by 33 percent between 2014 and 2020.⁶ It is time for policymakers to insist on transparency in pricing practices, promote approval and adoption of biosimilars and crack down on patent abuses that keep new drugs off the market. Therapies developed with federal dollars should provide a return on that investment to taxpayers.

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ASSESSING RISK TO DRIVE VALUE

Risk stratification is another means of driving value across the health ecosystem. For example, UPMC Health Plan adopted the Risk Analysis Index (RAI) tool to quickly predict a patient's risk for poor outcomes following surgery, including postoperative death, readmission and extended hospital stays. Through UPMC's payer-provider partnership, organization leaders were able to socialize the routine risk assessment and importantly, develop a pathway for patients identified as "frail" by their index scores to receive an additional evaluation. This "pause" provides clinicians an opportunity to take a step back, gather more information, engage the patient further in shared decision making and, where appropriate, care planning to mitigate risk and optimize patients' health before surgery to improve outcomes. After implementing the RAI tool and completing approximately 50,000 frailty screenings, UPMC observed a number of benefits: 21 percent of patients were referred to a non-operative approach, cancellations and delays on the day of surgery were prevented, length of hospital stay and the one-year mortality rate following elective surgeries were both reduced.

⁶ Tara Marsh. "Prescription Drug Prices Rise Faster Than Any Medical Good or Service." GoodRx. September 17, 2020. <https://bit.ly/2EjpQxi>

3. Put Communities First



! The Problem

The current health care system imposes countless barriers on individuals in need of care, is slow to reflect or adapt to changing needs of consumers and does little to prioritize the total health of communities.

The COVID-19 crisis has revealed the fault lines that define our system and its disconnect from the health of individuals and their communities. A community-based approach to health care puts the patient at the center, surrounded by clinicians, health plans and social service partners, to meet the individual needs of patients. Community-driven care assesses and addresses both the clinical and social needs of the individual with a tailored approach.

It is critical that our health care system make strategic investments to address unmet social needs. To make real progress in this area, health systems should integrate social workers, community health workers, gerontologists and other community-based partners into care delivery teams. This integration can be incentivized through investment and reimbursement as a standard component of any health benefit design.

Many ACHP member plans currently have well-developed programs in their communities that integrate social care and medical care. Central to the success of these efforts are broad social service partnerships, often with the health plan serving as a connector between the most vulnerable patients and available services. There is great potential to expand these opportunities by including social needs as a criterion in federal grant applications, including non-health grants such as housing and education. Further, health plans acting as the vital connector should be provided the authority and funding to work with federal agencies, states and communities to create financing partnership models that assist with federal inter-agency coordination to address community and social needs more effectively.

*Health systems should **integrate social workers, community health workers, gerontologists** and other community-based partners into care delivery teams.*



ADDRESSING SOCIAL NEEDS THROUGH FEDERAL PROGRAMS

- Expand Medicaid's home and community-based service programs to meet critical needs of individuals with the services that support daily living.
- Provide Medicare Advantage plans additional flexibility and the full quality bonus to provide services to patients with chronic conditions and those who have unmet social needs.
- Distinguish Medicare Advantage plans offering innovative benefit designs to manage chronic conditions through copay-only formulary designs or special supplemental benefits for the chronically ill.

In addition to addressing social needs, a community-driven approach provides consumers with personalized information and easy-to-use tools that empower individuals and families to engage in their health care. Consumers need actionable and specific cost and quality information based on their coverage, location and personal preferences. Independent certification of consumer-oriented transparency tools would validate that price and quality information is accurate, timely and relevant to patients and family members trying to make informed decisions about care.⁷

*It is time to **drive access** to information and **empower individuals** to make their best choices.*

Importantly, transparency tools and other technology must be balanced with strong consumer protections, especially related to personal health data. Modernizing current laws and regulations governing health privacy, data and security can spur innovation while also providing guardrails for new entrants such as third-party app developers. Equitable and consistent security standards would further safeguard consumer privacy. It is time to drive access to information and empower individuals to make their best choices.

EMPOWERING CONSUMERS AND PROTECTING HEALTH CARE DATA

- Create easy-to-use consumer tools that are independently certified for accurate, timely and relevant information accessible to patients and families.
- Modernize governance of health privacy, data and security and create guardrails for non-traditional entrants such as third-party app developers.
- Create a new privacy security framework that protects data regardless of where it is stored, maintained or accessed applicable for both HIPAA and non-HIPAA covered entities.



EMPOWERING CONSUMERS THROUGH TRANSPARENCY

Priority Health's online Cost Estimator tool is tailored to an individual's insurance coverage, offering full transparency into cost and quality data, helping the consumer choose the best option for care. Available across commercial, individual and Medicare Advantage plans, the tool shows a range of prices for medical services and pharmaceuticals. Priority Health also offers financial rewards for using the tool, incentivizing individuals who simply search for a procedure and learn more about it, all the way to allowing them to share in the savings generated when they choose services based on value. Shoppers who select procedures that are priced below the fair market price, for instance, can earn back hundreds of dollars. The tool's utilization rates far exceed industry average, the health plan has reported more than \$11 million in shared savings and has paid out roughly \$2.6 million in rewards to members. That translates to about \$680 saved per procedure.

⁷ Certification of Health Care Digital Tools: Personalized, Timely Pricing Gives Consumers the Information They Need to Make Smart Choices. The Alliance of Community Health Plans. Feb. 11, 2020. <http://bit.ly/Transparency-FN>.

TIME FOR ACTION

The COVID-19 pandemic has shined an unforgiving spotlight on the shortcomings of our nation's fragmented \$3.6 trillion health care system, badly in need of reform. Now is a pivotal opportunity to refocus and improve. ACHP member plans are committed to being part of the solution and are taking concrete steps to lead the way.



Focus on Chronic Disease

Few of the targeted health outcomes are more important than preventing and managing **chronic disease**. As chronic conditions are responsible for 75 percent of total health care costs and the majority of deaths in the United States⁸, achieving this goal will reduce costs and improve quality of life. ACHP members will be the first health plans to track and improve population-based outcome measures for chronic disease. Focusing on diabetes and heart disease, ACHP member plans and their provider partners pledge to measure and address the specific drivers of these chronic conditions in their communities.



Improve Affordability

ACHP will also release an annual **Report on Affordability** that details initiatives and proven successes for improving affordability. Drawing on the experiences of ACHP member companies, the report will offer on-the-ground examples that reduce the cost of care in communities across the country. When health plans manage premiums, provide enhanced benefits, lower costs for governments and employers and innovate to deliver value-based care, the system — and outcomes — improve.

Emerging from the COVID-19 pandemic, we can fashion a better health care system devoted to affordability, effectiveness, equity, transparency and value. Our post-pandemic world deserves a system that, above all, addresses patients' needs and produces the best health outcomes for everyone.

This roadmap shows the way.

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ABOUT ACHP

The Alliance of Community Health Plans (ACHP) represents the nation's top-performing nonprofit health plans to improve affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to tens of millions of Americans. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data-driven systems improvement.

⁸ Richard V. Milani, MD, & Carl J. Lavie, MD. "Health Care 2020: Reengineering Health Care Delivery to Combat Chronic Disease." *The American Journal of Medicine*, 2015;128(4):337-343. April 2015. <http://bit.ly/HC-2020-FN>.

