

December 15, 2017

## *Dear Policymaker:*

To further transform the U.S. health system from one focused on merely treating illness to one that also promotes prevention and healthy living, innovation is necessary to ensure that Americans have access to a high-quality, cost-effective and person-centered health care.

This paper leverages the extensive expertise of our healthcare organizations, which collectively have well over 100 years of experience in both providing healthcare services and administering healthcare programs that serve over 80 million Americans across the country, to provide specific recommendations for creating an efficient and effective healthcare delivery system. We believe that for all Americans to thrive, access to affordable and comprehensive healthcare coverage, innovative service delivery that leverages the latest technology, and a stable marketplace must be assured.

The recommendations outlined in this document represent new ways to deliver health care that is coordinated, provided closer to home and more economically deployed through the use of innovative strategies. We look forward to ongoing collaboration with system partners to create a services delivery system that improves health and service while achieving maximum value and reducing costs.

Sincerely,



Patti Darnley, *President and Chief Executive Officer, Gateway Health*



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# *Ecosystem of Care*

**Improving Health Outcomes and Bending  
the Cost Curve in Healthcare Programs**

Gateway Health



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### Executive Summary

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To further transform the U.S. health system from one focused on merely treating illness to one that also promotes prevention and healthy living, innovation is necessary to ensure that Americans have access to a high-quality, cost-effective and person-centered health care. Access to affordable coverage options is limited in numerous communities across the country. Additionally, rising healthcare costs, greater difficulty in securing physician appointments and longer waits at emergency rooms challenge the achievement of favorable health outcomes and erode individual satisfaction with a healthcare business-as-usual approach.

Gateway Health believes that for all Americans to thrive, access to affordable and comprehensive healthcare coverage (without annual or lifetime caps), innovative service delivery that leverages the latest technology, and a stable marketplace must be assured. To that end, we have developed a model of service delivery that incorporates four key elements we believe are critical for a sustainable ecosystem of care that improves health outcomes while bending the cost curve.

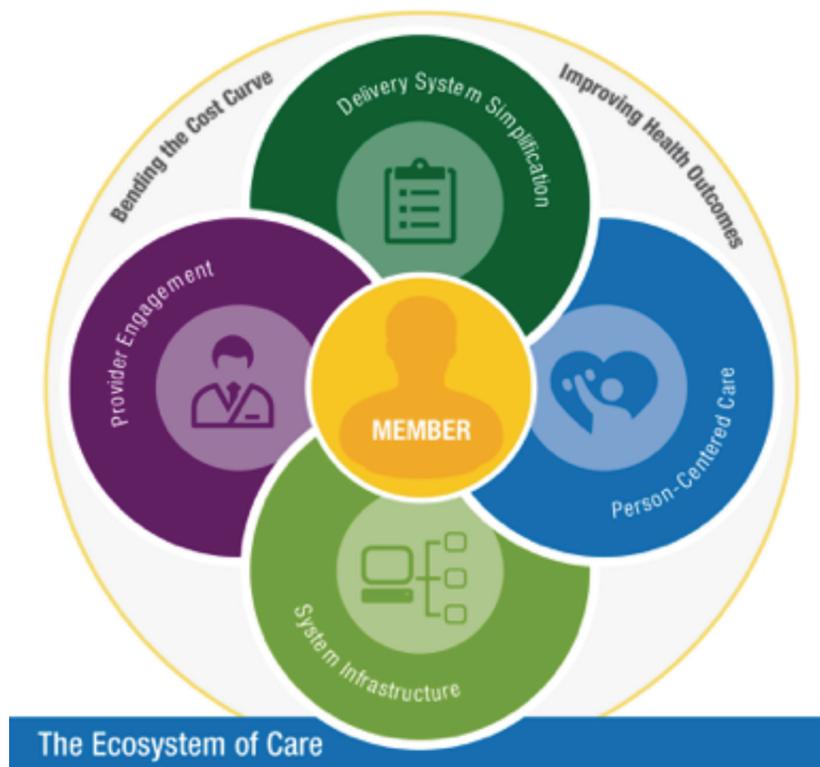


Figure 1: Necessary elements of the Ecosystem of Care to drive quality and bend the cost curve.

**Person-Centered Care:** The healthcare delivery system should be flexible to meet the specific needs of each individual and family. Programs should fully account for social determinants of health (health literacy, education, age, gender, housing, food instability, transportation, employment) that impact individuals' ability to access and engage in healthcare services, with the goal of helping individuals and families learn to make good choices that positively affect their health and wellness for the long term.

**System Infrastructure:** Payment reforms that align incentives across programs and providers to deliver better, more efficient care is critical for system transformation. Funding must be adequate to cover the true cost of care and consider program growth and innovation. Alternative payment models (APMs) should consider the resources necessary to support providers in adopting comprehensive population-based payment methods.

**Provider Engagement:** Developing accountable, accessible and high quality provider networks requires an adequate workforce of professional and paraprofessional workers, meaningful performance measurement and outcomes, performance-based payment, and strong analytic support. Further, providers need access to actionable data to help them make informed decisions and connect individuals to appropriate care at the point of service.

**Delivery System Simplification:** Streamlining administrative functions and regulations through integrated programs would reduce fragmentation in care, mitigate duplication of services, and lower administrative barriers at all levels (federal, state, health plan, provider). Investing in meaningful technology to improve access to critical information at the point of care and enhance data sharing will lead to better care and system efficiencies.

## **COLLABORATING ORGANIZATIONS**

The recommendations outlined in this paper represent the collective expertise of the following healthcare organizations, which collectively have well over 100 years of experience in both providing healthcare services and administering healthcare programs that serve over 80 million Americans across the country.

**Gateway Health:** Gateway Health is a not-for-profit, privately held, mission-driven, provider-led managed care organization serving individuals through Medicaid and Medicare Advantage plans, including Dual Eligible Special Needs Plans (D-SNPs) and Integrated Care Plans. Gateway serves members across Pennsylvania, Delaware, and West Virginia and they serve Medicare Advantage individuals in Pennsylvania, Ohio, North Carolina, and Kentucky.

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For 25 years, Gateway has worked alongside state partners, providers, and communities to bring comprehensive care and provide person-centered care management to their members, including low income older adults, children, the disabled, and those diagnosed with behavioral health conditions. Gateway is owned equally by Highmark Health and Mercy Health System, a member of Trinity Health.

**Highmark Health:** Highmark Health is proud to serve nearly 50 million Americans in all 50 states and the District of Columbia through their businesses in health insurance, healthcare delivery, post-acute care management solutions, managed vision care, retail eyewear and eye care with technology-based solutions. Highmark Health shares a deep commitment to getting health care right by improving the healthcare system, the health of local communities as well as the healthcare experience of the individuals they serve.

**Mercy Health System:** Mercy Health System is a diverse, integrated system providing comprehensive healthcare services in a community-based setting. Mercy Health System, a member of Trinity Health, comprises three acute care hospitals, a home healthcare organization, several wellness centers, physician practices, a federal PACE program. With 250 primary care and specialty physicians, Mercy Health System is a teaching community health system affiliated with Drexel University School of Medicine and the Philadelphia College of Osteopathic Medicine. As a mission-driven regional health ministry, Mercy Health System is a recognized leader in improving health care for communities and individuals served.

**Trinity Health:** Trinity Health is one of the largest multi-institutional Catholic healthcare delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity cares for more than one million Americans each year.

## OVERVIEW

Based on our decades of collective experience serving millions of individuals nationally, we know that a tailored, person-centered healthcare experience is one that:

- **Fully accounts for the social determinants of health** that impact an individual's ability to access essential healthcare services (age, gender, education, health literacy, food insecurity, homelessness, transportation, economic instability)
- **Tailors health interventions** to the unique needs of individuals and families
- **Offers a full continuum of services** from prevention to treatment and averts unnecessary inpatient and out-of-home care
- **Meets and individual's unique whole health needs** (physical, behavioral health and psychosocial) to truly meet them 'where they are'

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- ***Incentivizes medication adherence and treatment compliance***
- ***Reduces the use of intensive medical services*** and promotes management of chronic conditions

Building a healthier world requires fresh thinking and innovation. It calls for everyone in health care to rally together to improve health and service while achieving maximum value and reducing costs. We believe the recommendations outlined in this document represent new ways to deliver health care that is coordinated, provided closer to home and more efficiently deployed through the use of current technologies and innovations.

## *Ecosystem of Care*

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With total spending at \$3 trillion a year, or 18 percent of the U.S. economy, America's healthcare system is the most expensive in the world. Despite its high spending, the U.S. does not have the best health outcomes. [Life expectancy, for example, is 79.1 years in the U.S. and 80.9 years in the U.K.; while the U.S. spends more on health care than any country in the world, it ranks 12th in life expectancy among the 12 wealthiest industrialized countries, according to the Kaiser Family Foundation, a non-profit organization focusing on health issues.]<sup>1</sup>

Reform is necessary to create a sustainable healthcare system that offers individuals access to the care they need to achieve and maintain improved health and wellness. State and federal policy-makers, health plans, providers, and individuals must come together to develop an effective healthcare delivery system that improves clinical outcomes, slows disease progression, and minimizes barriers to quality care.

This document outlines Gateway's vision of healthcare transformation success, and is intended to encourage healthcare leaders and policymakers to engage in the dialogue needed to ensure high-quality, cost-effective, person-centered care for all Americans. We further describe each component of the ecosystem of care and provide recommendations for creating an outcomes-oriented system that bends the cost curve.

### **PERSON-CENTERED CARE**

The nation's healthcare delivery system must be flexible to meet the specific needs of each individual and family. It must address each individuals' whole health needs (medical, behavioral health, psychosocial, and substance use) through an integrated approach. Through innovative partnerships, payers, providers and communities should collaborate to mitigate the effects of the social determinants of health (housing, food instability, health literacy, age, gender, education, transportation, employment) on individuals' ability to access and engage in healthcare services.

For example, Gateway has been using its hallmark, person-centered, comprehensive assessment to gain information about an individual's Behavioral, Economic, Environmental, Medical, Social and Spiritual (BEEMSS) strengths and risk factors for over 15 years. The Care Coordinator engages in an intensive level of dialogue during a BEEMSS assessment that delves into areas that influence an individual's health and wellbeing, and drives a person-centered approach. From each

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<sup>1</sup> Source: <http://petersonhealthcare.org/identification-uncovering-americas-most-valuable-care/executive-summary>

assessment or reassessment, an individualized plan of care tailored to the individual's identified needs emerges. In our experience, this holistic and highly-personal approach is critical for supporting a person-centered model of care that helps individuals take responsibility for their health care, reduces costs and improves health outcomes.

#### **Engage Individuals in Healthcare Decision-Making**

When individuals and their families are active participants in their care, health, the experience of their care, and economic outcomes can be substantially improved. In our experience, engagement can be enhanced through the following strategies.

##### *Recommendations:*

- Using **low-cost premiums and health savings accounts** to encourage individual participation in preventive care. Arkansas, Indiana and Michigan are using this approach in their Medicaid programs.
- **Engaging individuals with easy-to-use-and-access information** that helps them find relevant and qualified doctors, the best hospitals for treatment, and the costs of treatment. For example, consider expanding the 'Physician Compare' initiative, which allows individuals to access useful information (location, specialty) about groups, individual physicians, and other clinicians currently enrolled in Medicare. Incorporating information on quality and satisfaction scores will enable individuals to have valuable information when selecting healthcare providers.

#### **Create Systems to Serve the Unique Needs of Vulnerable Individuals**

Chronic illnesses are significantly more prevalent among low-income and other disadvantaged populations. Low-income adults are nearly five times as likely to report being in fair or poor health as adults with family incomes at or above 400 percent of the federal poverty level, and they are more than three times as likely to have activity limitations due to chronic illness<sup>2</sup>. Low-income American adults also have higher rates of heart disease, diabetes, stroke, and other chronic disorders than wealthier Americans<sup>3</sup>. Therefore, implementing strategies such as those outlined below is crucial for addressing these health disparities, improving population health and reducing healthcare costs.

##### *Recommendations:*

- **Fund public health prevention programs** that effectively address social determinants of health such as supportive housing and community-based service providers.
- **Maintain a dedicated stream of funding for public health, wellness, and prevention initiatives** that prevent chronic disease and promote health through physical activity, healthy eating, tobacco cessation, and more.

<sup>2</sup> Braveman, P., and S. Egerter. 2008. Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America. Princeton, NJ: Robert Wood Johnson Foundation. <http://www.commissiononhealth.org/PDF/ObstaclesToHealth-Report.pdf>.

<sup>3</sup> Aron, L., Dubay, S., Luk, K., Simon, S., Woolf, S., Zimmerman, E. 2015. How Are Income and Wealth linked to Health and Longevity? Urban Institute and Virginia Commonwealth University.

- **Give health plans and provider networks the ability to tailor care** to individuals who are chronically ill in ways that best meet their needs.
- Reduce fragmentation in care by **integrating state plan services and waiver programs**, enabling individuals to access necessary services without additional application and enrollment processes.
- **Use alternative payment models** to encourage health systems to **address the social determinants of health**.
- **Allow for continued insurance coverage** regardless of life changes (employment, relocation, family change) to reduce gaps in insurance coverage that hinder individuals' access to care and may lead to skipped medical tests and treatments, producing preventable suffering and more expensive care.
- **Support an integrated model** that delivers a full array of medical, behavioral health, substance use services and community supports by expanding substance use benefits and implementing alternative payment models focused on improved care coordination.

## SYSTEM INFRASTRUCTURE

Our experience has taught us that affordable coverage incentivizes individuals to purchase insurance and responsibly engage healthcare services. In order for our healthcare system to be affordable and sustainable, we need to take action to reduce costs and promote effective, efficient care. This requires adequate federal funding that covers the true cost of care for all enrollees and considers program growth. Further, alternative payment models (APMs) must consider the resources necessary to support providers in adopting comprehensive population-based payment methods.

### Expand the Use of Alternative Payment Models

APMs such as Accountable Care Organizations (ACOs), bundled payments and advanced primary care models are already delivering on the promise of better care at lower costs. For example, in 2015 ACO models achieved an average quality score of 91 percent while achieving cost savings<sup>4</sup>. To ensure that healthcare programs receive the maximum benefit from these new models, we recommend that policymakers consider the following strategies.

#### *Recommendations:*

- Use per member per month (PMPM) payments to **reimburse primary care providers and medical homes for managing individual's preventive care needs**.
- Encourage the use of **shared savings models**, which have proven to be effective in increasing quality and individual satisfaction<sup>5</sup>.
- Incrementally **reduce Federal Medical Assistance Percentages (FMAP) for states that continue with fee for service models** and for states that allow health plans to reimburse providers using a fee-for-service methodology. FMAP currently stays the same for states that adopt APM models.

<sup>4,5</sup> Source: <http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/>

- **Expand the State Innovation Model (SIM)** and build on early lessons learned to drive statewide health system transformation.
- Establish benchmarks for the percentage of medical spend in **value-based payment models** that states and health plans must achieve to continue participation in federally funded programs. For example, some states such as Arizona and Pennsylvania have established targets for the percentage of medical spend that must be allocated to value-based payment models.
- **Align APMs across payers** to foster a system-wide commitment to achieving the Triple Aim - better health, better care and lower costs-for all individuals regardless of where or how they access the healthcare system.

## PROVIDER ENGAGEMENT

To meet increasing demand for healthcare services, the availability of healthcare providers needs to keep pace. We should further innovate within this system, using technology to connect and match individuals to the right healthcare professionals who are readily accessible and offer online appointment availability, and to whom the individual's relevant medical information can be delivered in an easy-to-access format.

### Expand Workforce Development Efforts

As experts in the delivery of healthcare services, we know that facilitating access to care requires us to implement strategies for workforce development. We support a system that allows practitioners to work at the top of their licensure, giving individuals access to the best care, provided by highly qualified providers. As demonstrated in the following recommendations, we believe that access to critical services in underserved and rural areas can be improved through focused efforts on workforce development.

#### *Recommendations:*

- **Increasing the scope of healthcare extenders** to address the primary care shortage and free physicians to care for more complex cases requiring their expertise.
- **Funding the use of community healthcare workers and peer supports** to engage individuals in health education and provide assistance in navigating the service delivery system, increasing individual knowledge of appropriate service utilization and reducing reliance on high cost care (emergency departments, hospitals).
- **Supporting the interstate medical licensure compact** to enable providers to work across state lines without having to obtain additional licensure.
- Providing additional **funding for existing federal and state bonus and loan repayment** programs to recruit and retain healthcare providers in underserved and rural areas.
- Promoting the use of **integrated, collaborative care teams** that enable health professionals to draw on individual and collective skills and experience across disciplines, enhancing the quality and safety of care.

#### **Leverage Information Technology Solutions**

Providers need actionable data at every point of contact to provide the best medical care and direction. Knowing the medications an individual takes, the preventive screenings they require, and the tests other treating physicians have ordered provides the opportunity for the best outcomes and reduces costs associated with inefficiency and redundancy.

Further, readily available health technologies offer the potential to support primary care services and provide immediate specialty consultation at a reduced cost. The solutions outlined below will work across multiple programs and health information systems, promoting greater efficiency and effectiveness.

#### *Recommendations:*

- **Integrate criteria for recording, analysis and billing of clinical services** into meaningful use requirements.
- Proliferate the **use of low-cost, scalable technologies** such as activity monitors, remote sensors, avatar coaches, distance consults, self-service kiosks and bio-metric scanners to improve care delivery.
- Require states to **give providers access to meaningful data** at the time of each patient encounter, empowering providers to reach better conclusions and implement better and more expeditious interventions that achieve superior health outcomes.
- **Fund information-sharing tools** (cloud-based tools, health information exchanges) to enhance coordination of care and information sharing.
- **Promote consistency and accuracy in data collection and sharing** by creating consistency in definitions and data collection processes.
- Develop an IT platform that supports an **all-payer claims database** to reduce administrative burden and facilitate timely and accurate claims payment across systems.

#### **DELIVERY SERVICE SIMPLIFICATION**

Current regulatory environment increases administrative burden and costs and compromises provider participation. Redundant administrative processes and inconsistent requirements (such as provider credentialing) associated with multiple programs results in increased costs, low provider participation in Medicaid and Medicare programs and inefficient service delivery. Simplifying program design and streamlining administrative functions and regulations through integrated programs reduces fragmentation in care, decreases duplication of services, and eases administrative burden at all levels (federal, state, health plan, provider).

#### **Simplify Program Design**

The proliferation of health insurance products, each with its own complex benefit design and payment methods inflicts high administrative costs on hospitals, physicians, and other providers. Simplifying program design through the strategies outlined below would preserve innovation and choice while improving efficiency, effectiveness, and equity.

##### *Recommendations:*

- **Implement a continuous enrollment policy** that reduces disruptions in health plan enrollment due to changes in a person's insurance coverage, employment status, or family structure which make care coordination difficult and increases administrative expenses. As individuals experience life events, their health insurance changes, leading to duplication in services (multiple screenings and testing), poor continuity of care as individuals have to "start over" with courses of treatment and physicians, and higher costs for the individual and the system.
- **Streamline Medicaid waiver options** available to states and require states to integrate programs as part of the waiver approval process. Currently, many states have multiple waivers with differing eligibility requirements and benefits, requiring individuals to complete numerous applications and receive care from multiple systems, proliferating fragmentation in care and duplication of services and contributing to rising costs.
- **Integrate federally funded health insurance programs** into a single program with standard eligibility criteria, benefit design and administrative requirements. Medicare, Medicaid, Children's Health Insurance Plan (CHIP) and waiver programs have separate requirements for provider participation, eligibility and administration. This adds administrative burden to providers, health plans and states, increasing costs and contributing to confusion for providers and individuals.

#### **Streamline and Reduce Federal Regulations**

Administrative complexity exists at all levels of the healthcare system, resulting in inefficient spending and delays in care. To reduce costs, increase quality and promote better care, healthcare providers need to be free to focus on care delivery without undue administrative burden.

Decreasing the resources needed to support the healthcare delivery system through streamlined processes such as those outlined below, will lead to better care and more efficient and cost-effective systems.

##### *Recommendations:*

- **Standardize administrative functions** such as enrollment, eligibility criteria, and benefits across federally funded healthcare programs.
- Create a **centralized, mandatory provider enrollment and credentialing system** that will provide all essential data to public and private payers.

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- **Coordinate reporting and enrollment systems** across national, state, and local regulatory bodies to reduce redundant tasks that take away from care.
- **Integrate electronic administrative transactions** with health information-technology initiatives so all stakeholders can communicate electronically and in real time for improved care delivery and efficiency.
- **Focus quality measurement and reporting** on a reduced number of meaningful Patient-Reported Outcome Measures (PROMs) that are aligned across programs and address desired outcomes - better health, better care and lower costs.

## **SUMMARY**

Gateway Health is committed to building people-centered health service delivery models that improve care, achieve better health outcomes and lower costs, enabling Americans to thrive. In our experience, person-centered care is based on meeting people 'where they are'. It is a basic human priority required for individuals to flourish and be productive. Comprehensive coverage, tailored health management approaches and innovation will allow people to use our nation's healthcare system more effectively, leading to increased provider and payer accountability, lower costs, a healthier population and a more vibrant and productive economy.