



Aligning for Value

An Interview with ACHP's Ceci Connolly



Ceci Connolly is the president and chief executive officer of the Alliance of Community Health Plans (ACHP). In her role, she works with some of the most innovative executives

in the health sector to provide high-quality, evidence-based, affordable care. Connolly has spent more than a decade in health care, first as a national correspondent for the *Washington Post* and then in thought leadership roles at two international consulting firms. She is co-author of *LANDMARK: The Inside Story of America's Health Law and What it Means for Us All*, and has covered six presidential campaigns and numerous natural disasters, including Hurricane Katrina. She is the first non-physician to receive the prestigious Mayo Clinic Plummer Society award for promoting deeper understanding of science and medicine and, in 2001, was awarded a fellowship to Harvard's Kennedy School of Government. Connolly serves on the board of Whitman-Walker Health, is a founding member of Women of Impact (WOI) for Health Care, and serves on the national advisory committee of the Altarum Institute Center for Sustainable Health Spending. *Group Practice Journal* interviewed her recently when she was speaking to the board of directors of AMGA Foundation.

GPJ: *What are some of the biggest trends that will have the greatest impact on the healthcare industry in the next 10 years?*

Connolly: Technology and consumerism are two of the most significant forces hitting the health sector today, though the pace of change varies widely by market and line of business. Technology enables care to be delivered more conveniently and will continue

to evolve as clinical teams and health plans become truly patient-centered. The industry is already adapting to the demand for technology, convenience, and access. Health systems and many provider groups have successfully invested in telemedicine, and a number of health plans have developed apps to provide even greater access to health information.

We will also see the government's role as purchaser evolve as the number of Americans with government-supported health care grows. About 10,000 baby boomers become eligible for Medicare every day, which will expand Medicare enrollment from 57 million beneficiaries today to 75 million in 10 years. At its current expenditure of \$600 billion annually, Medicare accounts for about one-fifth of all national health spending—and that will double in 10 years to \$1.2 trillion. In addition, since the passage of the Affordable Care Act (ACA), 17 million previously uninsured Americans have gained coverage through Medicaid and the exchanges.

The market itself also continues to change as we see mergers, new entrants, creative partnerships, and employers contracting directly with health systems. Consumers are demanding convenience and the market is responding—evidenced by recent actions from companies such as CVS, Walgreens, and Amazon refashioning themselves to compete. There's no doubt this trend will continue as convenience-driven consumers drive the direction of the economy.

For decades, baby boomers have driven product innovation, member engagement strategies, and customer service—and as they live longer and make up the majority of Medicare beneficiaries, they will reshape that market as well. However, as millennials—an even larger demographic group—reach their mid-30s, they will become the major decision makers for families, companies, and governments, purchasing insurance products, bringing their own distinct set of values and preferences that will necessitate innovation in the insurance market.

GPJ: *What do you regard as the biggest challenges facing leaders in the healthcare industry?*

Connolly: The rising cost of health care will continue to challenge industry leaders. In 1960, U.S. healthcare spending as a percentage of U.S. Gross Domestic Product (GDP) was just above 5%. By 2010, it was almost 18%. And a recent study published in JAMA indicates that healthcare spending rose by nearly \$1 trillion between 1996 and 2013. Prescription drug costs continue to rise at unsustainable rates, increasing premiums as a result. A growing, aging population and the increasing cost of specialty care causes even more strain on the system. We have to get costs under control if we want a sustainable healthcare system that works for plans, providers, and patients alike.

Leaders will also face challenges, including implementing value-based care, establishing

population health efforts, and creating mutually beneficial partnerships. But, we must continue to press ahead because American consumers deserve a high-value, high-performing health system.

GPJ: *What was it that led you to transition from a journalist to a career in health care? And how does your experience as a journalist support your current leadership role?*

Connolly: After spending nearly a decade writing about health care—and documenting the good, bad, and ugly—I wanted to get closer to the action. I believe strongly that the ACHP model of bringing coverage and care together offers the brightest future for the U.S. health system and our citizens. Aligning incentives in partnerships that can be formal, integrated delivery systems or informal arrangements leads to better health outcomes and greater value. Getting doctors and insurers on the same page—the patient page—is what drew me to ACHP and gets me out of bed every morning, even in these challenging times.

GPJ: *As the president and CEO of the ACHP, how do you feel health plans and providers can work together more productively for the patient community?*

Connolly: To create real value in care, payers and providers have to collaborate on coordinating care to improve patient outcomes. The organizations we work with have long recognized that when the relationship between payers and providers is mainly a struggle over money, patients lose because their needs are not prioritized. But when payers and providers are aligned with one another in aiming to improve value, combine data, and rationalize payment models, it's possible to better manage chronic

conditions, deliver high-value care, and address the social needs that drive so many adverse health outcomes.

We know from experience that better results are possible when organizations collaborate across traditional silos. For example, by embedding behavioral health case managers in primary care offices, Capital District Physicians' Health Plan, Inc. in upstate New York reduced emergency department visits by 76% for patients with mental health conditions, saving more than \$1,100 per patient. To meet social needs, collaboration with regional organizations outside the healthcare sector is often essential. Presbyterian Healthcare Services in New Mexico, for instance, works with La Cosecha, a community-supported agriculture program, to grow fruits and vegetables and distribute them to low-income families.

GPJ: *AMGA members have said fairly uniformly that the payer community is not engaged in the transition to value. What is your perspective on whether payers are engaged or not in this challenging transition?*

Connolly: Not only are they engaged in the transition, but nonprofit, provider-aligned, community-based plans have led the movement away from fee-for-service medicine to new payment approaches.

Some of these health plans for years have relied on salary or salary-plus-value incentives to pay physicians. Others provide capitated payments. Under both approaches, volume is not your friend—rather the motivation is to keep a patient population healthy.

Also, the Medicare Advantage program, now comprising nearly one-third of Medicare enrollment, pays plans on a per capita basis. While MA plans use a variety of

models in paying participating physicians, all of the plans have to focus on providing the right care at the right time if they're going to sustain their MA business. The same is true for Medicaid, where the majority of enrollees are now in managed care plans reimbursed on a per capita basis.

A couple of examples of promising developments:

Security Health Plan in Marshfield, Wisconsin, with many payers in its market, employs the Five-Star Quality Rating System used by the Centers for Medicare & Medicaid Services. Using the same guidelines as the federal government enabled providers to more easily accept alternative payments from a variety of plans in the region, without placing an undue administrative burden on the practice.

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Independent Health in Buffalo, New York, set up a value-based payment model with primary care practices five years ago. Because that approach has now been adopted by the local BlueCross BlueShield plan, most of the revenue for a majority of primary care physicians is tied to quality and efficiency—and that, in turn, has spilled over to the use of specialists and hospitals that are also committed to value.

It's not surprising that the shift from paying for volume to paying for value will take time and is likely to unfold in fits and starts across the country. But at the local level, led by health plans aligning payer and provider incentives and investing in practice transformation, the transition is off to a promising start.

GPJ: What are the key issues payers must address in getting to value-based payment?

Connolly: First and foremost, to get to true value, there has to be financial risk for all of the players, and that includes providers. It means maybe getting paid less if you're not a high-value clinician or health system. It might even mean fewer scans or surgeries or hospital beds. That can disrupt local economies, so we don't want it to happen overnight, but unnecessary, inappropriate, wasteful services are just that.

Some clinicians may need additional time to shift to value-based payment and government should continue to provide incentives and support as the transition occurs.

It's also important to tailor measures to the performance

improvement goals of individual physician practices to account for the infinite variations in healthcare systems across the country. At the same time, developing actionable performance data—which includes quality, cost, and patient experience—is also key. The data should highlight clear improvement targets and a path for reaching them.

Health plans are an essential part of this process and should regularly communicate with physician practices to review data, pinpoint improvement opportunities and share best practices, and, most importantly, be good partners.

There's evidence to suggest financial incentives are not uppermost in changing physician behavior, but purchasers seeking better value should be willing to compensate for

necessary investments and additional time as new processes are implemented.

GPJ: You are a founding member of Women of Impact for Health Care. What have you witnessed in the workforce that encourages you when it comes to women's influence in the health field?

Connolly: I would be lost without this incredible network of compassionate, smart, inspiring, brave women. They prove every day that women leaders are making an enormous difference in health care. At the same time, progress has been too slow. The number of female CEOs and board members is troublingly small. Thank goodness WOI and other similar organizations are pushing the envelope every day. **GR**

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