ONC’s Karen DeSalvo
Exclusive interview on interoperability challenges

2015 INDUSTRY OUTLOOK

PHARMA PRICING STRATEGIES

Payers find creative solutions in specialty pharmacy

- Prior authorizations
- Specialty pharmacy use
- Narrower networks
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For your **Benefit**
from DON HALL, MPH

2014: A YEAR OF GROWTH, CHANGE

Addressing 2015’s biggest question marks

From January to June of 2014, an estimated 12 million previously uninsured individuals received health coverage due under the Affordable Care Act (ACA). This unprecedented growth in enrollment challenged every aspect of health plan operations from customer service to premium billing to care management to provider network services. Providers also felt the impact, resulting in the development of new provider entities and models of care.

There are distinct differences between many of the newly insured and previously insured populations. Newly covered members include individuals who were previously uninsurable due to pre-existing conditions, as well as Medicaid expansion adults—some of whom are homeless. New enrollees with chronic high-cost conditions and/or significant behavioral issues are pushing health plans into new frontiers in care management.

A number of new entities emerged from the ACA including state and federal exchanges and co-ops. Despite early missteps, the exchanges were able to enroll more than 8 million individuals, including those enrolled through newly created co-ops in the 26 states in which they operate.

Due to the number of newly covered individuals, provider access was a big concern early in the year. While it’s uncertain whether the issue will remain in the future, care delivery models including telemedicine, nurse practitioners and physician extenders, and walk-in clinics that expand access beyond traditional means have grown substantially.

**Little left unchanged**

The legislation also spurred significant changes in health insurance offerings and renewed interest in care models. Guaranteed issue replaced individual underwriting, and essential health benefits were mandated. Dependents up to 26 years of age could be covered on a parent’s plan and strict medical loss ratio requirements were established. Add to that an emphasis on accountable care organizations, patient-centered medical homes and a more intensive effort to comprehensively manage care with a focus on lowering costs and improving outcomes, and it becomes clear that little on the healthcare landscape was left unchanged.

In fact, 2014 has seen the most significant changes in the healthcare industry since the advent of Medicaid and Medicare in 1965. The early predictions that the industry could not adapt to the ACA or that Americans would lack access to care, failed to take into account the resilience and innovation inherent in plans, providers, technology companies and a myriad of other service providers from care management to pharmacy benefit managers.

We move toward the end of the year with new approaches to improve health outcomes, slightly better affordability and an enhanced ability to respond to new environments. And the change we saw in 2014 is just the tip of the iceberg as many things put in place are still in their infancy.

**Looking ahead**

An unknown for 2015 is whether rates of uninsured will continue to fall. Will health insurance rates be competitive enough to attract more purchasers? The individual penalty/tax for those opting out of insurance coverage increases from $95 to $325. Will that be enough to get more people to move from the uninsured ranks? A number of states that opted out of Medicaid expansion for 2014 are looking at how they could participate going forward. Should this occur, it would have a significant impact on uninsured populations, health plans, and providers in those states.

Other trends include the impact of higher deductible plans on utilization, the continued growth in specialty drugs, the integration of electronic medical records and the appearance or growth of disruptive competitors in the healthcare market. Of course, the law of unintended consequences will prevail and the biggest changes are likely to occur in the areas we least expect.

**ABOUT THE AUTHOR**

Don Hall, MPH, is principal of DeltaSigma LLC, a consulting practice specializing in strategic problem solving for managed care organizations. He also is an editorial advisor for MHE.

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EXECUTIVES CHARGED WITH WEIGHING TECH INVESTMENTS

ACOs struggle with HIT interoperability

"Poor interoperability across systems and access to data is challenging for organizations attempting to do this," says Jennifer Covich Bordenick, CEO of eHealth Initiative. "The fact that 100% of the respondents found interoperability a significant challenge is telling. Everyone is struggling with this.

"I think this is wake up call for all healthcare decision-makers," Bordenick adds. "Executives need to carefully weigh their technology investment decisions, as it will directly impact their ability to deliver care and manage costs."

Organizations need policies and technology in place that allow them to access and share data with groups outside of their organization, she says. "Patients don’t live and breathe within a single network. If you want to successfully manage a patient’s care, you need to go beyond the ‘walls’ of your network," Bordenick says. "ACOs will need to find ways to work with competitors and groups they may not do business with right now and figure out cost-effective ways to connect."

ACCESS ISSUES

However, few ACOs report patient-facing tools that could increase access to care, such as self-service scheduling (33%), phone-based telemedicine (28%) or video-based telemedicine (24%). Given that a quarter of the ACOs contracting with the Centers for Medicare & Medicaid Services are forming in rural and underserved areas, it is concerning that organizations may be unable to leverage telemedicine to overcome access challenges or better manage populations in remote geographic areas.

Of the ACOs surveyed, 35% were in mature stages of operation (more than two years), 20% were in advanced stages of operation (between 18 and 24 months) and 20% were in intermediate stages of operation (12 to 18 months). Nearly all responding ACOs were of a medium to large size with between 101 to 500 physicians (39%) or more than 500 (41%) physicians. The ACOs primarily serve between 10,000 to 100,000 patients.
Several states initially opposed to expanding Medicaid coverage are now using alternative strategies to broaden coverage, lured by hefty federal funding and support for flexible “premium support” programs. More than 26 states and the District of Columbia, most led by Democrats, initially tapped the higher federal subsidies to expand Medicaid to cover childless, healthy adults with incomes between 100% and 133% of the federal poverty level. These expansion programs helped spur more than 7 million Americans to enroll in Medicaid over the past year.

Now more “red” states are following suit, adopting market-based approaches to provide benefits to low-income individuals in the “gap” between traditional Medicaid and higher-income consumers who can purchase coverage through state or federal exchanges.

Hospitals and providers have put pressure on states to devise ways to expand Medicaid coverage. Hospitals in states with limited Medicaid programs continue to experience heavy emergency room visits and uncompensated care by uninsured who cannot pay the fees. Conversely, health systems in Medicaid expansion states report notable reductions in charity care and higher admission rates, according to a report from PriceWaterhouseCoopers.

Private options
Recent Medicaid expansions in Republican states largely utilize Medicaid funds to subsidize individuals enrolling in health plans through public exchanges. In August, the Centers for Medicare and Medicaid Services (CMS) approved a premium support program in Pennsylvania, backed by Republican governor Tom Corbett. The demonstration plan provides assistance to some 500,000 low-income individuals; they will pay premiums limited to 2% of household income beginning in 2016 to purchase benefits from managed care plans on the state’s exchange. Pennsylvania hospitals urged this action to moderate the continued use of emergency rooms for uncompensated care.

Utah is talking to CMS about its three-year Healthy Utah pilot project that would use Medicaid funds to provide subsidies to some 50,000-75,000 individuals not eligible for Medicaid but unable to afford insurance. New Hampshire has expanded Medicaid but now seeks a CMS waiver to adopt a premium assistance model. And Indiana’s conservative governor Mike Pence may propose a private option to expand coverage to healthy adults without adding them to the state’s Medicaid rolls.

These states are following the lead of Arkansas, which gained CMS approval in September 2013 for a private option program that permits newly-eligible adults to enroll in managed care organizations (MCOs) offered to all consumers. Many of the 225,000 Arkansans eligible for the added coverage signed up, dropping the uninsured rate from 23% to 12% this year. Unfortunately, the program has been hit with political opposition at home and has run up higher-than-expected outlays, as revealed in a recent report from the Government Accountability Office (GAO). GAO is urging CMS to do more to monitor state Medicaid payments and controls on MCOs, particularly as more states follow the Arkansas model.

More than 20 states continue to hold out on Medicaid expansion. One is Virginia, where Republican legislators forced Democratic governor Terry McAuliffe to scale back his Medicaid expansion proposal by limiting added benefits to only 25,000 uninsured individuals with serious health problems. But Tennessee and Wyoming governors are talking expansion, and pressure on gubernatorial candidates in upcoming elections may lead to changes in Florida, Georgia and North Carolina. Experts predict that managed care plans will deliver care to 75% of Medicaid beneficiaries by 2015, and even more in the future, as states look to MCOs for more budget predictability and better care coordination.

ABOUT THE AUTHOR
Jill Wechsler, a veteran reporter, has been covering Capitol Hill since 1994.
BE ACCOUNTABLE FOR POST-ACUTE CARE

Care coordination technology and discharge planning are essential

Until recently, hospitals have not been accountable for coordinating patient care following discharge; that responsibility has traditionally fallen to other providers. But the Affordable Care Act has changed the game, migrating risk from payers to providers and requiring hospitals to focus their attention on what happens to patients during post-acute care. As a result, effective care coordination and discharge planning are essential for navigating and easing transitions, and ultimately improving payers’ bottom lines.

Enhance care coordination

Having skilled discharge planners or care managers on staff is vital to coordinate and facilitate post-acute care transitions properly, particularly for high-risk, high-criticality patients. Care or services can include a number of medical and nonmedical providers and include:

- Rehabilitation hospitals;
- Long-term care facilities;
- Home care organizations;
- Hospice;
- Outpatient services such as physical or occupational therapy;
- Transportation companies;
- Grocery or meal delivery services; and
- Cleaning and laundry services.

However, discharge staff are often overburdened by having to manually plan and coordinate every patient transition regardless of their risk potential or criticality.

By pairing staff with care coordination technology, hospitals can better prepare, plan and streamline patient discharges to:

1 Focus resources more effectively

- Healthcare information technology solutions such as web-based automated transition software are intended to make processes more efficient, thus allowing hospitals to focus their human resources more effectively when personal interventions are truly needed.

2 Engage family at admission

- Family engagement is important to achieving better patient outcomes. Based on the geometric mean length of stay for specific diagnoses, hospitals know approximately when patients will be discharged and can use this information to begin planning the patient’s discharge with the family as early as the time of admission.

- When integrated with care coordination technology, portal and mobile technology can also be leveraged to empower families to communicate with providers.

3 Facilitate, automate discharge process

- Using IT-enabled solutions instead of manual processes can enable hospitals to extract and automatically send discharge information to a receiving provider.

- Hospitals can also expedite the discharge process with technology by receiving responses from post-acute providers in as little as 30 minutes rather than days. This can be especially beneficial for hard-to-place patients.

4 Eliminate workarounds

- Some hospitals have resorted to placing patients under “observation status” for hours rather than admitting them in order to avoid penalties associated with readmissions and other quality measures. Eliminate this workaround by using coordination technology and analytics to stratify the patient’s risk for readmission.

ABOUT THE AUTHOR

Wayne Sensor is chief executive officer of Ensocare, a provider of care coordination solutions that helps hospitals achieve strategic priorities of reducing readmissions and length of stay.
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The Merck Access Program can help answer questions about access for KEYTRUDA. Call 855-257-3932. Representatives are available Monday to Friday between 8 AM and 8 PM ET.
Prior authorizations, specialty pharmacies seen as solutions

By JEFFREY BENDIX

Spending on specialty pharmaceuticals has been skyrocketing in the United States, and shows no signs of slowing down. In 2012, the U.S. spent about $87 billion on specialty pharmaceuticals—complex drugs and biologics that target relatively small portions of the population and often require special patient monitoring—and spending is expected to reach nearly $400 billion by 2020, according to a study by UnitedHealth's Center for Health Reform and Modernization.

While long a source of concern in the healthcare insurance industry, the issue drew wider attention earlier this year after sofosbuvir (Sovaldi) was approved for use in the U.S. for the treatment of hepatitis C—at a cost of $1,000 per pill, or $84,000 for a treatment regimen.

Continued on page 12
ilead [Gilead Sciences, Sovaldi’s manufacturer] did the industry a favor by bringing the costs of these drugs to the forefront,” says Bob Taketomo, Pharm.D., president and chief executive officer of Ventegra, a managed care contracting service organization. “People in the pharmaceutical and healthcare industries are asking what can we do in terms of ensuring appropriate use of these agents through benefit design and utilization management strategies?”

In mid-September, Gilead Sciences announced plans to sell Sovaldi in India for about $10 per pill. The company also said it had licensed Indian pharmaceutical companies to produce the drug for sale in India and other developing countries for far less than the cost in the U.S.

The growing costs of specialty pharmaceuticals is driven largely by their increasing availability, which in turn is the result of advances in pharmaceutical science and the economics of the industry.

“I think what we’re seeing is that the categories of blockbuster drugs for the more common disease states, like diabetes and hypertension, have had effective medications that are now coming off patent,” says Michael Zeglinski, R.Ph., vice president of pharmacy operations for pharmacy benefit manager (PBM) Catamaran and director of BriovaRx, Catamaran’s specialty pharmacy. “So the pharmaceutical companies are looking to the next generation of medications. And what they have left are disease states with smaller populations.”

In recent months several new major drugs for treating diabetes have come on the market, such as dapagliflozin (Farxiga), canagliflozin (Invokana), and empagliflozin (Jardiance). Zeglinski notes, however, that these drugs had been in development for the past five to 10 years.

“The current pipeline is filled with new drugs for other conditions, including treatments for orphan diseases that up until now haven’t received much attention or R&D investment,” he says.

Confronted with the escalating costs of specialty drugs, payers and PBMs have been employing a variety of strategies in an attempt to limit their financial exposure and improve patient outcomes, as shown in responses to Managed Healthcare Executive’s State of the Industry survey. The most common response among those surveyed has been to require some form of prior authorization to label (48.5%) or to studies used to gain FDA approval, before agreeing to provide coverage (17.9%).

Payers use prior authorizations for two reasons, says Howard Flushman, MBA, research director for specialty focused payer services for HealthStrategies Group. The first is medical monitoring, which Flushman defines as “ensuring the right doctor is giving the right drug to the right kind of patient for the right diagnosis in the right type of setting.”

The second is product selection control—making sure the product is being used according to label, under the correct protocols, and so on. In addition, he notes, “prior authorizations are the payer’s most significant data source on what the treatment plan for that patient is likely to be.”
Managed healthcare executive

Because of the burden prior authorizations impose, plans are experimenting with ways of minimizing them, says Flushman. Primarily these efforts consist of negotiating with a hospital system or physician group to use only agreed-upon medications and protocols for treating certain conditions in exchange for not requiring prior authorizations. “Only when [the treatment] becomes highly predictable to a payer can they negotiate a utilization management program that says ‘Doc, you don’t need a PA because we trust that every one of your breast cancer patients is going to be treated this way,” Flushman explains.

Requiring the use of specialty pharmacies is another tool payers use to limit their exposure to the cost of specialty drugs. Unlike retail pharmacy chains, specialty pharmacies have the resources to monitor patient adherence and reaction to drugs. That’s especially important in the case of oral oncology drugs, Flushman notes, because of the adverse reactions they produce in many patients. “Patients sometimes say they don’t want to take the [oral oncologics], but it’s life-threatening if they don’t, so someone needs to work with the patient,” he says.

Specialty pharmacies enable a “holistic approach” to patient care while addressing cost concerns, according to Zeglinski. “Most patients who receive specialty pharmaceuticals have numerous comorbidities as well, so we’re not treating just that one disease state but the entire drug portfolio for that patient.”

Like most specialty pharmacies, BriovaRx employs nurses who provide regular clinical counseling to patients using specialty pharmaceuticals. “The nurses walk them through the process and ensure they are taking their medications appropriately, they’re not having any adverse effects and are being as adherent as possible,” Zeglinski explains.

Much of the counseling BriovaRx provides takes place remotely using video technology available on most computers and mobile devices. “It’s very simple, the patient doesn’t have to install anything,” he says.

In addition to mandating the use of specialty pharmacies, some payers have begun narrowing their networks of them, says Susan Weber, director of brand access analysis for Health-StrategiesGroup, and requiring split fills of specialty prescriptions. “Payers are saying that a lot of patients have adverse event issues, so let’s cut the fill to a two-week supply and make sure they’re staying on therapy before giving them the other half. This saves them a lot of money, because some of these drugs can cost thousands of dollars per month,” Weber says.

Along the same lines, Weber adds, some payers are negotiating contracts with biopharmaceutical companies, especially producers of oncology drugs, under which the payer will require first-line use of the specialty drug on its formulary in return for receiving a discount from the manufacturer.

“What everyone’s challenge is today is to manage the disease, not just its individual elements.”

—HOWARD FLUSHMAN, MBA

The Pharmacy Benefit

Another way payers are attempting to reduce costs is by covering specialty pharmaceuticals under a plan’s pharmacy benefit rather than its medical benefit. That’s because claims submitted under the pharmacy benefit, unlike those submitted under the medical benefit, include a national drug code number. That provides payers with large quantities of data on prescription drug use among a plan’s beneficiaries, says Flushman, which better enables them to forecast their future expense levels.

The ultimate goal for payers, Flushman adds, should be to collect enough data to measure costs and outcomes for an entire episode of care, rather than just the medication.

“A general rule of thumb is that if plans don’t have a larger unit of cost to measure, they default to managing just individual unit product prices. What everyone’s challenge is today with these oncology and other specialty drugs is to manage the disease, not just its individual elements.”

2015 Industry Outlook continued on page 14
NARROW NETWORKS EXPANDING IN 2015

By Joanne Sammer

Narrow network plans will play an increasingly significant role in the healthcare landscape in the future. However, there are still some wild cards that could impact how successful these plans will be in 2015.

By definition, narrow network health plans offer consumers a trade off. Consumers get a lower plan premium and health plans have more control over the providers from whom plan members can obtain care. “The challenge for health plans is to somehow communicate to plan members that the term ‘narrow network’ does not mean a lower quality of care or less access,” says David Smith, director of payer services with Leavitt Partners in Chicago. “Plans will have to make sure that these are high performance networks that deliver a better experience to members due to better patient management.”

Early results from narrow network plans are encouraging. A study published by the National Bureau of Economic Research found that individuals enrolled in a narrow network plan in Massachusetts spent 40% less on medical care. These savings came from both fewer services used and the price paid for those services. Although these individuals made more visits to the primary care physicians, the savings came from fewer emergency room visits, less hospital care and less spending on specialists.

To attract individuals to these plans, transparency will also be crucial. Narrow network plans “have to be offered in a context where the consumer can choose a narrow network plan and believe that they are getting something in return for sacrificing some of the choice of provider,” says Paul Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy at the Schaeffer Center for Health Policy and Economics at the University of Southern California. That means making sure consumers have all available information necessary, including exactly which providers are in the plan, to make an informed choice. Few things will undermine the narrow network faster than members signing up thinking their chosen providers are in the network only to find otherwise when they seek care.

The providers chosen for these networks will not necessarily be the least expensive. “Insurers have more tools available to make good decisions about which providers to invite into their narrow network plans,” says Ginsburg. “Provider cost is being assessed not just by looking at unit prices but by looking through claims data for the overall cost experience of different providers.” Narrow network plans are also likely to find ways to tie physician pay to quality metrics, while also introducing other risk- and accountability-based measures.

As more people purchase health insurance through an exchange, Smith projects tremendous growth in narrow network plans with more co-branding between payers and hospital systems. “There will be a high prevalence of narrow networks over the next several years,” he says. “Everything that’s happening from an economic perspective and the ascendance of the consumer will continue to drive this.”

How would you describe members’ reaction to narrow- and tiered-network health plan designs?

<table>
<thead>
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Source: Managed Healthcare Executive original research, October 2014
Today, more than ever before, 'success' in the health insurance industry may be elusive because of significant market trends driven by the Affordable Care Act (ACA)," says William Lindsay, president of the Lockton Employee Benefits Group-Mountain West. Some segments of the industry can be expected to fare better than others. The key factor will be how plans adapt and align their strategies, capabilities, and practices—rating setting, benefit designs, marketing, retention, risk management, care management, network performance, data collection, and analytics—to the requirements of the ACA, according to Kip Piper, chief executive officer Washington, D.C.-based healthcare research firm, Medonomics. Moreover, "success will also vary as much by geographic region as market segment," says Lindsay.

Overall, commercial insurance plans, contrary to popular opinion, could do well under the ACA as a result of increased demand for coverage. While new regulation will reduce the margins realized by insurers as a result of increased enrollment, a new report by the Milliman Group finds some bright spots: high-risk or high-utilizer populations—including newborns, adult females, and the elderly—can actually be as profitable for plans as other beneficiaries. An important factor may be quickly identifying high-demand members and engaging them in interventions programs.

The ACA employer mandate is intended to spur development of employer-sponsored health plans, particularly among small to medium-sized businesses. "Insurers who administer self-funded employer health plans will flourish," Lindsay says. "I expect to see growing employer interest in self-funding, especially in the under-500-life market. These ASO [administrative services only] providers will need to innovate because the approach used by large employers will not fit the small employer market expansion." However, a recent report by the financial industry research firm S&P Capital IQ suggests that, with exchanges providing a government-subsidized alternative, many employers may eliminate employee insurance plan contributions and elect to pay the $2,000-to-$3,000-per-employee penalties imposed under the ACA instead.

The Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) projects managed care penetration in government health plans will grow substantially over the coming years as federal and state officials, as well as consumers, look to control costs. Federal law requiring better coordination of "dual eligibles"—individuals who qualify for both Medicare and Medicaid—is expected to spur increased utilization of managed care in both programs.

"Medicare Advantage (MA) plans will continue to expand because of consumer demand for them," says Lindsay. However, beginning in 2015, sequestration cuts, designed to curb the federal budget deficit, will reduce government reimbursements to MA plans, threatening profitability. As a result, plans are variously expected to exit some markets, reduce plan offerings, reduce benefits, or narrow networks. "The degree of (MA) insurer success will vary geographically because of rating rules," Lindsay adds.

**UNEXPECTED SUCCESS IN WAKE OF ACA LANDSCAPE**

By Bob Pieper

"Today's managed Medicaid, already on the upswing, is likely to continue growing as a result of Medicaid expansion under the ACA and more states turning to managed care as a Medicaid cost control. However, managed Medicaid is generally a slim profit endeavor for the insurers who run the plans. A few plans are betting that more dual eligibles will help improve profit margins.

"Individual insurance sold through the public exchanges will expand with time, (as will) consumer acceptance of this new market force," says Lindsay. But insurer profitability will likely vary depending on the demographics of who enrolls and the effectiveness of the insurer case management in dealing with pent up demand for care, he notes. "I expect great volatility in this market," says Lindsay.

Some 7.3 million people obtained and paid for coverage through public health insurance exchanges this year. Another 700,000 selected but never paid for exchange plans after either finding coverage elsewhere or simply opting not to pay premiums. CMS Administrator Marilyn Tavenner told the House Committee on Oversight and Government Reform last month.
ONC’S PLAN TO SOLVE THE INTEROPERABILITY PUZZLE

By MEDICAL ECONOMICS EDITORS

HEALTHCARE IS A DECADE AWAY from a national, interoperable health information technology platform. And while infrastructure expansion and improvements will advance at a blistering pace over the next three years, more work is clearly needed, says Karen B. DeSalvo, MD, MPH, MSc, the national coordinator for Health Information Technology of the U.S. Department of Health and Human Services (HHS) in an exclusive interview with Medical Economics.

In fact, despite dismal numbers of physicians and institutions attesting to the government’s meaningful use stage 2 of the electronic health record (EHR) incentive program so far in 2014 (see table, page 72), DeSalvo says the slow start isn’t indicative of a stalled program, rather one that is in a fluid state of development and policymaking.

In doling out more than $24.6 billion in EHR incentives from 2011 to June 2014 to about 408,000 healthcare providers, the government is in this for the long haul.

The payoff, DeSalvo says, will be an interconnected, digital healthcare platform built to share and learn to improve healthcare delivery and, ultimately, better protect public health. An interoperable technological infrastructure will cut duplication of testing, streamline the gathering and dissemination of medical information all contributing to the inefficiencies of a U.S. healthcare system fragmented by size and specialty.

“It is very important for our country to digitize one-fifth of this economy,” DeSalvo says, “and have a much better way to address the [needs of the] population and public health at the same time.”

THE VISION

The government’s push to digitize health records is about public health. Digital medical records will help in gathering data for comparative effectiveness research; they will help public health officials better respond to outbreaks or other health emer-

“MY GOAL IS THAT WE SET A PATH TOGETHER AND A ROAD MAP SO THAT EVERYONE CAN BE BROUGHT ALONG.”

—KAREN B. DESALVO, MD, MPH, MSc, THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
gencies, and they will give physicians analytical and clinical tools to better assess their patient populations to prevent disease, intervene before a major health event, or prevent unnecessary hospitalizations.

And its success and failure relies on IT systems that have the ability to securely exchange healthcare data. That’s why the concept of interoperability is so crucial and so heavily tied to the government’s meaningful use 2 EHR incentive program and meaningful use 3.

Ultimately, a fully functioning interoperable healthcare system would make “the right data available to the right people, at the right time across products and organizations in a way that can be relied upon and meaningfully used by recipients,” ONC says in a white paper detailing “A 10-Year Vision to Achieve an Interoperable Health IT infrastructure.”

So, what is interoperability? The Healthcare Information and Management Systems Society (HIMSS) describes it this way:

“In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged.” Data could be shared by clinicians, labs, hospitals, pharmacies and patients regardless of the application or vendor.

“Interoperability means the ability of health information systems to work together within and across organizational boundaries in order to advance the health status of, and the effective delivery of healthcare for, individuals and communities.”

In practice, an interoperable system would allow physicians to easily transfer or view patient health information from other physicians or healthcare organizations involved in the care of their patients, receive hospital notifications regarding their patients, or review recommendations from a nurse practitioner in a retail clinic if treatment was initiated, and much more.

“Health is more than getting people to a doctor,” DeSalvo says. “It’s about where they live, learn, work and play. It’s about the choices our patients make when they leave our offices.” Technology has the ability, for the first time, to free providers from the confines of the examination room and help guide health decisions in ways physicians would think unimaginable just a decade ago.

Remote monitoring and telehealth are just two examples that offer promising and novel approaches to care delivery, DeSalvo says, and it’s the technological innovation that will make it a reality.

British writer Arthur C. Clarke was credited with three laws of prediction. In this case, the third law applies, DeSalvo says: Any sufficiently advanced technology is indistinguishable from magic.

**THE REALITY**

In 2014, HIT hasn’t been able to wave its wand to make interoperability appear for most office-based practices.

Continued on page 19
## Medicare EHR Incentive Payment Schedule for Eligible Professionals (EP)

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## Medicaid EHR Incentive Payment Schedule for Eligible Professionals

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Source: ONC
Continued from page 17

While there have been successes related to tasks like e-prescribing, development of health-care information exchanges, and adoption and use by larger healthcare systems, DeSalvo says, office-based practices are feeling the growing pains associated with time to input data, workflows, costs, patient engagement, or simply do not yet see the benefits to patient care.

Many primary care physicians are frustrated, according to recent Medical Economics surveys about the current state of EHR technology. Physicians are pressed for time and money, and this new technology seems to be placing even more demands on both.

While health information technology is in its adolescence, DeSalvo says, the history of advances in cell phone technology offers a glimpse of the future.

In the early days, cell phones were cumbersome, the batteries died far too quickly, and coverage was limited in most cases, DeSalvo says. The introduction and adoption of smart phones not only happened quickly, it was transformative, and represents the kind of magic technology can deliver.

"My expectation and hope for the e-health environment is that we let innovation happen in such a way that we are making the care experience as magical as it should be, so the joy of medicine comes out and electronic health records are part of a larger portfolio of support for electronic health information, [and so] that doctors and other providers really focus on patients and health as opposed to technology," she says.

"My goal is that we set a path together and a road map so that everyone can be brought along," she says. "At the end of 10 years, this country will have built an interconnected data and communications system. In the next three years, we have to get the basic infrastructure, the fundamentals in place."

According to DeSalvo, while that work is happening, technological advances are posing many other questions related to portability, contracting, care coordination, physician payments, and patient-generated health data. Ultimately, "technology is pushing us to consider that this is also coming faster than we thought."

Technology’s great evolution will be used to help build tools to enhance the relationship between patients and physicians, to improve access to care and their knowledge about care decisions, DeSalvo says.

But it will take time.

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**ONC’s technology goals**

**3-year vision**

Improve interoperability so providers can send, receive, find and use essential health information.

**Examples of some tasks include:**
- Look up immunization histories
- Share basic patient information between primary care physicians and specialists
- Receive automated hospital electronic notification care summaries following discharge.

**6-year vision**

Technology’s evolution will better enable patients to be “active participants in managing their care, especially as it relates to patient experience, self-rated health, and self-generated data.” Individuals, care providers, and public health departments will send, receive, find and use an expanded set of health information across the care continuum to support team-based care.

**Examples of some tasks include:**
- Patients routinely contribute information to their health records
- Patients integrate data from their health records into apps and other health tools
- Clinical settings and public health are connected through bi-directional interfaces that enable seamless reporting to public health departments
- Patients manage information from their own devices and share the information seamlessly across multiple platforms
- Clinical decision support. Clinical trial recruitment, data collection and analysis will be more standardized, and health information technology systems will enable analysis of aggregated data and use of local data to support health research and public health. Individuals, care providers, and researchers contribute information shared across the health IT ecosystem, with rapid advancement in methods for deriving meaning from data without sharing PHI.

**10-year vision**

“Advanced, more functional technical tools will enable innovation and broader uses of health information to further support health research and public health.” Data collection will be more standardized, and health information technology systems will enable analysis of aggregated data and use of local data to support health research and public health. Clinical trial recruitment, data collection and analysis will be accelerated and automated.

- Patients manage information from their own devices and share the information seamlessly across multiple platforms.
- Clinical decision support. Clinical trial recruitment, data collection and analysis will be accelerated and automated.
- “Individuals, care providers, public health and researchers contribute information shared across the health IT ecosystem, with rapid advancement in methods for deriving meaning from data without sharing PHI.”

Source: Connecting Health and Care for the Nation: A Ten Year Vision to Achieve Interoperable Health IT Infrastructure
STAR RATINGS TAKE CENTER STAGE
Payments will only be awarded to four-star or higher Medicare plans starting January 1, 2015 by JOANNE SAMMER

Now that the star ratings program run by the Centers for Medicare and Medicaid Services (CMS) is a formal program and no longer a demonstration, health plans need to quickly adjust to the program’s new and more stringent requirements.

“In January, CMS will only award payments to plans with ratings of four stars or higher,” says Mike Burgin, vice president and general manager of clinical and quality outcomes at Inovalon, a data analytics company in Bowie, Maryland. “That is likely to have a significant and adverse effect on the financials of any plan that does not meet that threshold.”

This is especially true as continued pressure on Medicare payments reduces plans’ already thin profit margins.

“Many plans are profitable or unprofitable based on this bonus,” Burgin says.

Getting better
Maintaining and improving star ratings won’t be easy. The measures for attaining the four-star designation are only getting more difficult.

“For certain measures, raising the bar means higher cut-points, and also greater weights for measures that are no longer in their introductory year,” says Vanessa Pawlak, a senior manager in the healthcare advisory practice at Ernst & Young. “CMS is also making changes based on the lessons the demonstration has provided, such as considering modifications to the methodology for calculating Part D measures and including measures for complex care—for example, within special needs plans.”

To drive better Medicare star ratings in this environment, Pawlak suggests that plans increase integration between medical and pharmacy.

“Some of the highest rated plans over the demonstration period were contracts that had more integrated healthcare benefit designs,” she says.

To enable this type of integration, she recommends leveraging programs or improvement initiatives that have multiple impacts points.

“For example, influencing the medication therapy management program not only helps with managing chronic conditions, where plans have traditionally struggled, but also helps with the member experience, patient safety, drug pricing and so on,” says Pawlak. “The idea is to enable programs and improvement initiatives that simultaneously impact clinical, administrative and operational aspects of the care continuum and the stakeholders within it.”

From an administrative standpoint, plans must make sure they have the data and technology infrastructure necessary to track and manage performance measures.

If plans do not have access-relevant data or have the tools to help analyze that data, monitoring and measuring performance becomes much more difficult.

Citizens Choice, a Medicare Advantage plan in southern California, has developed an alert system to ensure that the plan knows where it stands on each measure on a daily, weekly and monthly basis.

“This way, monitoring performance becomes part of the daily routine and not just a two-month project to meet a number,” says Ken Kim, MD, chief medical officer for Alignment Healthcare in Irvine, California, which recently acquired Citizens Choice. “I would like to know on a daily or weekly basis where I stand with all the measures.”

For example, to improve care management for patients with rheumatoid arthritis, Kim says that the plan needs to know immediately whenever patients are diagnosed to ensure they are on the proper medication and getting the necessary physical therapy.

“If your reports are run months after the diagnosis, the resulting intervention could be too late,” he says. With a daily alert, “it becomes part of the clinical delivery system.”

Influencing outcomes
Health plans cannot improve their star ratings on their own. Many of the measures will depend on the actions of providers and plan members. Therefore, “a strong clinical connection and working
The relationship with providers is essential,” says Kristen Neal, vice president for Stars Part C & Clinical at Cigna-HealthSpring. This helps the plan keep performance high on clinical measures and provides a clear link to members.

“We emphasize the clinical measures because we have that interaction with the physician,” says Neal.

However, a plan’s link to patients is also critical. After all, it’s the patient who has to get that prescription filled and follow the physicians’ directions for their day-to-day care. Having clear ways to maintain communication with members is crucial for follow up and reminders. For example, patients may not be taking their medication or may be experiencing side effects that they do not communicate to their providers.

Some plans have invested heavily in provider liaisons and case managers to support members. This is not limited to large plans. Kim notes that Citizens Choice’s small plan size can be an advantage.

“We can afford to be a little more personal and individualized,” he says. “We have hired a physician liaison who makes in-person visits to doctors’ offices rather than just sending them a bunch of data or making a phone call.”

### An era of constant change

In many ways, the star-rating program now defines Medicare Advantage plans in the eyes of potential members and other stakeholders.

“The stars are almost like your reputation,” said Kim.

However, the ratings program is not static and the changes taking hold in January are not likely to be the last for the program. Like most areas of healthcare, the star ratings program is likely to continue evolving over time, and plans need to pay attention to those changes.

“The stars program seems like just another small program,” says Pawlak. However, its ratings stand out in the healthcare marketplace that is becoming increasingly focused on quality, outcomes and helping consumers take a more active role in their care.

“It’s only a matter of time before stars spreads to Medicaid, the exchanges and commercial business,” she says.

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**What drives the stars?**

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<tr>
<td>Make it a priority</td>
<td>Senior management needs to assign resources and responsibility for improving star ratings. An organization-wide focus on quality starts at the highest levels.</td>
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<td>Push it down into the organization</td>
<td>Everyone involved in the plan and the healthcare delivery system for members needs to be involved in improving performance against metrics. That means providing appropriate incentives that are aligned with what is required, including desired actions and outcomes, and communication about and support for required changes.</td>
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<td>Provide feedback</td>
<td>The plan needs to know how it is performing on specific metrics and so do providers.</td>
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<td>Develop a supporting infrastructure</td>
<td>The right systems can help plans keep tabs on their performance and collect and share necessary data with providers. Data should be integrated and shared across the organization and delivery system.</td>
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<tr>
<td>Focus on members</td>
<td>If members are to take control of their healthcare, they need the tools and information to support those efforts. Becoming a member-centric plan is an important goal for plans that want to improve their star ratings. That means finding ways to manage members holistically across the continuum of care.</td>
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<td>Reinvest in the program</td>
<td>During the star rating demonstration, non-profit plans tended to out-perform for-profit plans. Vanessa Pawlak, a senior manager in the healthcare advisory practice at Ernst &amp; Young, suggested that this can be traced to non-profits’ practice of reinvesting in the organization and using those resources intelligently to improve star ratings over time.</td>
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<td>Get to know the requirements</td>
<td>CMS, which runs the star ratings program, has certain expectations of plans. “Plans that have been in the Medicare business longer have been through enough CMS scrutiny to more clearly understand CMS expectations, intent and the rules,” said Pawlak. Compliance is another key area for focus. Plans will be penalized for compliance violations, such as marketing outside the window allowed for Medicare Advantage plans.</td>
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Source: Managed Healthcare Executive

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**Joanne Sammer** is a freelance writer based in Kansas City, Kansas.
FOSTERING HOSPITAL-PHYSICIAN RELATIONSHIPS

When physicians and hospitals have a robust and interdependent relationship, everyone wins by JOHANNA EPSTEIN

Historically, physicians and hospitals have had an almost adversarial relationship that too often has been characterized by a lack of trust. But recent shifts in healthcare now emphasize the need for greater cooperation between them.

For example, payers now are tying reimbursement to outcomes such as reductions in unnecessary readmissions, operating room times, and disease rates. Hospitals cannot meet these expectations without the help of physicians.

On the flip side, the infrastructure required to engage in timely and accurate data reporting is becoming too great for physicians to handle on their own. Furthermore, patients are demanding a better overall healthcare experience.

Building robust physician-hospital relationships can be challenging, but the benefits to all parties—patients, providers, hospitals and payers—are significant. Here are five strategies for strengthening physician-hospital relationships that can lead to better clinical decisions and patient care:

1. Set expectations
When developing a physician contract, hospitals should clearly define their expectations in terms of performance improvement activities such as reducing infections, establishing better communication with nurses or achieving clinical benchmarks. Physicians should be involved in setting these expectations and in making strategic decisions about how to support them.

2. Put a physician leadership structure into place
To keep the hospital-physician partnership alive and growing, hospitals need physician leaders who are adept at fostering communication by reaching out and listening to their colleagues. These individuals should frequently visit providers to talk about expectations and share data. Physicians do not want to feel they are being managed by hospital administrators. Therefore, it is critical for physician leaders to take a visible and active role in establishing and sustaining rapport among their peers.

3. Offer something tangible
For physicians to feel that they are fully part of an organization, they need to see how they are benefiting from the arrangement. While money is certainly a motivator, it is not necessarily the best or only one. Sharing technology can be a great way to engender a partnership while also improving a hospital’s interoperability. Hospitals that share their electronic health records (EHRs), for example, make it easier for physicians to “talk” clinically with the hospital. At the same time, physicians gain the ability to report information to payers along with the hospital, improving reimbursements for both parties.

4. Communicate frequently
Hearing from a hospital’s medical director once a year is simply not sufficient to foster a strong connection. Hospitals need to commit to regular two-way communications, such as bringing all affiliated and employed physicians together for quarterly dinner meetings with speakers, networking opportunities and chances to swap information.

5. Share decision-making
This may be the single biggest factor in solidifying physician-provider collaboration. Physicians need to feel that they are just as much a part of decision-making as the hospital CEO. As with all relationships, if physicians feel a hospital is hiding something, it can derail the partnership. When physicians and hospitals have a robust and interdependent relationship, everyone wins. Patients receive better care, physicians receive more support, the hospital achieves its goals for quality and cost reduction and payers save money—all because the ability to treat patients effectively goes up while the costs go down.
Innovative Ideas for Drug Utilization and Management

READMISSIONS DECLINE IN WAKE OF CMS PROGRAM

Medication reconciliation remains key

by MARI EDLIN

The rate of hospital readmissions declined slightly in the fourth quarter of 2012 following the launch of the Hospital Readmissions Reduction Program (HRRP), while reimbursements for hospitals with excess readmissions decreased by 1% in 2013.

Hospital reimbursements are expected to decrease by an additional 2% in 2014 and 3% in 2015, according to the Centers for Medicare and Medicaid Services (CMS), the agency that initiated the program.

The HRRP penalizes hospitals when patients with heart attacks, heart failure or pneumonia are readmitted within 30 days of discharge. By 2015, acute exacerbation of chronic obstructive pulmonary disease and elective total hip and knee arthroplasty will join the conditions that could trigger penalties. CMS chose the conditions based on their impact on patient volume and costs.

CMS estimates that the cost of readmissions for Medicare patients is $26 billion annually. More than $17 billion of that amount can be saved if patients receive appropriate care during their first admission, according to CMS.

The HRRP went into effect on October 1, 2012. CMS reported that the 30-day, all-cause readmission rate dropped to 17.8% in the fourth quarter of 2012 after averaging 19% for the previous five years, translating into an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries.

The Dartmouth Institute says that the biggest factors behind readmissions are:

- Patients are confused over which medications to take and when;
- Patients do not understand what’s wrong with them;
- Hospitals do not provide patients or doctors with important information or test results;
- Patients do not schedule follow up appointments with their doctors; and
- Family members lack sufficient knowledge to provide adequate care.

Medication reconciliation remains key

By Marise Dlin

Medical Home Initiative in 2006 in part to help reduce hospital readmissions. PHN helps facilitate patient follow-ups with primary care physicians within five to seven days of discharge.

To address readmissions, nurse case managers call patients within 48 hours and review medications, making sure they understand the need for them.

Geisinger has seen an approximate 36% reduction in readmissions annually since 2007 in sites backed by PHN, according to Graf.

Medication reconciliation—a must

About one-fourth to one-third of readmissions are due to medication problems such as non-adherence, estimates Robert Oscar, R.Ph., president and chief executive officer of Richmond, Virginia-based RxEOB, a provider of software applications for health plans and pharmacy benefits.

Oscar points to medication reconciliation—reviewing what a patient was prescribed prior to admission and post-discharge—patient education, and electronic information exchange among providers as important factors during the transition of care process.

Reconciliation helps avoid medication omissions and duplications that stem from patients being prescribed brand and generic drugs, says Oscar.

“Educating patients soon after discharge ensures they understand what they were taking before and after hospitalization in case there have been changes,” says Oscar.

It also helps them understand what to expect from a new drug so as to prevent non-adherence.
Pharmacy Best Practices

how to access new drugs, and how to manage insurance issues, he adds.

“When patients do not know what they are taking and why, it could put them back into the hospital,” says Oscar, who notes that pharmacists are in the best position to manage drug reconciliation.

With so many older adults on polypharmacy, Oscar emphasizes the need to work directly with patients. Caregivers at patients’ homes and doctors at long-term care facilities need to know all medications that a patient is taking.

Health systems need to engage staff to oversee patients after discharge. “Management should not stop once patients walk out the door,” Oscar says.

A different perspective:

Long-term care facilities

Marybeth Terry, Pharm.D., president, Southern Pharmacy Services in Pink Hill and Kernersville, North Carolina and Wytheville, Virginia, knows all too well the challenges associated with older adults and their multi-medication regimens. The pharmacy addresses the medication problems for residents of assisted living and skilled nursing facilities, adult care homes and independent living communities.

Terry believes that in many cases hospitals discharge patients without sufficient information. “If patients’ drugs are not reconciled after discharge, they can forget to take them and will land back in the hospital,” she says. “We have to look at patients as a whole, not just provide a Band-Aid approach.”

She applauds the HRRP for putting pressure on hospitals to focus more on patients at discharge. Noting that health plans have access to patient information and are focused on quality ratings, she says they have an opportunity to keep track of members during transition periods.

Terry agrees with Oscar that a lack of adherence, lack of understanding, and lack of coordination regarding medication can lead to hospital readmissions. She believes pharmacists are in the best position to monitor a patient’s drug use.

But a study published in the Journal of Managed Care & Specialty Pharmacy showed that providing comprehensive medication management services post-discharge did not have any significant effect on readmissions or emergency department visits at 30 days, 60 days and six months after discharge.

Other studies have indicated that interventions by pharmacists have helped reduce readmission rates. Southern Pharmacy relies on consultant pharmacists to work with doctors at different facilities to keep abreast of prescriptions because non-adherence is a major issue for many of the patients the pharmacy serves, Terry says.

Southern Pharmacy initiated a program in 2003 that monitors patients who are transitioning from a hospital to a long-term care facility. Pharmacists analyze patients’ disease states; compare medications prior to admission and at discharge; identify red flags such as duplications, omissions, adverse side effects and interactions; stay in communication with doctors; and keep track of all medications.

Terry says consultant pharmacists are available 24/7 to handle problems and to follow up with physicians if patients are not taking their medications appropriately. She says that it is not just a question of non-adherence but also improper doses and administration, along with misunderstanding by patients of why they are taking a particular drug.

Mari Edlin is a freelance writer based in Sonoma, Calif.
CMS EXTENDS ACCENTURE CONTRACT FOR HEALTHCARE.GOV WEBSITE

Functionality has improved but problems persist

by BOB PIEPER

Accenture Federal Services will operate the healthcare.gov website through July 10, 2015, under terms of a six-month contract extension issued September 2 by the Centers for Medicare and Medicaid Services (CMS).

That means Accenture, which took over the troubled health insurance website last January from CGI Federal, will maintain healthcare.gov through the second Obamacare open enrollment period which runs from November 15, 2014 to February 18, 2015.

However, neither Accenture nor the CMS has released detailed information on whether the firm has fixed lingering technical problems that continue to hinder payments to insurers and prevent enrollees from correcting errors in their accounts.

The federal health insurance marketplace’s second open enrollment period will be better than its first, Andy Slavitt, CMS deputy administrator, told a U.S. House of Representatives Energy and Commerce oversight subcommittee hearing earlier this year. However, it “won’t be perfect,” he cautioned.

Slavitt told lawmakers that although a number of important improvements have been made, work on the website will not be fully completed until sometime in 2015.

The U.S. Government Accountability Office (GAO), the investigative arm of Congress, wants CMS to put in place a mitigation plan to ensure timely and successful performance of the system.

Even its harshest critics agree that, today, healthcare.gov offers a far better consumer experience than when it was launched last October. A “technical surge” team of top information technology experts, appointed by the White House and led by former Google engineer Mikey Dickerson, successfully addressed most of the front-end issues that initially made it difficult for consumers to shop for insurance last fall. The website is now faster and more accurate.

However, a number of significant back-end problems remained when Accenture took over development of the site in January.

The CMS procurement document, which spells out terms of Accenture’s hiring, noted that healthcare.gov was still:
- Inappropriately denying Medicaid eligibility for many qualified consumers and sending inaccurate or incomplete enrollment information to state Medicaid agencies;
- Forwarding garbled or incomplete enrollment information to private insurers;
- Incorrectly determining the payment owed to private insurers or allowing the government to directly send electronic fund transfers for premium subsidies to insurers; and
- Not allowing consumers to correct errors in their enrollment information (many of which resulted from healthcare.gov malfunctions) or update their accounts to, for example, obtain coverage for newborn children.

During his Congressional testimony, Slavitt reported that coding corrections had largely eliminated problems with garbled or incomplete information. The Medicaid registration problems had likewise been largely solved.

However, the marketplace was still unable to perform all functions needed to correctly pay insurers or allow consumers to update enrollment information.

“Today we are paying the (insurance) issuers at an estimated basis …” Slavitt said, “... by the end of this year they’ll begin to get paid at a policy-level basis ...”

Next year, programmers will finish linking healthcare.gov to the back end of CMS’ system, he told lawmakers.

Slavitt would not promise the oversight subcommittee that healthcare.gov, will be “fully ready” in November, when people can start purchasing coverage for 2015.

The prospect of starting another enrollment period with important healthcare.gov functions still under construction raises concerns for the GAO.

If management of the website’s development project does not improve, “significant risks remain
Technology

that upcoming open enrollment periods could encounter challenges,” William Woods, the GAO’s director of acquisition and sourcing management, told the subcommittee. Two GAO reports, criticizing the development of healthcare.gov and the government’s management of the project, were released in conjunction with the hearing. To improve the development and management of federal IT resources, the White House announced in August the formation of the United States Digital Services (USDS), a corps of top information technology professionals charged with ensuring that state-of-the-art practices are followed in the development of government websites.

The new unit, headed by tech surge leader Dickerson, is intended to ensure that mistakes made in the development of healthcare.gov will not be repeated in the development of other federal sites.

The USDS staff have not said what role, if any, they will play in remedying the remaining problems with healthcare.gov; however, IT experts who spoke with Managed Healthcare Executive suspect they will have a role.

Accenture’s contract to run healthcare.gov had been set to expire in January. Earlier this year, CMS raised the prospect that a third IT services firm may be brought in to take over the website.

In July, CMS released an 84-page solicitation for a contractor “capable of working under aggressive time constraints” to provide analysis, design, development, testing, implementation, documentation, services, maintenance and support for the federal health insurance exchange. Responses were originally due August 18; but that deadline was extended to September 18.

CMS had hoped to announce the successful bidder no later than 60 days before the November 15 start of the next enrollment period. That would have given Accenture two months to transition operation of the site to the new vendor. However, CMS officials decided that was too tight a time frame, so CMS now expects to award a new contract in February 2015.

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CMS implementing GAO security recommendations

The Centers for Medicare and Medicaid Services (CMS) is moving quickly to implement Government Accountability Office (GAO) recommendations to improve the security of the healthcare.gov website, before the November 15 start of the next open enrollment period, CMS Administrator Marilyn Tavenner told a congressional hearing last month.

A GAO audit, released September 18, makes six recommendations to implement security and privacy controls to enhance the protection of systems and information related to healthcare.gov:

- Ensure that system security plans for the Federally Facilitated Marketplace (FFM) and data hub contain all information recommended by the National Institute of Standards and Technology;
- Ensure that all privacy risks associated with healthcare.gov are analyzed and documented in privacy impact assessments;
- Develop computer matching agreements with the federal Office of Personnel Management and the Peace Corps to govern data that are being cross checked with CMS data to verify eligibility for tax credits and cost-sharing reductions;
- Perform a comprehensive security assessment of the FFM, including the infrastructure, platform and all deployed software elements;
- Ensure that the planned alternate processing site for the systems supporting healthcare.gov is established and begun in a timely fashion; and
- Establish security roles and responsibilities for contractors, including participation in security control reviews, to ensure effective communication among individuals and entities with responsibility for the security of the FFM and its supporting infrastructure.

The GAO report also makes 22 recommendations to resolve technical weaknesses in security controls.

The U.S. Department of Health & Human Services has agreed with three of the six privacy and security control recommendations, partially agreed with three, and agreed with all 22 technical recommendations, as well as outlined plans for implementing them. Testifying before lawmakers a day prior to the GAO audit release, Tavenner reported that 19 of the technical recommendations had already been implemented.

ADVERTISER INDEX

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A study appearing in Health Services Research by Independence Blue Cross and CTI Clinical Trial and Consulting Services demonstrates fewer emergency department visits for chronically ill patients cared for in a patient-centered medical home. The study—the largest of its kind with claims data from approximately 460,000 Independence beneficiaries enrolled in 280 primary care practices—found that the transition to a medical home was associated with a statistically significant 5% to 8% reduction in emergency department visits. These reductions were most evident among patients with diabetes, who experienced a 9.5% to 12% reduction. In other Independence news, the insurer won a 2014 Digital Accelerator Award, sponsored by Apigee, in the Best Data Analytics for Digital Business category. Independence uses its big data and predictive analytics to help solve challenging healthcare problems, and to better serve its customers.

Aetna and Baylor Scott & White Quality Alliance have signed a new accountable care collaboration agreement, introducing co-branded Aetna Whole Health plans to members in North Texas. These members will benefit from access to more than 900 primary care physicians, 27 hospitals, 2,800 specialists and six urgent care facilities in the Dallas/Fort Worth Metroplex. The plans were effective for self-insured customers on October 1, 2014, and are anticipated to be available for fully insured customers in early 2015. Additionally, Aetna announced a new accountable care agreement with Weill Cornell Physicians, Cornell University’s physician group, to enhance care for approximately 9,000 of Aetna’s commercial and Medicare members in New York. The accountable care arrangements involve the Weill Cornell Physicians’ 1,237 doctors, healthcare professionals and care managers who work closely with Aetna to coordinate healthcare services and demonstrate high-quality medical care.

Avalere Health examined access to 11 drugs used to treat rare diseases in a subset of bronze- and silver-level exchange plans in the 15 largest states. Results showed that, on average, these drugs were covered 65% of the time across plans; wide variation in plan use of utilization management by drug from 6% to nearly 75%; frequent placement of drugs on the highest tier of four-tier formularies; and greater than 70% of plans using coinsurance ranging from 10% to 50% in silver plans. The analysis was published in September in the Journal of Managed Care & Specialty Pharmacy. Analysis was funded by Novartis Pharmaceuticals.

Four Kaiser Permanente leaders have been named to Diversity MBA Magazine’s Top 100 Under 50 Diverse Executive & Emerging Leaders list. Margaret Lapiz, vice president, The Permanente Medical Group; Rich Smith, vice president, Human Resources, Northwest Region; Julie Stoss, vice president, Government Relations; and Todd Trotter, senior director, National Human Resources, Compliance, and Enterprise Risk Management, were recognized by the publication for their outstanding leadership. Diversity MBA Magazine serves multicultural professionals in corporate America as well as business students and entrepreneurs.
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